Improving choices and options - The views of ACT women about their sexual and reproductive health needs

Julia Tran

October 2018

Acknowledgements

WCHM would like to thank the ACT women who gave their time to contribute their views, experiences and opinions to this research - either as survey respondents or focus group participants. By sharing their views and experiences, we are able to influence and shape improved access and service responses in the ACT that will better meet their sexual and reproductive health needs and address their identified barriers and preferences.

Our thanks also to those local service providers that assisted WCHM throughout the research process, by providing input to our discussions about their views on the experiences of women and for assisting by promoting the research survey widely to women across the ACT. Special thanks goes to those organisations who helped in informing the design of the consultation and the questions, especially Sexual Health and Family Planning ACT and the Women's Health Service, and for contributing their specific expertise and valuable insights.

whm!
women's centre for health matters

Publication/Copyright Information

ISBN 978-0-9944342-9-6

About Women's Centre for Health Matters Inc.

The Women's Centre for Health Matters Inc. (WCHM) is a community based organisation which works in the ACT and surrounding region to improve women's health and wellbeing. WCHM believes that the environment and life circumstances which each woman experiences affects her health outcomes. WCHM focuses on areas of possible disadvantage and uses social research, advocacy, community development and health promotion to provide information and skills that empower women to enhance their own health and wellbeing, and to influence systems change with the aim to improve women's health and wellbeing outcomes.

About the Author

Julia Tran is a Health Promotion Officer at WCHM. Prior to joining WCHM, she worked as a research assistant in dementia and music at the MARCS Institute of Brain, Behaviour and Development, and interned in the Mental Health and Substance Abuse Unit at the Western Pacific Regional Office World Health Organization in the Philippines.

Supported by
ACT Government Health

Table of Contents

Executive Summary

The nature of women's sexual and reproductive health means that women need to use health services frequently, and over their life course. And sexual and reproductive health is linked to many other aspects of women's health, including maintaining their physical and mental health and wellbeing.

In the ACT today, it is true more than ever that there are more choices and options for ACT women so that they can manage and control their sexual and reproductive health needs, particularly in relation to their access to health screening support, their choices of contraception, and their options for termination of pregnancy.

ACT women should be able to access accurate information and timely affordable health care and services which are appropriate for these needs regardless of where in Canberra they live and how much money they have. But these improvements in options and access can be affected by women's social and economic circumstances - the social determinants of health.

This local ACT consultation by WCHM was an opportunity for ACT women to share their views about their sexual and reproductive health needs and for WCHM to understand which information and services ACT women access for their sexual and reproductive health including contraception, STIs, access to health screening, and termination of pregnancy; their knowledge and to find out what was working and not working for them.

The feedback from women in this research reinforces the impacts that the social determinants of health have on women's choices and access and highlights the social and financial impacts that ACT women can face in managing their sexual and reproductive health regardless of their age or socio-economic background.

The findings in this report highlight that women's barriers in this important area of their health include availability, affordability, and the accessibility and appropriateness of health services, supports and information, including the low number of bulk-billing GPs. And that women's work and caring responsibilities can impact on their ability to organise their time to focus on their sexual health and wellbeing. And because women in the ACT come from diverse backgrounds they require a range of sexual and reproductive health options to cater to their different needs.

For women to be able to make informed decisions about what is most suitable to them in their current life stage, and social and cultural context, ACT women told us they wanted access to accurate, reliable and up to date local information about their options so that they could choose and be informed about options which are most suitable for them. But this research shows there is a lack of access to reliable local information to inform their choices.

They wanted to be certain that the health service they access is a safe space where they can discuss their individual needs without judgement to maintain good sexual and reproductive health but identified that this was not always the case.

And while the financial and social situations and the different health needs of women can create barriers to accessing health care services, ACT women told us that the way that the health care system is organised can create barriers for women for them in being able to access effective health care and support when they need it, including the location of services with many of the specialist services located in the city or Woden.

The feedback from women in this report highlighted opportunities for improving access to sexual and reproductive supports in the key town centres. The consideration of community based health responses using points of access such as the Walk in Centres figured in the comments of many women, and in the suggestions for opportunities to adjust the service system to respond to the issues raised by women.

We asked women about their views and experiences of health screening services, and access to contraception and abortion.

The *Health (Improving Abortion Access) Amendment Bill 2018* will now provide women with a more accessible and hopefully affordable access to medical abortion, once the changes are implemented within the next 12 months. Which means that women will be able to make a choice not only about whether they want a health procedure, but also about who their healthcare provider will be. But women in our research reminded us that that having a job or assets is not the same as having available cash so there is a need to consider how the legislation can be matched with other supports, including financial, especially for those on lower incomes.

The research also highlighted that the affordability of contraception and the lack of knowledge by doctors about the wide range of contraception options can impact on ACT women's choices.

These findings help to fill gaps in our knowledge about equity of access and choice in sexual and reproductive health for women in the ACT and surrounding areas and show that there is still more work to do if we want all women to have the right choices for their circumstances.

WCHM hopes that this report will help to ensure that the voices of ACT's women about their sexual and reproductive health issues and health needs are recognised in the design of services and policy discussions about the sexual and reproductive health and wellbeing responses for women which are still needed in the ACT. And that this will improve local service responses and information provision so that they are responsive to the needs identified.

Introduction

WCHM has undertaken several consultations over the years with ACT women about their physical and mental health and wellbeing needs, which identified the need to explore the sexual and reproductive health needs and barriers to access for women in the ACT – especially given the impact it has across the whole life course of women.

Few qualitative studies have been conducted exploring sexual and reproductive health service experiences among Australian women. Most studies have been about the clinical provision of contraception rather than the women's experience of contraceptive use and of obtaining their preferred contraception. In addition, there is no substantial quantitative data on the prevalence of contraceptive use and access to safe terminations of pregnancy (TOP) in Australia in the last decade.

It is for these reasons that WCHM undertook a consultation with ACT women about their sexual and reproductive health including contraception, STIs, access to health screening, and termination of pregnancy, to understand the following questions:

- How ACT women access information about their sexual and reproductive health;
- How and where ACT women are accessing sexual and reproductive health services;
- Whether there are gaps and barriers to their access;
- How comfortable ACT women feel in seeking services and advice from health care providers about their sexual and reproductive health; and
- What is working and not working for them.

This report summarises the results of the consultation and provides the findings and narratives of the 510 ACT women who responded and completed all the survey questions, and of the 54 women and 24 doctors and nurses who participated in focus groups or interviews.

This report comprises several parts. The first part describes the methodology used and is followed by a review of the literature.

The findings are then presented, including the demographic characteristics of the survey respondents, and the responses for each of the main sections of the survey: sexual health, sexually transmitted infections (STIs), screening, contraception, and termination of pregnancy.

The discussion section explores the major themes from the consultation and looks more closely at the health issues, barriers and experiences facing women with disabilities in the ACT, and their preferences.

The conclusion outlines the overall key findings from the feedback.

Recommendations

1. WCHM and SHFPACT to work with ACT Government on increasing the accessibility for women and improving the affordability of sexual and reproductive health responses, including medical and surgical abortion.

2. WCHM and SHFPACT to work with the Capital Health Network to explore opportunities for working together to inform more affordable and accessible options for sexual and reproductive health services and support, and to support GP responses for women.

3. WCHM to work with ACT Health to explore options for improving access points for women to access affordable and accessible local options for sexual and reproductive health supports.

4. WCHM to work with ACT Health and key local women's health providers to consider the issues raised by women about the need for better access to local sexual and reproductive health information for women in the ACT.

5. WCHM to consider further exploration of the information and service access needs for women in relation to menopause, polycystic ovarian syndrome (PCOS), and fertility treatment.

Methodology

The research design involved three phases — a survey, a literature review and focus groups/interviews.

The aims of the survey were to consult with and collect quantitative and qualitative data from women in the ACT and surrounding areas about their sexual and reproductive health, their access to services and information; their needs and barriers; explore their understanding about maintaining sexual and reproductive health; and seek their opinions and personal stories. The survey was also used to recruit women who wanted to further share experiences and ideas in a focus group or interview setting.

Respondents qualifying for the survey were women living or working in the ACT or surrounding regions, who were aged 16 or over.

The online survey was developed in Survey Monkey, and to attract participation in the online survey, information was distributed through WCHM's email and Facebook networks (both WCHM's Facebook page and paid Facebook advertising); other community organisations and service providers; flyers and community newsletters; WCHM's networks and those of other community organisations, service providers, and the Community Development Network. Advertisements were also placed on the WCHM website, Facebook, Instagram, RiotACT[1] and The Canberra Times[2].

The survey was open from 24 October 2017 until 24 November 2017.

There were 691 responses, however only 510 responses were complete and eligible for analysis. The report focuses on analysing the findings from those 510 completed survey responses, and the views expressed in the focus groups and interviews.

The quantitative data from the survey was analysed using Microsoft Excel, and qualitative responses were analysed using a thematic inductive analysis approach.

In total, 99 women from the survey expressed interest in participating in further discussion, and upon contact, 40 agreed to participate in a focus group, face-face interview or a telephone interview. Focus groups and interviews were also advertised on the WCHM website, Facebook, and distributed through WCHM's networks and additional 14 participants joined the conversation.

Over a span of two months, a total of 54 women participated in focus groups according to age groups and availability or interviews for those who were unable to attend focus groups or requested anonymity. Focus groups generally lasted 120 minutes and individual interviews lasted between 40 and 90 minutes.

The discussion questions were designed to further inform the survey results, inform participants of available sexual and reproductive health resources in the ACT, and explore areas that WCHM wanted to understand in more depth. The discussion questions focused on women's experiences throughout their information seeking and availability of resources, and accessibility of services to managing their sexual and reproductive health, including contraception and safe termination of pregnancy.

[1] E Davidson, 'Let's talk about sex', RiotACT, retrieved on 21 June 2018, https://the-riotact.com/lets-talk-about-sex/220928
[2] F O'Mallon, 'ACT Health Minister Meegan Fitzharris says review into abortion access ready next year', The Canberra Times, retrieved on 21 June 2018, https://www.canberratimes.com.au/national/act/act-health-minister-meegan-fitzharris-says-review-into-abortion-access-ready-next-year-20171117-gznwy6.html

Because of the low number of volunteers in the 15 - 18 year age group and 60 years and over for the focus groups, WCHM sought contributions from sexual and reproductive health service providers in the ACT about these age groups in the form of focus group, interview or written statement. In total, 24 doctors and nurses agreed to participate in the study.

Focus groups and interviews were audio recorded and transcribed for data analysis. Thematic inductive analysis approach was used to organise and code the data.

As with all surveys and focus groups conducted to date by WCHM, we used a non-probability convenience sample. This means that the survey was widely promoted and all women who met the qualifying criteria were welcome to participate. Therefore, the number of women in our sample does not reflect the population of women in the ACT and is not representative. Rather, the findings in this report provide an indication of the issues and captures the themes from a sample of ACT women.

Literature review

Objectives

The objectives of the literature review were to:

- explore the recent available research on women and their sexual and reproductive health including contraception, STIs, and termination of pregnancy;
- place the WCHM research findings within the context of national and international evidence based literature;
- examine the research on how women access and use health services and information for their sexual and reproductive health needs, and the barriers to that access, including the experience of specific groups of women.

The literature review involved searching a wide range of online databases and relevant publications. Searches included broad terms such as 'contraception', 'abortion', 'termination of pregnancy', 'sexually transmitted infections', 'information seeking', 'knowledge', and more specific terms such as 'access to contraception', and 'access to abortion'.

Sexual and reproductive health of women

Sexual and reproductive health is a priority health issue for women, affecting them at every life stage. Good sexual and reproductive health is recognised as the complete state of physical, emotional, mental and social wellbeing relating to reproduction and sexuality, and is fundamental to the overall health of the individual and population at large.[3]

The human rights of women include their right to have safe and satisfying sex lives free from coercion, discrimination, violence, and the capability and freedom to reproduce, if, when and how often they choose.[4] While sexual health is inextricably linked to reproductive health, it is important to consider them separately in their own right, particularly when it comes to policy and legislative changes and development.[5]

For women to be able to maintain their own sexual and reproductive health, it is critical that they have access to accurate information and safe, effective, affordable and acceptable health services including but not limited to contraception, sexually transmitted infection (STI) testing, health screening including mammograms and pap smear, fertility and maternity care as well as termination of pregnancy (TOP) services and support.[6,7] Women need to be well-informed and empowered to be able to take control and make their own decisions about their sexual and reproductive health and wellbeing.

The impacts of poor sexual and reproductive health are both human and economic, and the prevalence and experience of poor sexual and reproductive health varies among different population groups.[8] In Australia, this is particularly true for those from socioeconomically

[3] United Nations Population Fund, *Sexual & reproductive health,* 2016, retrieved on 20 October 2017, http://www.unfpa.org/sexual-reproductive-health
[4] Australian Medical Association, *Sexual and reproductive health,* 2014, retrieved on 25 October 2017, https://ama.com.au/position-statement/sexual-and-reproductive-health-2014
[5] Ibid.
[6] United Nations Population Fund, *Sexual & reproductive health,* 2016, retrieved on 20 October 2017, http://www.unfpa.org/sexual-reproductive-health
[7] Australian Medical Association, *Sexual and reproductive health,* 2014, retrieved on 25 October 2017, https://ama.com.au/position-statement/sexual-and-reproductive-health-2014
[8] Ibid.

disadvantaged backgrounds, Aboriginal and Torres Strait Islander women, migrant and refugee women, women from the LGBTIQ community, younger women, older women and women living in rural and remote areas. [9]

There is substantial evidence indicating that investment in women's sexual and reproductive health has the potential to significantly minimise costs to the healthcare system as well as demonstrated benefits at a personal, family and community level. [10] The broad benefits of ensuring improved access to and provision of contraceptives and family planning service alone is considerable, including the prevention of high-risk pregnancy and obstetric complications, the reduction in the number of unsafe abortions and its consequences, reduced morbidity and mortality from cancers of the reproductive system, reduced transmission of STIs, and greater control of the timing and spacing of children. [11]

And if women can successfully plan and space the birth of their children they are more likely to have higher educational attainment, increased opportunities for employment and higher social and political participation in their community.[12] More broadly, investment in the sexual and reproductive health of women contributes to improving the status of women, reducing poverty and inequality as well as contributing to economic growth.[13]

Contraception

Contraceptives have contributed to improving the health and wellbeing of women as well as the general population, reducing maternal and infant morbidity and mortality, physical and mental health benefits associated with being able to time and space the birth of children, enabling greater participation in the workforce and economic self-sufficiency for women.[14,15]

No routinely collected data on the use of contraception that is complete and reliable is available in Australia, however, estimates from the United Nations show that 67.8% Australian women between 18 and 45 years of age are protected by a method of contraception and 65.1% use modern contraception (i.e. excluding fertility-awareness based methods and withdrawal).[16]

While contraceptive use appears to be highly influenced by age and culture, recent data indicates that the oral contraceptive pill remains the most commonly used form of contraception among Australian women (33.6%), followed by tubal ligation (22.5%), condoms (21.4%) and vasectomy (19.3%).[17] Conversely, the use of long acting reversible contraception methods (LARCs) such as intra-uterine devices (IUD) and contraceptive implants and injections are among the least preferred options used by women of reproductive age.[18]

Australia is falling behind other developed countries when it comes to the uptake of long and reversible contraception (LARCs) despite the proven safety, and effectiveness of these

[9] Australian Medical Association, *Sexual and reproductive health,* 2014, retrieved on 25 October 2017, https://ama.com.au/position-statement/sexual-and-reproductive-health-2014.
[10] Ibid.
[11] Ibid.
[12] 'Committee on Health Care for Underserved, 'Access to contraception', T*he American College of Obstetrics and Gynaecology,* Committee Opinion no. 615, 2015, pp. 1-6.
[13] Australian Medical Association, 'Sexual & reproductive health', 2014, retrieved on 25 October 2017, https://ama.com.au/position-statement/sexual-and-reproductive-health-2014
[14] Ibid,
[15] United Nations Population Fund, 'Sexual & reproductive health', 2016, retrieved on 20 October 2017, http://www.unfpa.org/sexual-reproductive-health
[16] United Nations, Department of Economic and Social Affairs, Population Division, 'Contraception', 2017, retrieved on 25 October 2017. http://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2017.shtml
[17] D Bateson, 'Gaps in good birth control', *Medical Observer,* 2014, retrieved on 20 August 2018, https://www.medicalobserver.com.au/news/gaps-good-birth-control
[18] SL Larkins and P Page, 'Access to contraception for remote Aboriginal and Torres Strait Islander women: Necessary but not sufficient', *The Medical Journal of Australia*, vol. 205, no. 1, 2016, pp 18-19.

methods, with a success rate of approximately 99% for avoiding unintended pregnancies. [19,20] This high success rate is largely due to the fact that once inserted, depending on the type, they may last several years and require no daily human involvement, significantly reducing the risk of user error. [21] While the reasons for the delay in the uptake of LARCs is not fully understood, there appears to be a number of consumer and provider barriers. It is suggested that poor awareness of contraceptive items, misinformation and concerns about side effects, limited access and availability to well-informed and trained providers, inconsistent Medicare rebates associated across the contraceptive range may be contribute to women's inability to make well-informed decision the low uptake.[22,23]

Of all existing contraceptive types only the condom, the emergency contraceptive pill (ECP) and fertility awareness-based methods (i.e. diaphragms, withdrawal, and natural family planning) do not require a prescription from a GP or family planning clinic in Australia. Therefore, doctors working in these settings are typically the first port of call for women seeking contraceptive information and access. Best practice care involves patient-centred care where consumers collaborate in decision-making about their own health.[24, 25] Therefore, patients need access to providers who have accurate, reliable and up to date information about available contraceptive options so that women can freely choose which methods they would prefer and be informed about which is most suitable for their own situation.[26, 27]

While some contraceptive methods may be 98-99% effective in pregnancy prevention, some methods such as the condom and the oral contraceptive pill are susceptible to human error reducing typical use to 80% effective.[28] Even when contraception is used, the World Health Organization (WHO) estimates there would still be 33 million accidental pregnancies worldwide.[29] Estimates for Australia suggest that between one in three women experience an unintended pregnancy in their lifetime, and studies of Australian women considering abortion have shown that around two thirds of women were using contraception prior to becoming pregnant [30]. It is also estimated that half of unplanned pregnancies are terminated, so it is clear that access to affordable and appropriate contraception is important. [31, 32]

In Australia and internationally, the ECP has long been realised as a safe and effective way of avoiding unintended pregnancy. Since 2004, the ECP became available from pharmacies without prescription in Australia.[33] The rescheduling of the ECP is thought to have been successful in reducing barriers such as the time between the incidence of unprotected intercourse and obtaining the medication as well as the time and financial cost associated with

[19] D Bateson, 'Gaps in good birth control', *Medical Observer,* 2014, retrieved on 20 August 2018, https://www.medicalobserver.com.au/news/gaps-good-birth-control
[20] B Winner et al., 'Effectiveness of long-acting reversible contraception', *The New England journal of medicine*, vol. 366, no. 21, 2012, pp 1998-2007.
[21] Ibid.
[22] D Bateson, 'Gaps in good birth control', *Medical Observer,* 2014, retrieved on 20 August 2018, https://www.medicalobserver.com.au/news/gaps-good-birth-control
[23] SC Dixon et al., "As many options as there are, there are just not enough for me': Contraceptive use and barriers to access among Australian women', *The European Journal of Contraception and Reproductive Health Care*, vol. 19, no. 5, 2014, pp 340-351.
[24] C Dehlendorf et al., 'Patient-centered contraceptive counseling: Evidence to inform practice', *Current Obstetrics and Gynecology Reports*, vol. 5, no. 1, 2016, pp 55-63.
[25] K Gemzell-Danielsson et al., 'Use of contraceptive methods and contraceptive recommendations among health care providers actively involved in contraceptive counseling — results of an international survey in 10 countries', *Contraception*, vol. 86, no. 6, 2012, pp 631-638.
[26] SC Dixon et al., "As many options as there are, there are just not enough for me': Contraceptive use and barriers to access among Australian women', *The European Journal of Contraception and Reproductive Health Care*, vol. 19, no. 5, 2014, pp 340-351.
[27] DL Goldhammer et al., 'What do young Australian women want (when talking to doctors about contraception)?', *BMC family practice*, vol. 18, no. 1, 2017, pp 35.
[28] Children by Choice, 'Contraceptive choice', *Children by Choice*, retrieved on 20 August 2018, https://www.childrenbychoice.org.au/factsandfigures/contraception
[29] World Health Organization, 'Safe abortion: Technical and policy guidance for health systems', *World Health Organization*, 2nd ed. Geneva, retrieved on 20 August 2018, http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/
[30] Abigail W, Power C & Belan I (2008) 'Changing patterns in women seeking terminations of pregnancy: A trend analysis of data from one service provider 1996–2006' in *Australia and New Zealand Journal of Public Health* (Volume 32, Number 3) pp. 230–7(8).
[31] H Rowe et al., 'Prevalence and distribution of unintended pregnancy: The understanding of fertility management in Australia national survey', *Australian and New Zealand Journal of Public Health*, vol. 40, no. 2, 2016, pp 104-109.
[32] CE Rissel et al., 'Sex in Australia: Attitudes towards sex in a representative sample of adults', *Australian and New Zealand Journal of Public Health*, vol. 27, no. 2, 2003, pp 118.
[33] SY Hussainy et al., 'Provision of the emergency contraceptive pill without prescription: Attitudes and practices of pharmacists in Australia', *Contraception*, vol. 83, no. 2, 2011, pp 159-166.

a GP visit to obtain a prescription, which are particularly important for women in rural and remote areas as well as women experiencing socioeconomic disadvantage.[34,35] However one Australian study looking at the provision of the ECP without prescription, suggests that since the changes in legislation, despite an increase in the provision of ECP and increased availability and accessibility, there has been no major impact on unintended pregnancy and abortion rates.[36]

Despite the successes and the acknowledgment of the ECP as a responsible way of avoiding unintended pregnancy, research indicates that even though awareness of the ECP appears high, only a minority of women are accessing it after unprotected intercourse or a contraceptive failure.[37] Comprehensive data surrounding the use of the ECP in Australia is available, but it is suggested that factors such as lack of awareness about the ECP's availability without prescription and its effectiveness for up to 120 hours after unprotected intercourse, as well as the stigma associated with emergency contraception, concerns about lack of privacy in the pharmacy setting and consumer misinformation remain significant barriers for women wanting to access the ECP.[38,39,40]

One of the key limitations of most contraception apart from the male and female condoms, is their failure to protect against the transmission of sexually transmitted infections (STIs).[41] Condoms are highly effective at reducing the risk of contracting an STI, however have a high failure rate when it comes to avoiding unintended pregnancy.[42] Therefore, improving consumer and healthcare provider knowledge about the different types of contraception and the promoting the practice of dual protection to avoid both unintended pregnancy and STI infection is important for all women of reproductive age who are at risk of contracting an STI.[43]

Sexually Transmitted Infection and Health Screening

Women's adherence to reproductive health screening advice and recommendations is complex and impacted upon by diverse physical, emotional and psychological issues.[44] For example, many reproductive health screening practices involve exposure of and contact with intimate body parts with the health practitioner and discussion of potentially stigmatized topics such as sexual behaviours and sexual health practices.[45] Additionally, research suggests that women often find experiences of reproductive health screening as highly distressing with anticipated pain a major factor contributing to non-adherence to recommendations.[46,47]

---

[34] Marie Stopes Australia, *Emergency contraception awareness high but access low among Australian Women,* 2017, retrieved on 20 October 2017, https://www.mariestopes.org.au/your-choices/emergency-contraception-low-uptake-australia/
[35] SY Hussainy et al., 'Provision of the emergency contraceptive pill without prescription: Attitudes and practices of pharmacists in Australia', *Contraception*, vol. 83, no. 2, 2011, pp 159-166.
[36] Ibid.
[37] D Bateson, 'Gaps in good birth control', *Medical Observer,* 2014, retrieved on 20 August 2018, https://www.medicalobserver.com.au/news/gaps-good-birth-control
[38] D Bateson, 'Gaps in good birth control', *Medical Observer,* 2014, retrieved on 20 August 2018, https://www.medicalobserver.com.au/news/gaps-good-birth-control
[39] Marie Stopes Australia, *Emergency contraception awareness high but access low among Australian Women,* 2017, retrieved on 20 October 2017, https://www.mariestopes.org.au/your-choices/emergency-contraception-low-uptake-australia/
[40] SY Hussainy et al., 'Provision of the emergency contraceptive pill without prescription: Attitudes and practices of pharmacists in Australia', *Contraception*, vol. 83, no. 2, 2011, pp 159-166.
[41] SL Larkins and P Page, 'Access to contraception for remote Aboriginal and Torres Strait Islander women: Necessary but not sufficient', *The Medical journal of Australia*, vol. 205, no. 1, 2016, pp 18-19.
[42] D Bateson, 'Gaps in good birth control', *Medical Observer,* 2014, retrieved on 25 October 2017, https://jeanhailes.org.au/contents/documents/Resources/Medical__health_articles/Medical_Observer/2014/Gaps_in_good_birth_control_August2014.pdf
[43] SL Larkins and P Page, 'Access to contraception for remote Aboriginal and Torres Strait Islander women: Necessary but not sufficient', *The Medical journal of Australia*, vol. 205, no. 1, 2016, pp 18-19.
[44] A Ghane, K Sweeny and WL Dunlop, 'A multimethod approach to women's experiences of reproductive health screening', *Women's Reproductive Health*, vol. 2, no. 1, 2015, pp 37-55.
[45] Ibid.
[46] Ibid.
[47] AM Friedman et al., 'Obese women's barriers to mammography and pap smear: the possible role of personality', *Obesity*, vol. 20, no. 8, 2012, pp 1611-1617.

Further, women frequently reported loss of dignity, embarrassment and desire for better communication with the health practitioner as influential factors. [48,49]

Women who are overweight and obese also face unique challenges in addition to those experienced by the general population, with research suggesting they are less likely to receive screening for breast and cervical cancer despite their elevated risk. [50] A study by Friedman et al (2012) found that women who are overweight or obese not only experienced anxiety about perceived pain and discomfort, embarrassment and modesty, fear of cancer and perceptions of being low risk, they also reported feeling ashamed of their weight, being subject to rude and unsolicited comments by physicians about their weight and inadequate medical equipment such as examination beds and gowns. [51] With over 50% of Australian women being classified as overweight or obese these women remain an important group for targeted strategies to improve their experience of and participation in reproductive health screening.[52]

Health literacy, defined as an individual's capacity to obtain, process and understand basic health information and navigate health services, has also been identified as a significant factor influencing an individual's knowledge of and adherence to reproductive health screening recommendations.[53] Women from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander women, women with disabilities and women from socioeconomically disadvantaged backgrounds are more likely to have poorer health literacy than the general population, suggesting an increased risk of screening non-adherence and cancer diagnosis.

With cancers of the female reproductive system among the leading cancers in Australia and worldwide, improving women's health literacy is suggested to be one of the first steps to improving knowledge of reproductive health screening and reducing health disparities among some of Australia's most disadvantaged populations. [54]

According to figures from the Australian Women's Health Survey 2018, conducted by Jean Hailes, the main reasons that women undertook sexual health screening in the past five years were:

- Starting a new sexual relationship;
- Having unprotected sex;
- Thought their partner had another sexual partner;
- Thought they might have had a STI.[55]

These findings demonstrate that women in long-term monogamous relationships may not feel STI testing is relevant to them and therefore not do not see it as priority to be informed about contracting and preventing STIs and seek STI testing.

Safe termination of pregnancy

Abortion can be either spontaneous or induced, with the former often regarded as a miscarriage and the latter as a termination – a procedure that is performed to end a pregnancy.

[48] A Ghane, K Sweeny and WL Dunlop, 'A multimethod approach to women's experiences of reproductive health screening', *Women's Reproductive Health*, vol. 2, no. 1, 2015, pp 37-55.
[49] AM Friedman et al., 'Obese women's barriers to mammography and pap smear: the possible role of personality', *Obesity*, vol. 20, no. 8, 2012, pp 1611-1617.
[50] AM Friedman et al., 'Obese women's barriers to mammography and pap smear: the possible role of personality', *Obesity*, vol. 20, no. 8, 2012, pp 1611-1617.
[51] Ibid.
[52] Australian Bureau of Statistics, 'Overweight and obesity 2011-13', *Profiles of Health,* Australia, 2013*,* cat. no. 4338.0, 2013, retrieved on 7 November 2017, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4338.0~2011-13~Main%20Features~Overweight%20and%20obesity~10007
[53] K Kim and HR Han, 'Potential links between health literacy and cervical cancer screening behaviors: A systematic review', *Psycho-Oncology*, vol. 25, no. 2, 2016, pp 122-130.
[54] K Kim and HR Han, 'Potential links between health literacy and cervical cancer screening behaviors: A systematic review', *Psycho-Oncology*, vol. 25, no. 2, 2016, pp 122-130.
[55] Jean Hailes, 'Women's health survey 2018: Understanding health information needs and health behaviour of women in Australia', Melbourne, VIC, 2018, retrieved on 5 September 2018, https://jeanhailes.org.au/contents/documents/News/Womens-Health-Survey-Report-web.pdf

Abortion is a public health issue concerning all women of reproductive ages, and safe termination of pregnancy has been available to Australian women since the early 1970s. However, abortion law in Australia is decided at the local rather than national level.

In Australia, the number of healthcare professionals certified to prescribe or perform a termination of pregnancy (TOP) is growing, however, access to safe TOP is still difficult for women. Public provision of TOP is very limited - and mostly to critical cases.

Surgical termination of pregnancy

Surgical TOP (STOP) is the most known TOP procedure. It is performed under general anaesthetic or local anaesthetic with sedation. First trimester terminations are usually performed as a day procedure using vacuum aspiration. Later trimester terminations require dilation and curettage. This procedure involves the risk of anaesthesia and post-operative infection and complications such as uterine injury and excessive bleeding can occur.

Medication termination of pregnancy

Innovative technology has allowed abortions to occur whilst avoiding surgical technique in very early gestation (up to 9 weeks) and medication to induce a TOP has been proven safe and effective. Drugs for this procedure involves one, or in conjunction of mifepristone (RU486), misoprostol, and methotrexate.

Compared to STOP, the MTOP has allowed women to access safe TOP early, more private and is less time-consuming, less traumatic and less medicalised. This is especially important to women living in rural or remote areas, experiencing domestic violence, or young women where making multiple visits to a clinic can prove difficult in terms of time, money and transportation.[56] The availability of choice for women between MTOP and STOP has shown to be important for both women and service providers but does not end the spell for STOP as there will always be a need for Australian women based on later gestation, pre-existing conditions, and personal preference.[57,58] Since then MTOP became widely available on the Pharmaceutical Benefits Scheme (PBS) in 2013, the number of Marie Stopes Australia's patients choosing MTOP over STOP has grown from 24.7% in 2012 to 39.7% in 2017 and is catching up to countries such as England and France where MTOP has been available for much longer and is the preferred option.[59]

The latest national estimates of termination of pregnancy was published in 2005 using 1985 to 2003 data from Medicare claim statistics.[60] Currently in Australia, only South Australia and Western Australia health departments have current and available data on abortions. Therefore, changes and trends are difficult to estimate because data is not routinely collected for the ACT. Access to accurate abortion rates is vital to inform policy and workforce, and service development, but no current data is available for the ACT. Surgical TOP (STOP) for combined NSW and ACT can be estimated from the Medical Benefits Schedule Item 35643, however this is labelled under dilation and curettage in which there is no differentiation whether the procedure was carried out for an induced abortion or spontaneous miscarriage.[61]

[56] M Shankar et al., 'Access, equity and costs of induced abortion services in Australia: A cross-sectional study', *Australian and New Zealand Journal of Public Health*, vol. 41, no. 3, 2017, pp 309-314..
[57] D Newton et al., 'How do women seeking abortion choose between surgical and medical abortion? Perspectives from abortion service providers', Australian and New Zealand Journal of Obstetrics and Gynaecology, vol. 56, no. 5, 2016, pp 523-529.
[58] P Goldstone and M Thompson, 'The tyranny of distance for Australian women seeking abortion', *O&G Magazine*, vol. 20, no. 2, 2018, pp 45-47.
[59] Ibid
[60] A Chan and LC Sage, 'Estimating Australia's abortion rates 1985-2003', *Medical Journal of Australia*, vol. 182, no. 9, 2005, pp 447-452.
[61] The Department of Human Services, *Medicare Item Reports*, (Canberra, ACT: Australian Government), retrieved on 20 August 2018, http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

Termination of pregnancy (TOP) in the ACT

Since 2002, the ACT is the only Australian jurisdiction where abortion is not in the Crimes Act and there are no temporal restrictions on women.[62] The ACT regulates TOP in the same way as any other medical procedure and therefore lessens the stigma attached to abortion. This uniqueness in the ACT also means that the power of choice lies in women's hands as there is no need to obtain a specific justification or 'health exception' from doctors for women in the ACT to elect a TOP.[63]

With the approval of RU486 in the PBS,[64] MTOP became another available option for women in Australia requiring a safe TOP. However, the Health ACT 1993 law impeded the ability of qualified doctors to provide MTOP to women within the ACT without an approved surgical facility.[65] This meant women could only access approved provision of MTOP from the Marie Stopes Clinic, or GCA and the Tabbot Foundation which are located outside the ACT border in Queanbeyan, New South Wales.

In contrast, in New South Wales, Queensland, Western Australia and Tasmania, women can access medical abortion from licenced medical professionals prescribing RU486 in a general practice or telehealth setting without the need of providing consultation and prescription of the pills in an approved hospital setting.[66] Marie Stopes' ACT abortion service is open for a few days per week, therefore ACT women seeking TOP early need to travel interstate which means further financial burden such as loss of income from work, organising childcare, delaying regular household expenses, requesting financial assistance from others on top of the very high standalone procedure fee at a time of high stress.[67,68]

This will change as on Wednesday 19 September 2018, the ACT Legislative Assembly debated the *Health (Improving Abortion Access) Amendment Bill 2018* and voted 15 to 4 in favour of an amendment that will allow appropriately trained GPs to prescribe medication for termination of pregnancy in the ACT. This will be implemented within 12 months and recognises that medical termination of pregnancy does not have a clinical need for surgical facilities. As a result of the amendment, the right of a woman to make choices about her healthcare, and who she chooses to provide healthcare services, will be improved in relation to access to medical termination of pregnancy.

Barriers to accessing sexual and reproductive services

Cost is a barrier for many women in accessing sexual and reproductive services.

Women living in the ACT were reported in the Jean Hailes' Women's Health Survey to be least likely to be able to easily access a doctor or health service if required compared to other Australian states and territories.[69]

According to the Department of Health, 84.3% of GP visits across Australia in the 2016-17 financial year were bulk-billed, but for the ACT the rate is only 57.8%.[70] The low rates of bulk-billing GPs may be reflected in the high proportion of ACT residents delaying GP appointments. In 2016-17, the ACT recorded the second highest proportion of the nation, at

[62] *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT)
[63] R Sifris and S Belton, 'Australia: Abortion and human rights', *Health and Human Rights Journal*, vol. 19, no. 1, 2017, pp 209-220.
[64] *Health Act 1993 (Part 6 Abortions)* (ACT)
[65] Ibid.
[66] P. Hyland, E. Raymond, and E. Chong. 'A direct-to-patient telemedicine abortion service in Australia: Retrospective analysis of the first 18 months', *Contraception*, vol. 97/no. 5, (2018), pp. 461-462.
[67] P. Goldstone. and M. Thompson, 'The tyranny of distance for Australian women seeking abortion', *O&G Magazine*, vol. 20/no. 2, (2018), pp 45-47.
[68] M. Shankar, K.I. Black, P. Goldstone, et al. 'Access, equity and costs of induced abortion services in Australia: A cross-sectional study', *Australian and New Zealand Journal of Public Health*, vol. 41/no. 3, (2017), pp. 309-314.
[69] Ibid.
[70] The Department of Health, *Annual Medicare Statistics*, (Canberra, ACT: Australian Government, 2018), retrieved on 5 September 2018, http://health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics

7.1% of residents who delayed or did not visit a GP due to cost.[71] This has potential serious consequences as it poses difficulty in renewing scripts in a timely manner, comprehensive counselling for suitable contraception, and early intervention or detection of health issues.

In the ACT, women have access to only three local abortion service providers: Marie Stopes Clinic in Canberra, Gynaecological Centres Australia (GCA) in Goulburn or the Tabbot Foundation by telehealth. Any other option involves travel to another capital city.[72,73]

Even if a woman decides to seek TOP services in the ACT, she must be able to afford it because even though she may hold a Medicare and Healthcare card which gives access to rebates, these rebates have remained the same for many years - despite the increasing costs of TOP services - which leave many women with very high out-of-pocket co-payment costs.[74]

All these providers are non-government services and can charge those holding a Medicare card anywhere between $270 and upwards of $1400, depending on the provider and the gestational age of pregnancy.[75,76]

In addition, women accessing TOP from a standing clinic may want to add on contraception and insertion post-abortion which further increases the upfront financial burden of women's management of their sexual and reproductive health.

Affordability, waiting times and lack of appointments are an issue for women accessing services in the ACT.

In the 2018 WCHM report titled *ACT women's health matters! ACT Women's views about their health; their health needs; their access to services, supports, and information; and the barriers to maintaining their health* the main barrier identified by 50% of respondents was affordability. Appointment availability (ability to get in to see a health professional of their preference at a convenient time) was the second highest barrier identified by 49% of respondents and long wait times (the amount of time that a patient must wait, after making an appointment, to see a health professional) was identified by 42%.

The way a patient is treated by a health professional is an important aspect of their satisfaction with their care. The WCHM 2010 *It goes with the Territory!* report identified that younger women reported feeling misunderstood and having their health issues disregarded and marginalised by health professionals. Research participants also noted a medically orientated system focus that lacked holistic personalised care.[77]

In the *2016-17 Patient Experiences survey*, all respondents who had seen a GP were asked for their perceptions on how they were treated by the GPs.[78] Of those who saw a GP in the last 12 months, 75% reported that the GP always listened carefully to them, 81% reported that they always showed them respect and 76% reported that they always spent enough time with them. Males were more likely than females to report that the GP always listened carefully to them (77% compared with 73%), always showed them respect (82% compared with 80%), and always spent enough time with them (78% compared with 75%).

---

[71] Australian Government Productivity Commission, *Report on Government Services 2018*, (Canberra, ACT), retrieved on 5 September 2018, http://www.pc.gov.au/research/ongoing/report-on-government-services/2018/health/primary-and-community-health

[72] Sexual Health and Family Planning ACT, 'Pregnancy options', 2015, retrieved on 20 August 2018 http://www.shfpact.org.au/images/Documents/PregnancyOptions2015.pdf

[73] Tabbot Foundation, 'Abortion Canberra, ACT', *Tabbot Foundation* [website], retrieved on 20 August 2018, https://www.tabbot.com.au/medical-abortion/abortion-canberra.html

[74] Children by Choice, 'Abortion and Medicare', *Children by Choice* [website], 2016, retrieved on 20 August 2018, https://www.childrenbychoice.org.au/factsandfigures/abortionandmedicare

[75] Ibid.

[76] Marie Stopes Australia, 'Abortion', *Marie Stopes Australia* [website], retrieved on 20 August 2018, https://www.mariestopes.org.au/abortion/

[77] A Carnovale and E Carr, *It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010, pp. 47.

[78] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.

This report also found that women in the ACT have least time to attend appointments for health checks and second to last to get an appointment when needed.[79]

And for women the stigma of accessing a service known to deliver terminations can also be a barrier to accessing TOP services. In 2016, this was recognised when new legislation was brought into effect to implement safe access zones of 50 metres around clinics providing TOP services in the ACT. This buffer zone allowed women to exercise their right to accessing services of Marie Stopes clinic without having to endure judgement and harassment from protesters, and a right to privacy from being filmed.

At risk and diverse populations

The challenges to managing good sexual and reproductive health for some women are far greater than for others. Some women may be at risk of poor sexual and reproductive health due to poor health literacy, awareness about safe sex, and their ability to access to local services and health screening. Or they may be facing violence, stigma or discrimination from their family and/or the society they live in. Diversity in cultural, religious, economical, and social contexts and beliefs can influence women's health and the ways they access health information. These groups include (but are not limited to) young women, older women, Aboriginal and Torres Strait Islander women, culturally and linguistically diverse (CALD) women, sexual minority women, and women with disabilities.

Younger women across all health issues are generally at greater risk of poorer access to appropriate and reliable health care and least likely to seek health services.[80] In relation to sexual and reproductive health, young women compared to older women are less informed about available options for contraception and services, less financially independent, and have less ability to access transport to services[81] Young people are also concerned about confidentiality, discomfort in disclosing health concerns, waiting times, inconvenient opening hours, health provider's competence dealing with youth and unfriendly environments.[82, 83] Recommended methods to overcome structural barriers such as cost, and transport include co-locating confidential healthcare within schools, establishing youth-friendly outreach services and providing bulk-billed services for young people.[84]

At the other end of the spectrum, older women are often stereotyped as a population who is sexually inactive, and therefore are devoid of sexual and reproductive health needs and issues, and have no need for STI testing.[85] The sexual and reproductive health issues for older women are diverse and range from experiencing the effects of menopause, changes in hormonal levels affecting other health issues, being up to date about available contraceptive options, and considering screening of STIs when in new sexual relationships.[86, 87] Therefore there is a need for more resources and health practitioners accurately informing about sexual and reproductive health for mid and later life women.

Factors such as culture, stigma and trust can impact on Indigenous women's sexual and reproductive health and wellbeing, and their help-seeking choices. Young Indigenous women

[79] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.
[80] M Cummings, et al., 'Youth health services: Improving access to primary care', *Australian Family Physician*, vol. 41, no. 5, 2012, pp. 339-341.
[81] ML Booth, et al. 'Access to health care among Australian adolescents young people's perspectives and their sociodemographic distribution', *Journal of Adolescent Health*, vol. 34, no. 1, 2004, pp. 97-103.
[82] Ibid.
[83] M Cummings, et al., 'Youth health services: Improving access to primary care', *Australian Family Physician*, vol. 41, no. 5, 2012, pp. 339-341.
[84] G Alperstein, et al. 'Towards better practice in primary health care settings for young people', Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals, vol. 17, no. 2, 2006, pp. 139-144.,
[85] S Hinchliff, and M Gott, 'Seeking medical help for sexual concerns in mid and later life: A review of the literature', *Annual Review of Sex Research*, vol. 48, no. 2, 2011, pp. 106-117.
[86] Ibid.
[87] J Tetley, et al., 'Let's talk about sex – what do older men and women say about their sexual relations and sexual activities? A qualitative analysis of ELSA Wave 6 data', *Ageing and Society*, vol. 38, no. 3, 2018, pp. 497-521.

and Aboriginal Elders are identified in the literature as vulnerable groups in need of culturally appropriate and sensitive sexual and reproductive health services and education.[88, 89]

Australian research that women from CALD backgrounds may experience poor health outcomes in sexual and reproductive health,[90] such as higher rates of STIs and unintended pregnancies.[91] At the individual level, CALD women may face language and communication barriers, and stigma within their community, which make navigating and engaging with the health system difficult for both patient and the health provider.[92, 93, 94] These barriers may contribute to low utilisation and late presentation to services amongst CALD women in Australia, as observed by Aminisani et al in relation to Middle Eastern and Asian migrant women being less likely than Australian-born women to participate in cervical screening at the recommended interval.[95] Therefore, multiple factors need to be addressed to improve the indicators of sexual and reproductive health for CALD women.

Women who identify as lesbian, bisexual or engage in poly relationships have different health needs to women who are in monogamous and heterosexual relationships and therefore may be faced with having to inform about their sexual orientation and/or behaviours to seek suitable healthcare. According to Johnson and Nemeth, after experiencing biases and discrimination from service providers, they may disguise their sexual orientation or completely discouraged from seeking professional care and therefore this reduces opportunity for early detection and intervention.[96] Research has also shown that, compared with exclusively heterosexual women, sexual minority women are more likely to report to underuse health screening services or never having had a mammogram or pap smear.[97]

Research shows that while women with disabilities have the same sexual and reproductive health needs as those without disabilities the main assumption is that they are not sexually active.[98] Such attitudes from health providers because of lack of provider training, experience and hesitancy to start the conversation means that women with disabilities may be limited in their access to education, awareness and management of good sexual and reproductive health.[99]

[88] J Kelly, and Y Luxford, '*Yaitya tirka madlanna warratinna: Exploring what sexual health nurses need to know and do in order to meet the sexual health needs of young Aboriginal women in Adelaide*.' Collegian, vol. 14, no. 3, 2007, pp. 15-20.
[89] P Duley, et al., 'The strong family program: An innovative model to engage Aboriginal and Torres Strait Islander youth and elders with reproductive and sexual health community education', *Health Promotion Journal of Australia*: Official Journal of Australian Association of Health Promotion Professionals, vol. 28, no. 2, 2017, pp.132-138.
[90] Australian Medical Association, 'Sexual and reproductive health', Canberra, ACT, 2014, retrieved 25 October 2017, https://ama.com.au/position-statement/sexual-and-reproductive-health-2014
[91] Ibid.
[92] ZB Mengesha et al., 'Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: A systematic review', *Sexual Health,* vol. 13, no. 4, 2016, pp. 299-310.
[93] M Hach, 'Common threads: The sexual and reproductive health experiences of immigrant and refugee women in Australia', *Multicultural Centre for Women's Health*, Melbourne, VIC, 2012, retrieved on 28 September 2018, http://www.mcwh.com.au/downloads/publications/MCWH_CommonThreads_Report_WEB.pdf
[94] J Agu, et al., 'Migrant sexual health help-seeking and experiences of stigmatization and discrimination in Perth, Western Australia: Exploring barriers and enablers', *International Journal of Environmental Research and Public Health*, vol. 13, no. 5, 2016, pp. 485.
[95] N Aminisani, et al, 'Cervical cancer screening in Middle Eastern and Asian migrants to Australia: A record linkage study', *Cancer Epidemiology*, vol. 36, no. 6, 2012, pp. e394-e400.
[96] Ibid.
[97] RP Brown et al., 'Cancer risk factors, diagnosis and sexual identity in the Australian longitudinal study of women's health', *Women's Health Issues*, vol. 25, no. 5, 2015, pp 509-516.
[98] G Ride, and DC Newton, 'Exploring professionals' perceptions of the barriers and enablers to young people with physical disabilities accessing sexual and reproductive health services in Australia', *Sexual Health*, vol. 15, no. 4, 2018, pp. 312-317.
[99] W Greenwood, and J Wilkinson, 'Sexual and reproductive health care for women with intellectual disabilities: A primary care perspective', *International Journal of Family Medicine*, vol. 2013, 2013, pp. 8.

Findings

Demographics of respondents

This section provides a breakdown of the demographic characteristics of the 510 ACT women respondents who completed the survey questions.

Age

As shown in Table 1 13.7% (n=19) of respondents were 15-18 years; 35.8% (n=183) were 19-29 years; 29% (n=149) were 30-39 years; 15.8% (n=81) were 40-49 years; 10% (n=53) were 50-59; and 4.9% (n=25) were 60 years or older.

Age Group	Number	Percent
15 – 18	19	3.73%
19 – 29	183	35.88%
30 – 39	149	29.22%
40 – 49	81	15.88%
50 – 59	53	10.39%
60 and over	25	4.90%
All	510	100%

Table 1: *Age of surveyed women.*

Location

As shown in Table 2, 92.55% (n=472) of survey respondents lived in the ACT, 4% per cent (n=21) were living in Queanbeyan, and 3.3% (n=17) were living in surrounding rural NSW.

Age Group	ACT		Queanbeyan		Yass		Other	
15 – 18	16	84.21%	2	10.53%	0	0.00%	1	5.26%
19 – 29	171	93.44%	5	2.73%	3	1.64%	5	2.19%
30 – 39	137	91.95%	8	5.37%	1	0.67%	3	2.01%
40 – 49	74	91.36%	3	3.70%	1	1.23%	3	3.70%
50 – 59	50	94.34%	3	5.66%	0	0.00%	0	0.00%
60 and over	24	96.00%	0	0.00%	0	0.00%	1	4.00%
All	472	92.55%	21	4.12%	5	0.98%	12	2.35%

Table 2: *Participant place of residence.*

Sexual and reproductive health information

Information seeking

As shown in Figure 1, when asked if they found it easy to find reliable and relevant information about their sexual and reproductive health 73.33% (n=374) of all respondents selected ‘Yes’ and 26.67% (n=136) selected ‘No’. This was consistent across all the age groups.

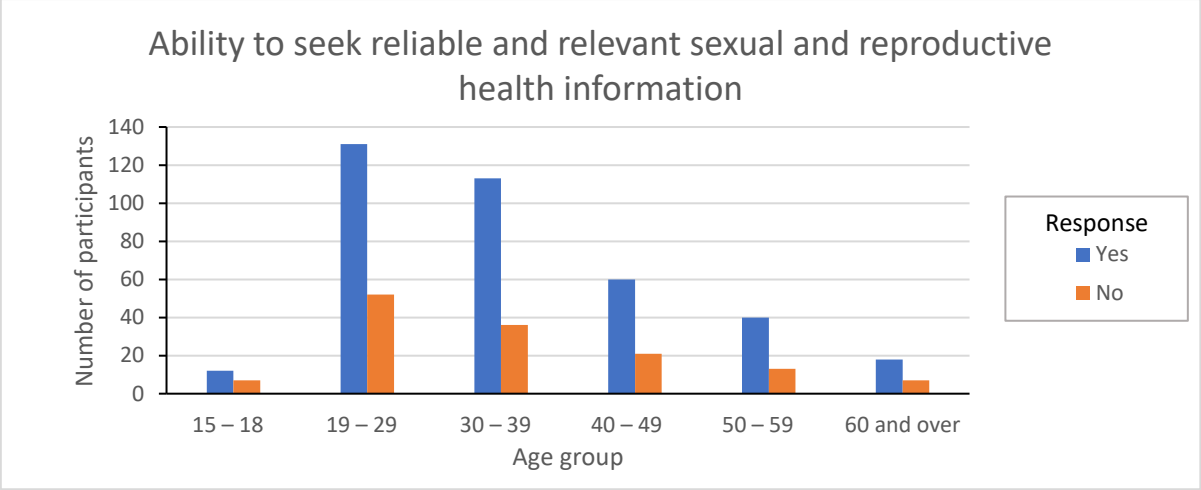

Figure 1: *Number of participants indicating ability to find reliable and relevant sexual and reproductive health information.*

As shown in Figure 2, of the 130 respondents who provided comments about why they answered 'Yes' to being able to find reliable and relevant information, the most common reasons were: independent research from the internet and books (n=66); from discussion with a GP or gynaecologist (n=50); being confident and having a personal interest in seeking information (n=32); and from discussion with a sexual health centre, women specific service or family planning clinic (n=22).

> *"Because of Sexual Education in school, the internet and access to medical centres I know all that I need to about my sexual and reproductive health, though I am one to actively seek this out."* (15-18 age group)

> *"I am able to search the internet and critically assess sources as I have a health background and am an academic. I appreciate not all women have this background that may help them find such information."* (30-39 age)

> *"Yes, good GP, although access to GP when you need it can be tricky. WCHM used to have an excellent info line which was so handy to speak with someone who had clinical knowledge, in our local region. The generic info lines available now do not deliver the same service."* (50-59 age)

> *"I have used SHFPACT and Canberra Sexual Health Centre over the years so know they are the repositories of a wealth of info."* (60+ age)

> *"Doctors' surgeries have pamphlets as do many government public areas. seeing a doctor is easy enough and the Internet had a lot of reliable sources (as well as a lot of rubbish)"* (60 and age)

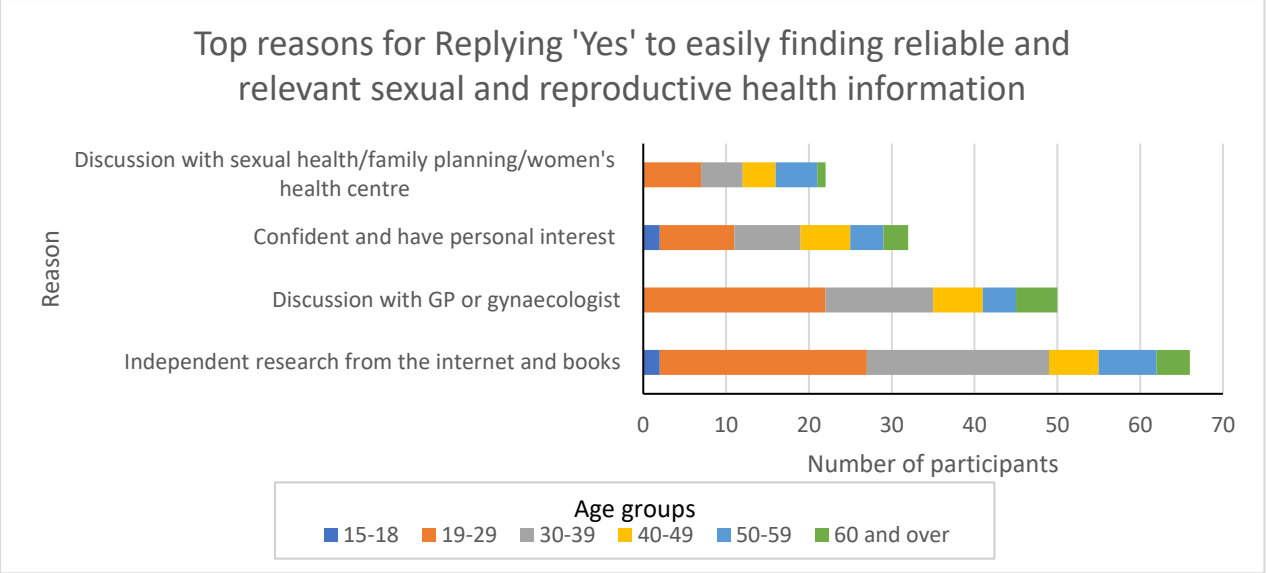

Figure 2: *Top reasons participants replied 'Yes' to finding reliable and relevant information about their sexual and reproductive health easy.*

Although most participants said 'Yes' to finding it easy to find reliable and relevant information about their sexual and reproductive health, some still commented that while they had a general understanding about health they still had difficulty finding specific information in relation to age appropriateness, chronic reproductive health conditions, menopause, and/or LGBTIQ+ friendly:

> *"Although I must say that information regarding peri-menopause, menstruation and menopause is filled with platitudes, mis-information and not very helpful dismissal of women's experiences."* (40-49 age)

> *"Yes to gynaecologist and reproductive health issues. However getting information and support relating to my sexual function (as impacted by Endometriosis and birth recovery) has been far more difficult. I think sometimes is can be a mistake to roll "sexual" and "reproductive" health in together as they can mean 2 very different things."* (30-39 age)

Out of the 80 participants who provided reasons why they had commented 'No' to easily finding reliable and relevant information about their sexual and reproductive health, the most common reasons as shown in Figure 3 were: not knowing where to find reliable information (n=21); having an understanding about general health but still having difficulty finding specific information in relation to age appropriateness, chronic reproductive health conditions, menopause, etc (n=21); difficulty assessing reliability and credibility of sources (n=18); health professionals reluctant to discuss/refer or provides conflicting information (n=13); and difficulty locating local and appropriate services and practitioners (n=11):

> *"I find it difficult to find specific details about reproductive and sexual health, unless I visit a doctor, as a general rule. General information about abnormalities is easier to access, but I also find it difficult to locate exact practices, decide what kinds of doctors to see etc. I also don't understand whether gynaecologists are separate from regular doctors in Canberra or not, or where to locate specialists."* (15-18 age)

> *"I had a hysterectomy in my 30's and don't know where to find information about how this will impact me as I get older."* (40-49 age)

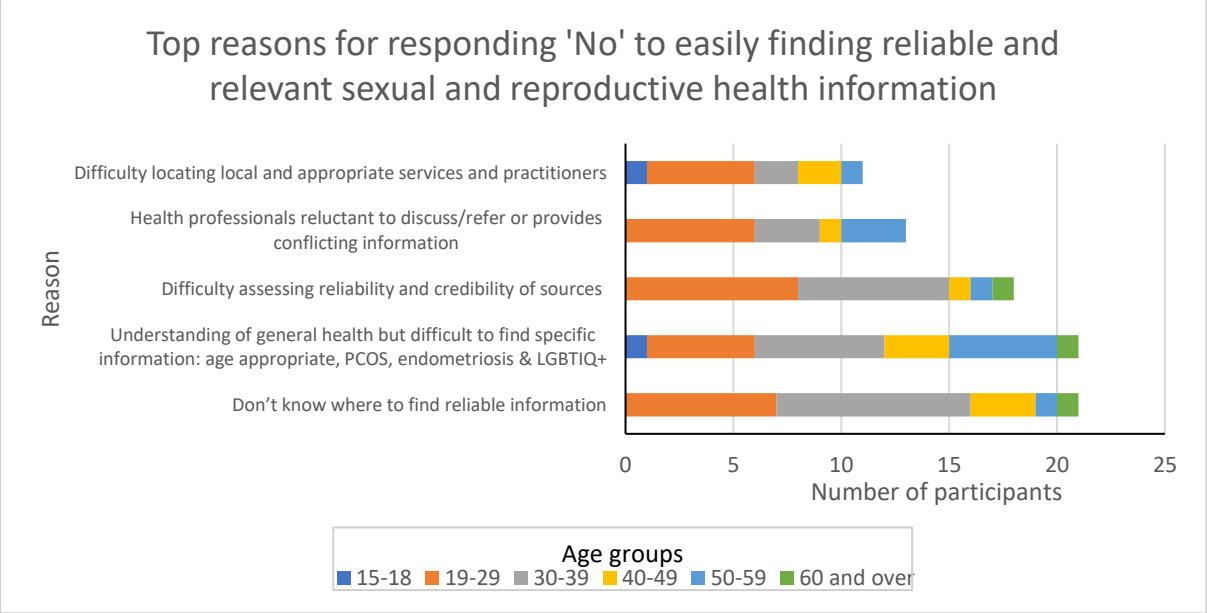

Figure 3: *Top reasons participants voted 'No' to finding reliable and relevant information about their sexual and reproductive health easy.*

Many of those who identified finding reliable and relevant sexual and reproductive health as difficult expressed having to be proactive with seeking information on the internet, or being informed but unable to manage their sexual and reproductive health due to prohibitive factors such as cost, waiting times, transport, appropriate service provider, and embarrassment:

> *"Google is the easiest source, however isn't a great source. It is difficult to find a GP that is either interested or knowledgeable enough about female health to make the appointment worthwhile. GPs are always reluctant to refer to gynaecologist as well. SHFPACT is a great resource, however is a nightmare for parking and accessing."* (19-29 age)

> *"The only real source is Google. All conversations I've ever raised with professionals (GP, sexual health nurses, OB-GYN) have been met awkwardly. Clear that none of them want to engage in an informative conversation. Pamphlets are useless. Forums where other women ask and discuss issues are by far the most useful/candid sources of information but unlikely to be accurate all of the time of course."* (30-39 age)

> *"My GP refers to gynaecologist, this means getting assistance takes time. Some information is accessible online but getting the medical support takes time"* (40-49 age)

> *"For most things the information is adequate. However I suffered from endometriosis for over 10 years before I found the right information and treatment. I understand that many women experience similar issues, especially with regards to endometriosis."* (40-49 age)

> *"It is easier now I have a diagnosis of adenomyosis - it was really difficult to get information that didn't just blame everything on being perimenopausal. Then, suddenly when I put all the symptoms together the GP suddenly got worried it could be cancer but imaging (excruciatingly painful imaging, at that) showed it to be adenomyosis."* (50-59 age)

As shown in Figure 4, when asked if they felt sexual and reproductive health information was appropriate for their age and stage of life, 384 respondents (75.29%) answered 'Yes' and 126 answered said 'No'.

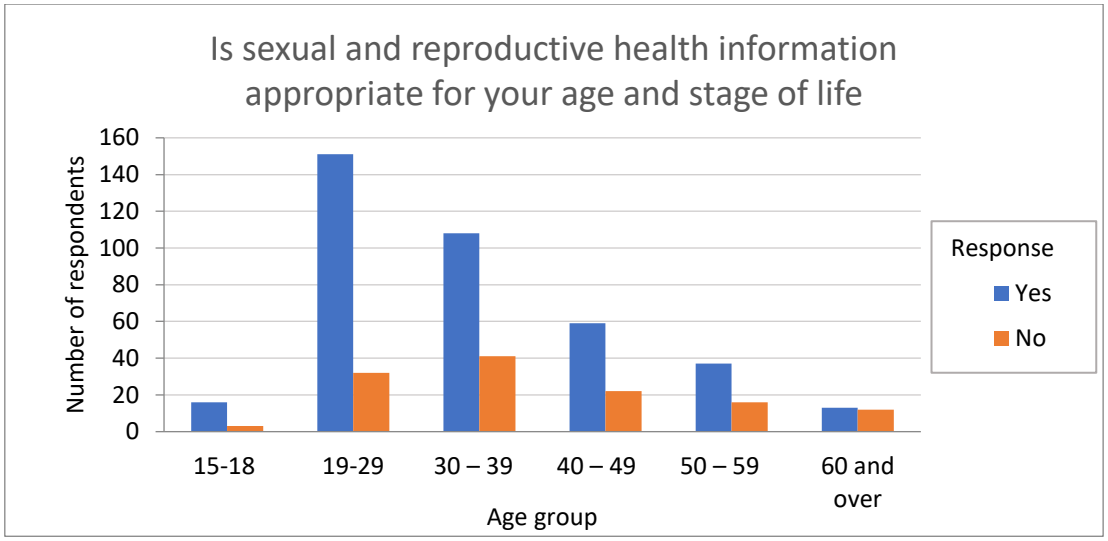

Figure 4. *Number of respondents indicating whether they felt sexual and reproductive health information is appropriate for their age and stage of life.*

Of the 60 respondents who commented 'Yes', the most common reasons were: it is important to learn about sexual and reproductive health no matter what age; available information needs to be communicated in suitable language; confidence in seeking appropriate and up-to-date information; and through discussion with GP or gynaecologist.

> *"I feel sexual and reproductive health information is important at most ages. Under the age of 10, perhaps not, but from there on it is important that everyone understands what to look out for, what is healthy, consent, safe sex, why people have sex, etc. I think an objective teaching of sex and reproduction should be given to everyone, across genders, and covering heterosexual and homosexual differences."* (15-18 age)

> *"I have PCOS, insulin resistance and scarring on my uterus, and my doctor has been wonderful in managing these and getting me into contact with specialists to help try to work to improve the chances of pregnancy"* (19-29 age)

> *"I don't bother looking locally or in real life. I find online sources to be better and more up to date with the latest research (i.e it takes an average of 12 years for the latest research to filter down to GP level, but studies available online can be read by anyone). The information I locate is very appropriate and relevant."* (19-29 age)

> *"Yes as I am at child bearing age. For me I learnt a lot about this area while I was young as I unfortunately experienced receiving a sexually transmitted infection the first time I had unprotected sex, and an intended pregnancy a few years later. Whilst this was traumatising as a 17 year old, I was not only treated but provided education and support around this from the nurses and of course I was careful and wiser towards my future. I wouldn't have this any other way as I have had people around me experience this now at an older age where we are trying to establish relationships or start families. It really is a heart breaking thing for them to experience and I am glad that I became a better and more educated person for being exposed to something so young. I have been able to educate others and also have loving relationships and know that I am always doing the right thing by myself and my partner."* (19-29 age)

> *"Always important as women we are always changing and have different needs throughout life."* (40-49 age)

> *"These days so much more is out there about older women's sexual and reproductive health if you know how to look in the right places."* (50-59 age)

"Although I am not sexually active I believe that one should be aware of the current situation re health information." (60 and over age)

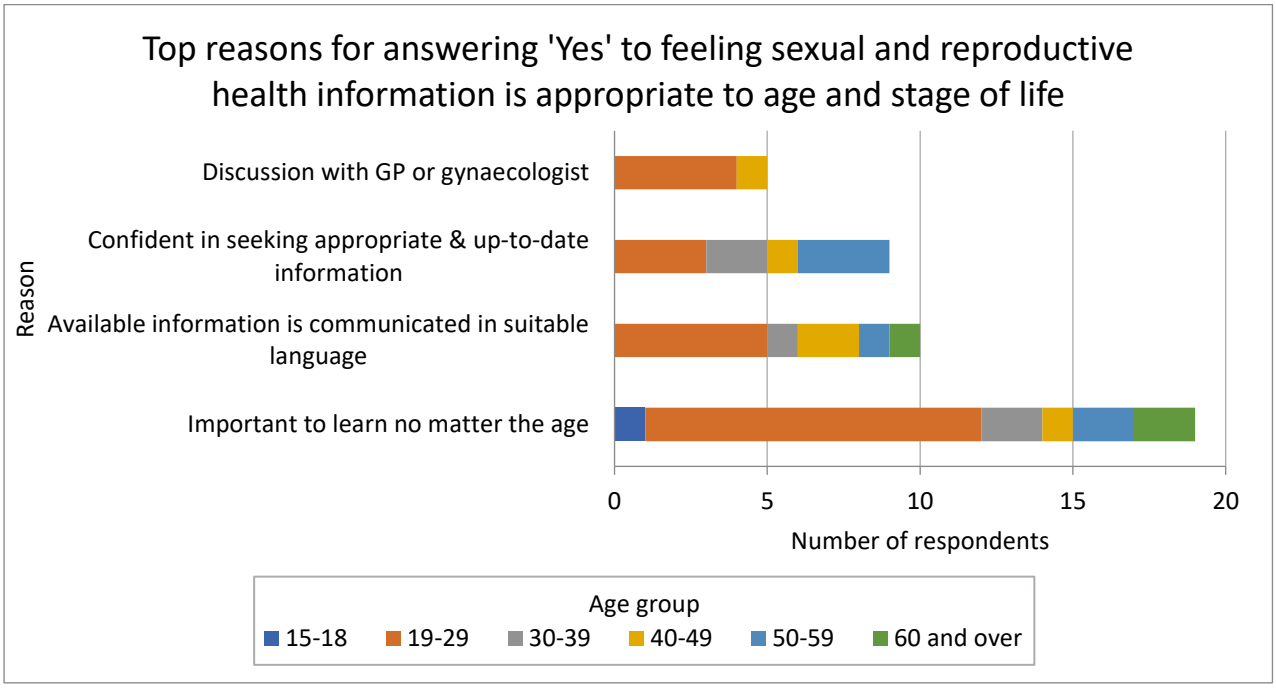

Figure 5. *Top reasons for selecting 'Yes' to feeling sexual and reproductive health information is appropriate to age and stage of life.*

As shown in Figure 5, of the 70 respondents who responded 'No' about whether sexual and reproductive health information was appropriate to their age and stage of life, the most common reasons were:

"Not taught enough about the actual act of sex" (15-18 age)

"I am in the long stage between puberty and pregnancy, which seems to be a bit of a void." (19-29 age)

"Sexual, yes. Reproductive, no. For example, I'm 26 and treated like I don't know my own wants or needs. I will not reproduce because of undesirable genetic traits (severe mental illness, for example) and the knowledge that I'll never be capable of caring for a child. My periods are very bad (endo), and I want to be sterilized. No doctor will accept this. Every doctor has had the view that just because I have a uterus and am of breeding age, I must want kids. This treatment invalidates my personhood. I am old enough to know what I want, which is to not reproduce. Finding information about sterilization for someone my age has proved near impossible." (19-29 age)

"I think I would fall into the almost ready for a family age group and yet not a lot of information is available on reproductive health and what to expect when trying, falling pregnant or even when a miscarriage occurs. I've found that it's only after something happens to you or a friend that you start to get information like what's involved medically and what next steps need to be taken whether it's a new pregnancy and having a blood test or a miscarriage and needing a d&c. You tend to find out from a GP or Dr as it's happening rather than having a base knowledge prior." (19-29 age)

"Often targeted at very young or older people, and misses the space of 18-25 year olds who are potentially engaging in sexual activity but are not doing so in strictly monogamous or family-building contexts" (19-29 age)

"I wish I knew more about how to get IUDs implanted and the cost. And who will do it for me." (19-29 age)

"More information should be freely and proactively shared about termination services" (30-39 age)

"The focus tends to be on young women who aren't ready to have children yet. I've had children and am done with that part of my life. But still want to make sure that I don't get pregnant. There are so many products on the market that I find it confusing." (30-39 age)

"Yes and no. Appropriate for my age. I am in a poly relationships and I also do kink/BDSM so it's hard to find information that helps in those areas, and medical people who are open-minded and knowledgeable." (30-39 age)

"I am in a same sex relationship, I find it's all heteronormative and difficult to decipher what applies to me." (30-39 age)

"Not for those with chronic, autoimmune diseases whose hormones are affected." (30-39 age)

"There is no proactive effort by the medical services I use (besides my GP) to address these issues. I am not immediately aware of any brochures or a one-stop place to find this information." (30-39 age)

"I think most easily accessible information is centred on safe sexual activity (internet based resources) - which is vitally important for young women. It would be great to see more easily accessible information for women heading into "later life" for want of a better word - what to expect to happen to you, what is normal/not normal, etc." (40-49 age)

"I need more information, not less. I need doctors and health professionals to be informed about the stage of life I am going through so that I can gauge what I need to be doing." (40-49 age)

"appropriate information for peri-menopausal and menopausal women in Canberra is limited. I have found sources online but Canberra-centric information about services etc is limited." (50-59 age)

"It's hard to get information about what is to be expected in peri-menopause vs what is something that warrants investigation. To have symptoms taken seriously and get support, even with a diagnosis, can be a challenge, too." (50-59 age)

"I feel that there is a huge disparity in the sex drive information for my age group and my reality. Also, there is little on the success of the treatments available." (50-59 age)

"Once you are past the teenage and breeding range. It appears your sexuality and sexual health except for poor you menopause Dissapears" (50-59 age)

"Older women are forming new relationships and often STIs aren't on their mind!" (60 and over age)

"Not generally, in the media or leaflets I see. It's aimed at younger people. There should be more understanding in community organisations and health services that sexual activity isn't only for the young. It would be very useful to have access to

information about older women's (and men's) issues too. Such things as "Is this normal?" "What can I do about this?" etc" (60 and over age)

Accessing sexual and reproductive health services in the ACT

Women respondents were asked where they would you go to access services for cervical screening, mammogram, contraception, emergency contraception, pregnancy termination, and STI screening. They were able to make multiple selections for each category.

STI testing

As shown in in Figure 6, the most common service where respondents would access STI testing were their regular GP (n=269, 52.75%), was followed by the Canberra Sexual Health Centre (n=129, 25.29%), SHFPACT (n=116, 22.75%), the Women's Health Service (n=50, 9.80%), gynaecologist (n=44, 8.63%), another GP practice (n=32, 6.27%), AN ACT Health Community Health Centre (n=26, 5.10%), and Walk-in centres (Belconnen or Tuggeranong) (n=26, 5.10%).

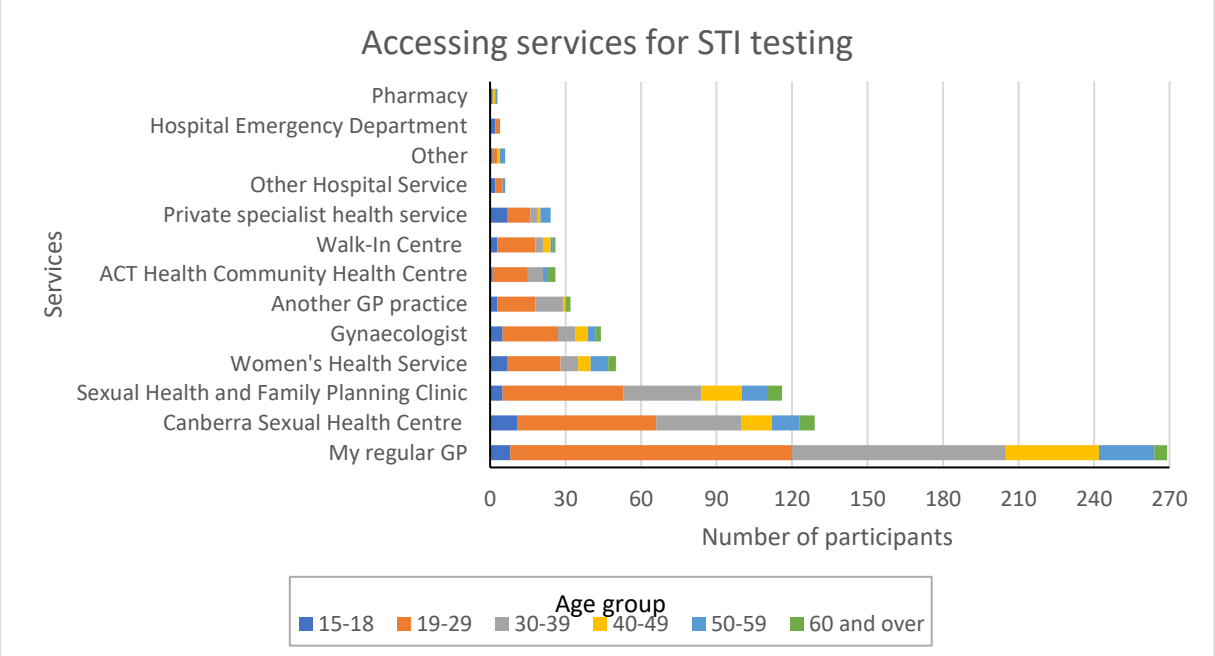

Figure 6: *Services that respondents would go to access STI testing in the ACT.*

When forum discussion participants were asked whether they would prefer to access a Walk in Centre (WiC) for STI testing, the majority agreed that WiCs would be more accessible than the currently available services in the ACT, especially for young women.

> *"I expect the walk-in centre to meet the needs of the general population. 50% of general population are women and this is something that all women have to go through – a place for regular check-ups."* (30-39 age)

> *"I think that would be an awesome resource for – especially teenagers. Looking at the fact that both Belconnen and Tuggeranong walk-in centres are quite close to colleges or to places where the "youths" hang out. But it's another place where information can be accessed in a free confidential space and I think for young Canberrans that's really vital. People are younger these days and it's not always thought about. I had a big night in Civic and what do I do now? I'm a mess. So I think anything like that is great."* (19-29 age)

Cervical Screening

A majority of 74.31% (n=379) of survey respondents selected that they would access cervical screening test with their regular GP, followed by accessing SHFPACT (n=99, 19.41%), gynaecologist (n=95, 19.63%), the Women's Health Service (n=56, 10.98%), Canberra Sexual Health Centre (n=50, 9.80%), another GP practice (n=34, 6.67%), and private specialist health service (n=26, 5.10%) as shown in Figure 5.

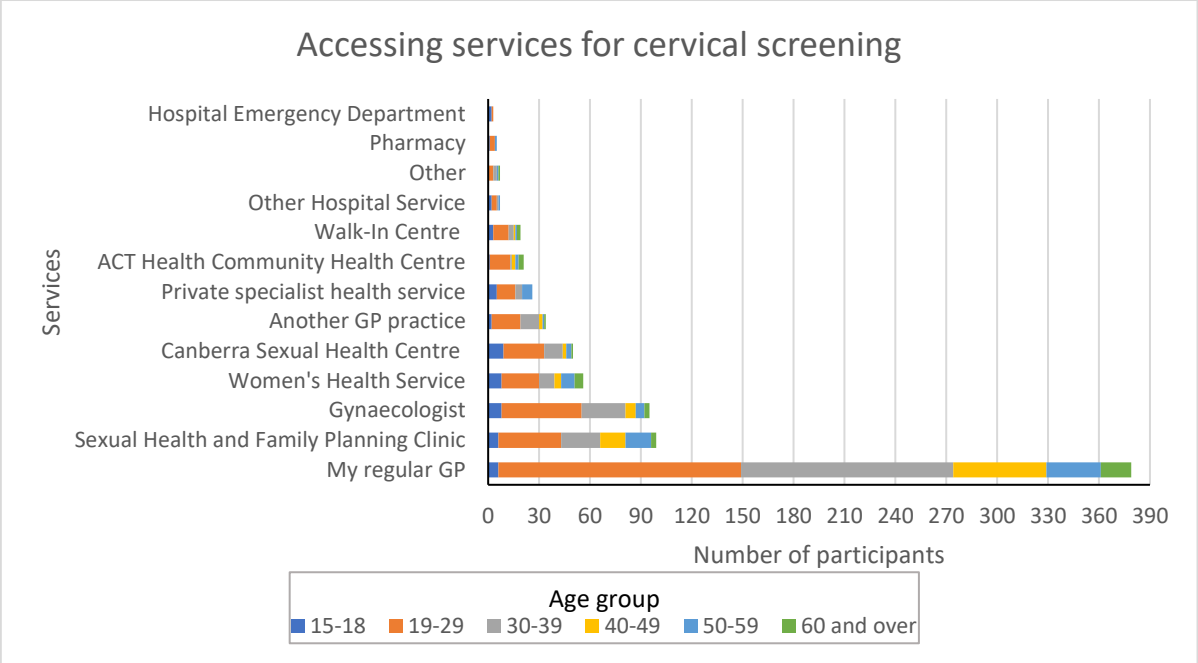

Figure 7: *Services that respondents would access for cervical screening in the ACT.*

Mammograms

As displayed in Figure 8, the most common service that survey respondents identified they would access for mammograms were their regular GP (n=202, 39.61%), followed by ACT Health Community Health Centre (n=72, 14.12%), Women's Health Service (n=63, 12.35%), and private specialist health service (n=44, 8.63%).

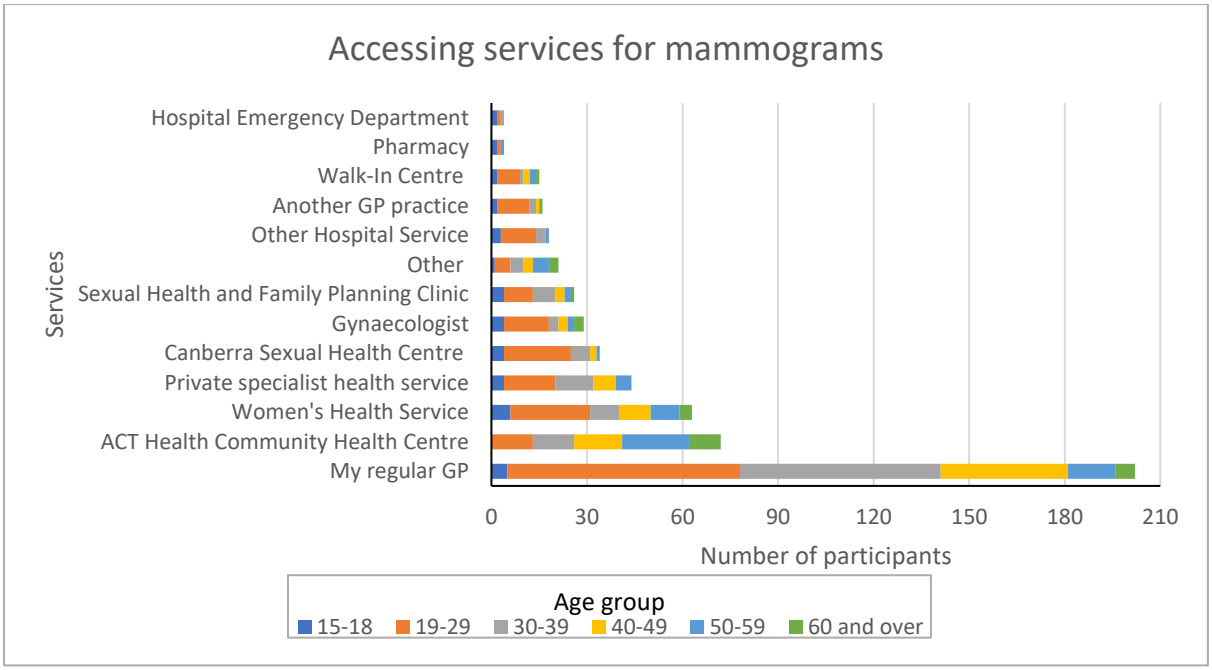

Figure 8: *Services that respondents would access for mammograms in the ACT.*

Contraception

The most common service that survey respondents identified they would access for contraception were their regular GP (n=370, 72.55%), followed by SHFPACT (n=91, 17.84%), the pharmacy (n=14.90%), and gynaecologist (n=61, 11.96%) as shown in Figure 7.

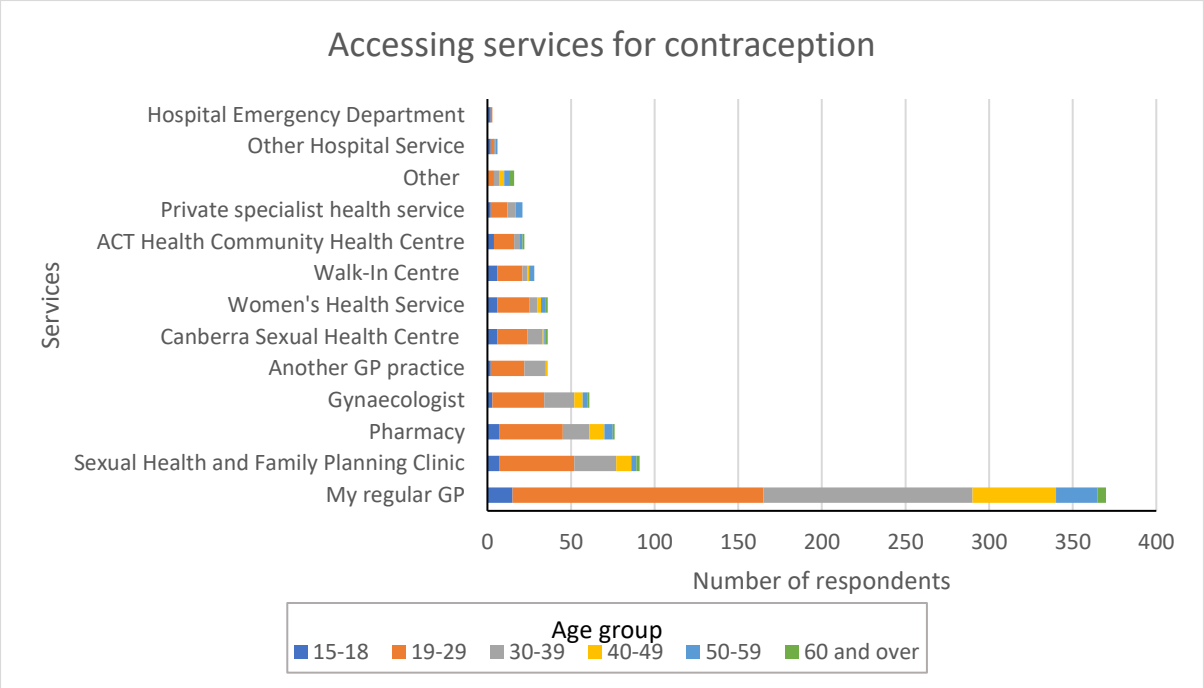

Figure 9: *Services that respondents would access for contraception.*

Emergency contraception

As displayed in Figure 10, the most common service that survey respondents identified they would access for emergency contraception were the pharmacy (n=247, 48.43%), followed by their regular GP (n=159, 25.29%), SHFPACT (n=79, 15.49%), and the Canberra Sexual

Health Centre (n=61, 11.96%). Because more women aged 40 years and over identified they would access their regular GP (n=43) for ECP rather than accessing the pharmacy (n=30), this appeared to show that – because they were less likely to need ECP – they were not aware of it's availability at the pharmacy.

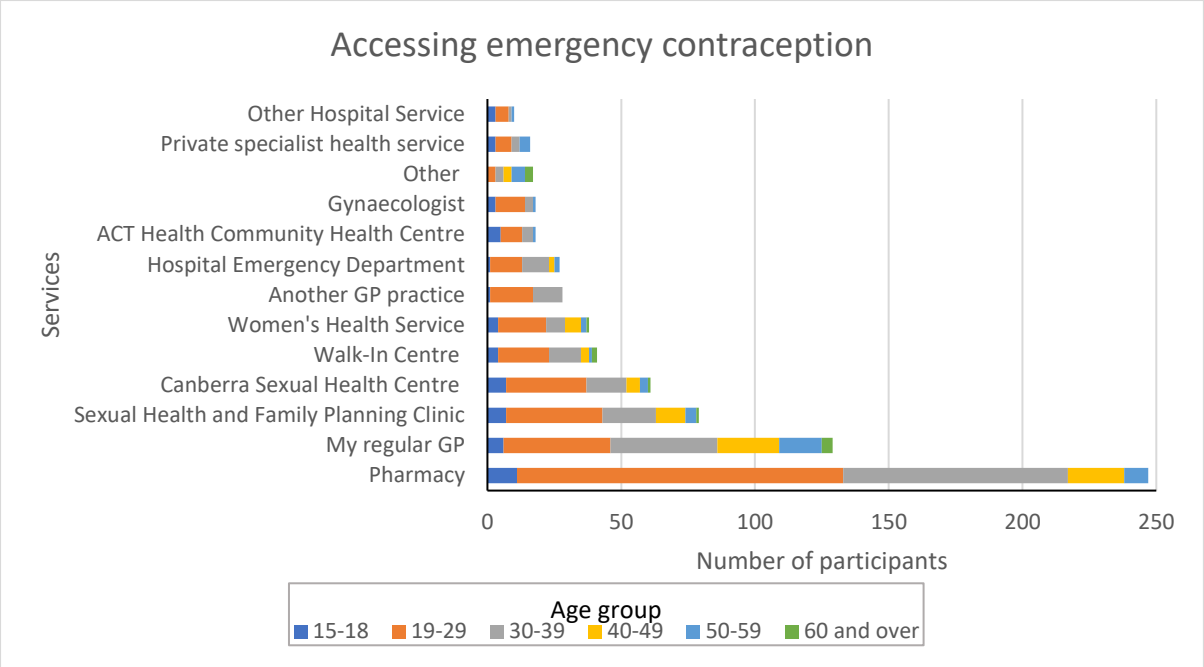

Figure 10: *Services that respondents would access for emergency contraception.*

Termination of pregnancy

As shown in Figure 11, the services that survey respondents identified they would access for termination of pregnancy were SHFPACT (n=129, 25.29%); closely followed by their regular GP (n=121, 23.73%); the Canberra Sexual Health Centre (n=78, 15.29%); and a private specialist health service (n=67, 13.14%).

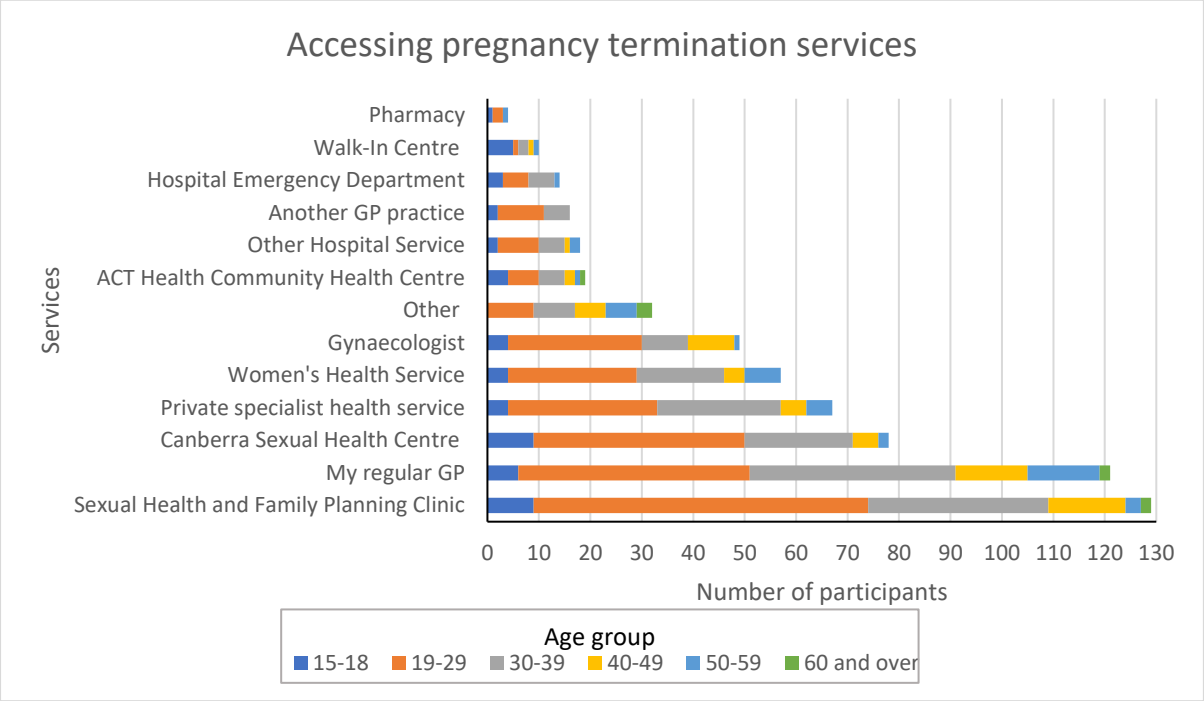

Figure 11: *Services that respondents would access for a termination of pregnancy.*

Sexually Transmitted Infections

A total of 498 participants responded to the questions about STIs. Table 3 shows the age groups that responded to the questions.

Age Group	Number	Percent
15 – 18	17	3.41%
19 – 29	182	36.55%
30 – 39	145	29.12%
40 – 49	81	16.27%
50 – 59	51	10.24%
60 and over	22	4.42%
All	498	100.00%

Table 3: *Number of participants responding to questions about sexually transmitted infections.*

Engaging in sexual activity with another person/s

When asked if they had engaged in sexual activity with another person/s in the last 12 months (as of October and November 2017), a total of 427 respondents indicated 'Yes' (85.74%) and 71 answered 'No' (14.26%) as shown in Figure 12.

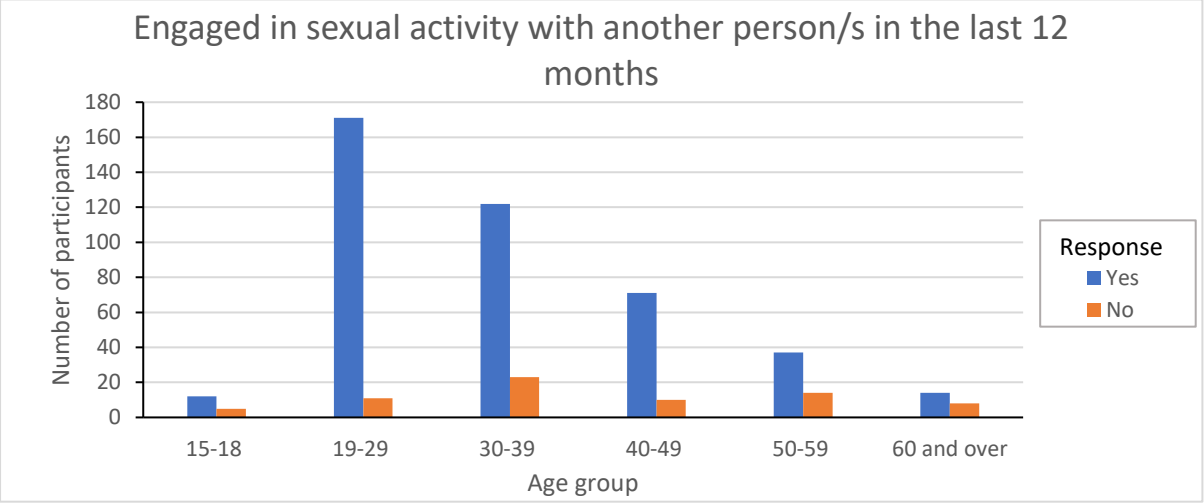

Figure 12: *Number of respondents who engaged in sexual activity with another person/s in the last 12 months.*

Ever been tested for STIs

When asked if they had ever been tested for STIs, 369 women responded 'Yes' (74.10%), and 130 answered 'No' (26.10%) as demonstrated in Figure 13.

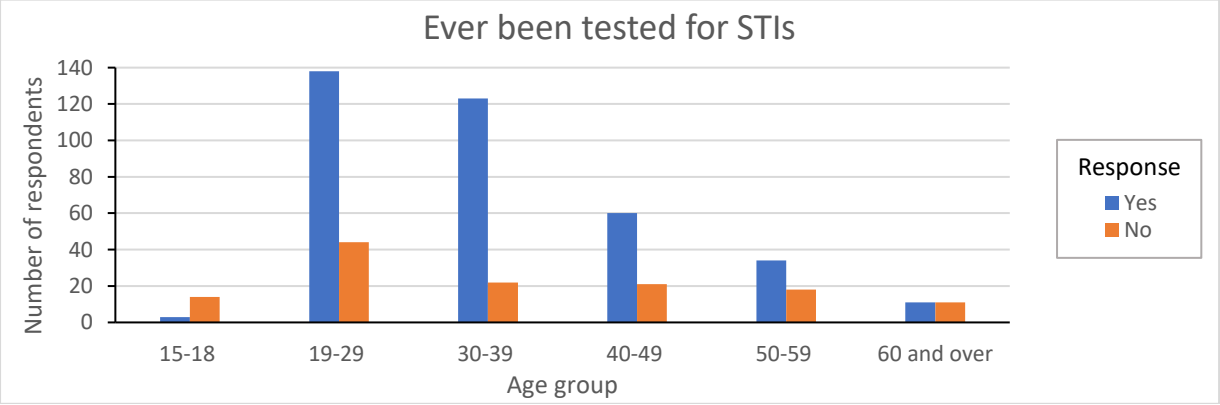

Figure 13: *Number of respondents who have ever been tested for STIs.*

Engaged in sexual activity and ever had an STI test

As shown in Figure 14, an average of 23.42% of respondents (n=100) who had sexual activity with another person/s in the previous 12 months stated that they had never had an STI test.

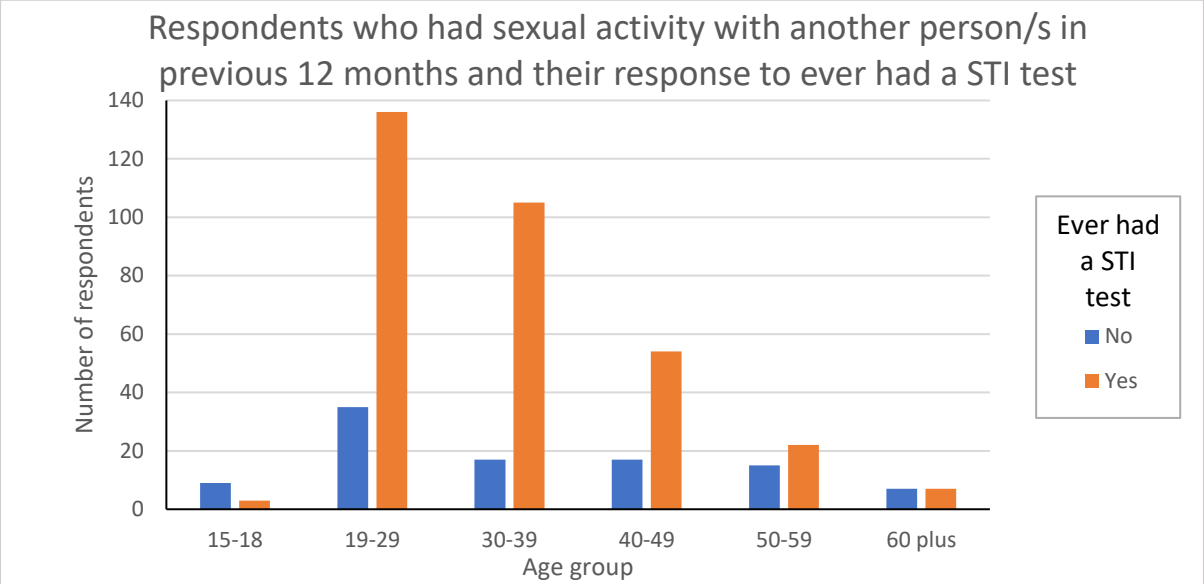

Figure 14: *Respondents who responded 'Yes' to having had sexual activity with another person/s in previous 12 months and their response to ever had a STI test.*

STI testing frequency

Survey respondents were asked how often they tested for STIs. As shown in Figure 15, 120 (24.10%) responded ‘Never’, 54 responded ‘Only after unprotected sex’ (10.84%), 49 chose ‘Once a year’ (9.84%), 34 specified ‘2-4 times a year’ (6.83%), 167 responded ‘Every few years’ (33.53%) and 74 stated ‘N/A’ (14.86%).

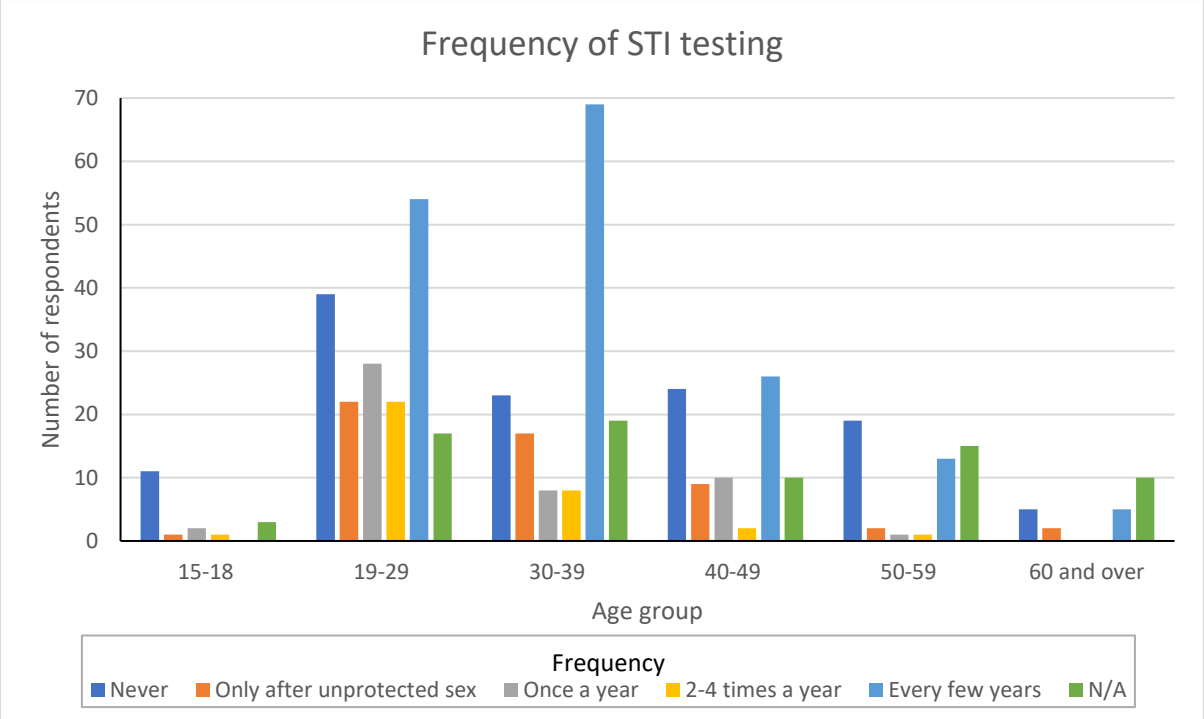

Figure 14: *Frequency of getting tested for STI*

A total of 349 participants also provided further comments about their selection.

'Yes' to have been tested for STIs

Of the 270 who stated that they had been tested for STIs the following were the most common reasons: only after sexual activity with a new person; when in a short term/casual/multiple relationship; good practice for overall health; when there are symptoms; included in pregnancy care routine or IVF; and regularly with pap smears:

> *"I have one sexual partner who has also been tested for STIs, and neither of us have been infected with one. I get more than one a year because the thought of having an STI is terrifying; i figure better safe than sorry."* (15-18 age, 2-4 times a year)

> *"I will not get tested unless I'm about to have sex for the first time with a new partner / having sex with someone different after someone else" (15-18 age, only after unprotected sex)*

> *"Regardless of sexual activity or number of partners, I think it is good to get checked because bacterial or viral infections can often have no symptoms, its better to be on the safe side and get checked out for any problems, I think that these kinds of sexual health checks should not be taught about in school as only being after you are sexually active, unfortunately because of that I think a lot of young people are too afraid to go and get checked because there is a lot of stigma around these issues and they may fear how others will view them. I think a lot more education needs to be given around these issues, particularly in the multicultural community. Sexual and reproductive health checks should be normal and not something that you do only when you 'find a problem'."* (19-29 age, once a year)

> *"I tried to go more and got told it wasn't necessary - even tho I had had multiple sexual partners since the last visit"* (19-29 age, once a year)

> *"Exposure to an STI & unplanned pregnancy at a very young age I have since remained vigilant about this as it was obviously traumatising. My GP is fantastic and supportive with me getting regular checks even though I have a long-term partner. Due to having anxiety about this in previous years, took me a while to realise I didn't need to test excessively (especially with a partner), however now I have decided it is helpful and peace of mind to test yearly and now I might be comfortable to do every 2 years with Pap smear (unless a relationship breakdown)"* (19-29 age, 2-4 times a year)

> *"Have forgotten to use protection on multiple occasions with different partners so I get tested regularly to keep them and myself safe"* (19-29, 2-4 times a year)

> *"I'm in a long term monogamous relationship. We were both tested before having unprotected sex. I don't think he would cheat, but I'm also aware that it could happen, and I'd prefer to stay safe and cautious."* (19-29 age, once a year)

> *"Most times I use other reasons to get blood tests to include STI screening. Or if there is easy available screening at free stations on UNI campus, or festivals. I tend not to do it more often because it's a hassle."* (30-39 age, every few years)

> *"I used to be in a long-term, monogamous relationship so screening seemed rather unnecessary. I am now in a position where I need to get screened more often as I have multiple partners, so the amount I will get screened will increase to at least yearly, but more likely 2-4 times a year."* (30-39 age, every few years)

“When ceasing or entering a serious relationship to ensure the health and safety of myself and potential sexual partners.” (30-39 age, every few years)

“Various reasons but most recently prior to IVF. Unlikely to have again unless my relationship status changes.” (30-39 age, every few years)

“Generally some STIs have been checked for routinely as part of my antenatal care. Otherwise I wouldn't have it done.” (40-49 age, every few years)

“I practice irregular casual sex and I like to be safe, and also if there's a problem with a condom.” (40-49 age, once a year)

“Had a partner who had sex with others, unbeknownst to me.” (40-49 age, every few years)

“Typically if I’m concerned, changed partners or have multiple partners.” (40-49 age, once a year)

“I asked to be tested after I discovered my husband was having an affair. That was nine years ago. I haven't been tested since. I don't know why. Haven't thought about it.” (50-59 age. N/A)

“With a faithful partner and most importantly no symptoms it doesn't seem necessary. I have regular pap smears.” (50-59 age, never)

“I would only consider STI testing when I have another sexual partner.” (60 and over, every few years)

“Partner occasionally strays” (60 and over, every few years)

‘No’ to have been tested for STIs

A total of 79 who stated that they had never been tested for STIs identified the following most common reasons: currently in a monogamous relationship: first and only sexual partner; no symptoms; fear of STI checking; I use a condom; and trust in partner/s:

“Because I haven’t told my parents yet and I’m scared of seeking medical assistance” (15-18 age)

“This is my first partner and I haven't gotten around to it. I feel unable to discuss it with my family or school” (15-18 age, never)

“I really should but I don't have any symptoms and no GP has ever suggested that I should” (19-29 age, never)

“Current partner is the only one I've ever had. He has only had one previous partner and has previously been tested and is clean so I don't see the point in needing to be tested.” (19-29 age, never)

“My husband and I have only ever slept with each other - I was tested for some STI's as routine screenings during my three pregnancies.” (30-39 age, never)

“I have only had the one sexual partner for 29 years and I believe I have been his only sexual partner for 29 years.” (40-49 age, never)

“Have a lovely husband who I trust.” (50-59 age, never)

"Never felt there was any reason to get tested as I have had no symptoms, and had the one sexual partner for about 20 years and before that the one partner for 26 years." (60 and over, never)

Comfort in talking to healthcare provider about STIs and/or asking for a STI check

As shown in Figure 16, when asked how comfortable they felt talking to their healthcare provider about STI's and/or asking for a STI check, a total of 149 women responded 'Very comfortable' (29.92%); 152 selected 'Somewhat comfortable' (30.52%); 76 'Neutral' (15.26%); 80 'Somewhat uncomfortable' (16.06%); and 41 'Very uncomfortable' (8.23%).

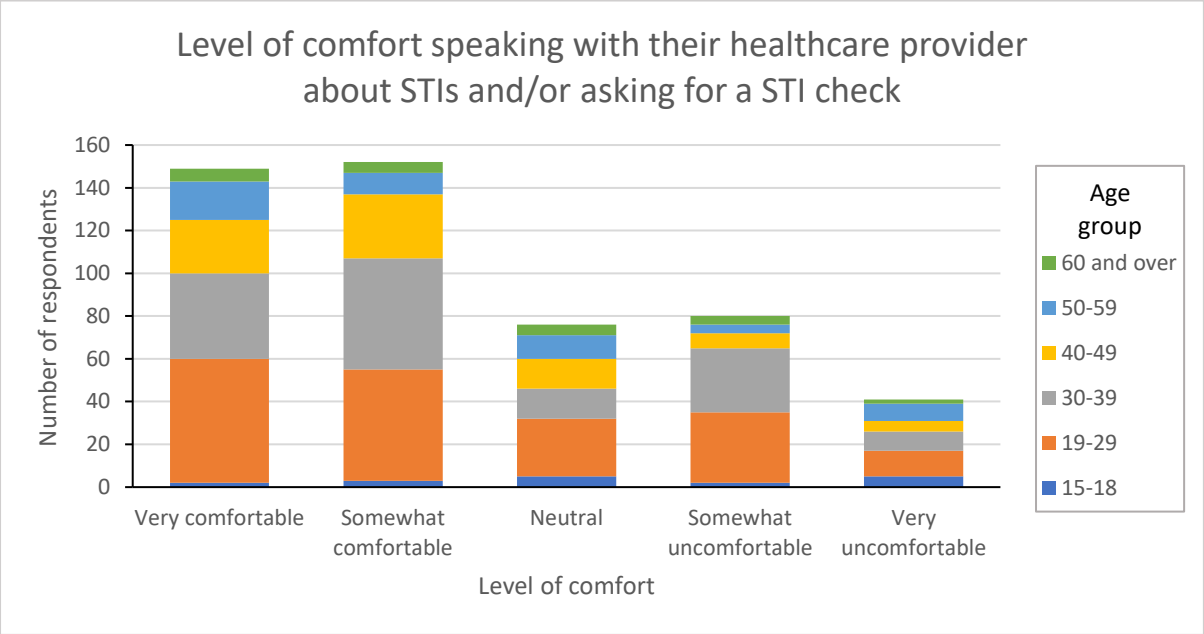

Figure 16: *Level of comfort speaking with their healthcare provider about STIs and/or asking for a STI check.*

'Very comfortable', 'Somewhat comfortable' and 'Neutral'

Out of the 377 participants who selected 'Very comfortable', 'Somewhat comfortable' or 'Neutral' about their comfort in speaking to their healthcare provider about STIs and/or asking for a STI check, 150 provided further comments. The top reasons identified were: a regular GP keeps track of medical history (n=50, 33.33%); trustworthy, supportive and approachable healthcare provider (n=37, 24.67%); STI checks are part of overall health (n=31, 20.67%); an awkward topic but not a barrier (n=26, 17.33%); and this conversation is normal for healthcare providers (n=24, 16.00%) as shown in Figure 17.

"I don't feel a stigma around STI screening, I think it is important and i am not uncomfortable about being healthy." (15-18 age)

'It's a little bit embarrassing but it's their job and you've gotta ask.' (19-29 age)

'My GP is a health professional, and she has always made sexual health a normal part of discussions about my general health. She checks my blood pressure, she listens to my lungs, why shouldn't she checks my reproductive health too?' (19-29 age)

'My doctor has already saved my life twice before I see no need to hide things from her. She's a very trustworthy person' (19-29 age)

'The women's health clinic in Canberra city is fantastic! The staff are very friendly and not judgmental.' (19-29 age)

'I go to SHFPACT and they have always been wonderful' (19-29 age)

'I really like my GP. She is a progressive easygoing GP who is easy to talk to.' (30-39 age)

'I go to the clinic at TCH. They are open and understanding, so I feel comfortable.' (30-39 age)

'SHFPACT are brilliant - I couldn't ask my GP about these things' (40-49 age)

'I am interested in maintaining my own health and don't want to let any sense of embarrassment get in the way. However I do get uncomfortable if the medical provider treats it as a source of potential shame. I find it easier when they are as matter of fact as I am.' (40-49 age)

'It needs to be done so why be embarrassed.' (40-49 age)

'only now after finding a dr I can get to listen to me... surprising how many do not take middle aged women seriously' (50-59 age)

'Have had the same doctor for 15 years. Feel nervous talking about this but I usually practice what I am going to say first to reduce nerves and some embarrassment.' (60+ age)

'Because I am perfectly at ease with the functions of the body, and quite happy to discuss them' (60+ age)

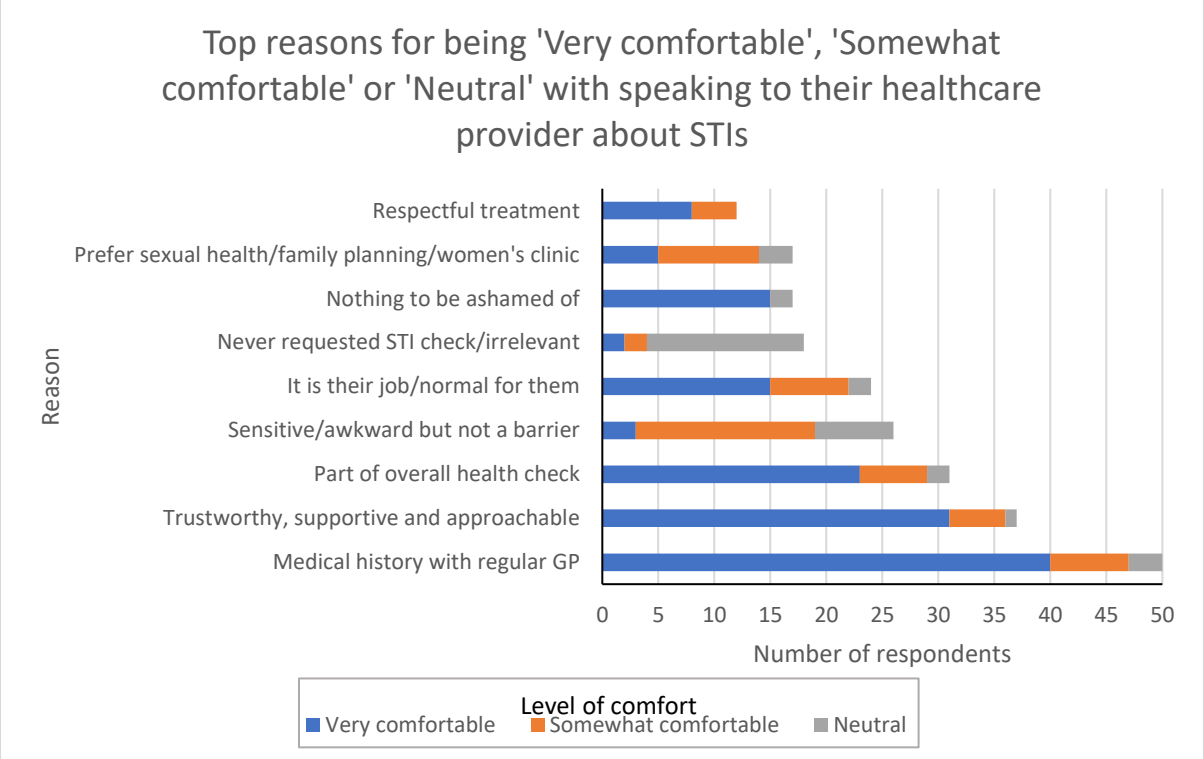

Figure 17: *Top reasons respondents identified for why they rated 'Very comfortable', 'Somewhat comfortable' or 'Neutral' with speaking to their healthcare provider about STIs or asking for a STI check.*

'Somewhat uncomfortable' or 'Very uncomfortable'

Out of 121 respondents who selected that they were 'Somewhat uncomfortable' or 'Very uncomfortable' with speaking to their healthcare provider about STIs or asking for a STI check, 63 provided further comments. The main reasons identified as shown in Figure 17 were: afraid of judgement (n=24, 38.10%); uncomfortable topic (n=16, 24.40%); stigma, embarrassment and being too shy to ask (n=7, 11.11%); and previously affected by trauma or abuse (n=7, 11.11%).

> *"Because I'm a very shy person and I feel uncomfortable talking about those areas"* (15-18 age)
>
> *"Because I am not straight and I am afraid of judgement."* (19-29 age)
>
> *"There is a stigma surrounding STI's and as a young woman I feel that there is a lot of judgement around what women do (i.e. sexual liberty). I think if health care professionals were more approachable and open to discussion I wouldn't feel as uncomfortable. Despite this I certainly wouldn't avoid talking about STI's with my heath care provider as it's my right to ask about my health."* (19-29 age)
>
> *"I find it awkward and prefer to talk to someone I won't see again"* (19-29 age)
>
> *"is difficult as a queer woman - I prefer not to talk about sexual health with doctors as they are often homophobic or at the least heteronormative and it is too stressful"* (19-29 age)
>
> *"I have PTSD related to childhood sexual abuse. I am scared that talking about that might make the GP want to do a vaginal exam."* (19-29 age)
>
> *"I've never had any screening of any sort. Sexual abuse survivor with anxiety disorder"* (30-39 age)
>
> *"I've had strange responses in the past, when the doctor is uncomfortable with my sex life or when they have been too intrusive. For example, once I wanted an STI check because I was sleeping with two men, both without protection, and I had come to distrust one of them, so I wanted an STI check. The doctor was very intrusive about why we weren't using condoms and what contraception we were using. I didn't need to share these details with them. I just needed a routine STI check, so I could make my own decisions."* (30-39 age)
>
> *"They don't bring it up. Stigma attached to asking for the test. They assume you must have an STI to be asking"* (30-39 age)
>
> *"There's a lot of shame and stigma attached to STIs and I have experienced rushed-bordering on rude GPs that make the experience more uncomfortable"* (30-39 age)
>
> *"Don't have a good relationship with my GP and I was sexually abused as a child"* (40-49 age)
>
> *"My GP is younger than me and seems a bit unsure of talking sexual health with an older woman."* (40-49 age)
>
> *"My GP is Christian and when I told him I was a sex worker he said all my health problems were because I had forsaken God. I will never ask for sex related services from anyone other than specially trained staff"* (50-59 age)

"I feel uncomfortable asking my gp for an STI check because I've known her forever and she knows me as a married woman, not as a woman who occasionally has other sexual partners." (60 and over age)

Feeling well-informed about STIs, risks, prevention and safe sex

When respondents were asked if they felt well-informed about STIs, risks, prevention and safe sex, a total of 446 selected 'Yes' (49.56%) and 52 selected 'No' (10.44%) as shown in Figure 18.

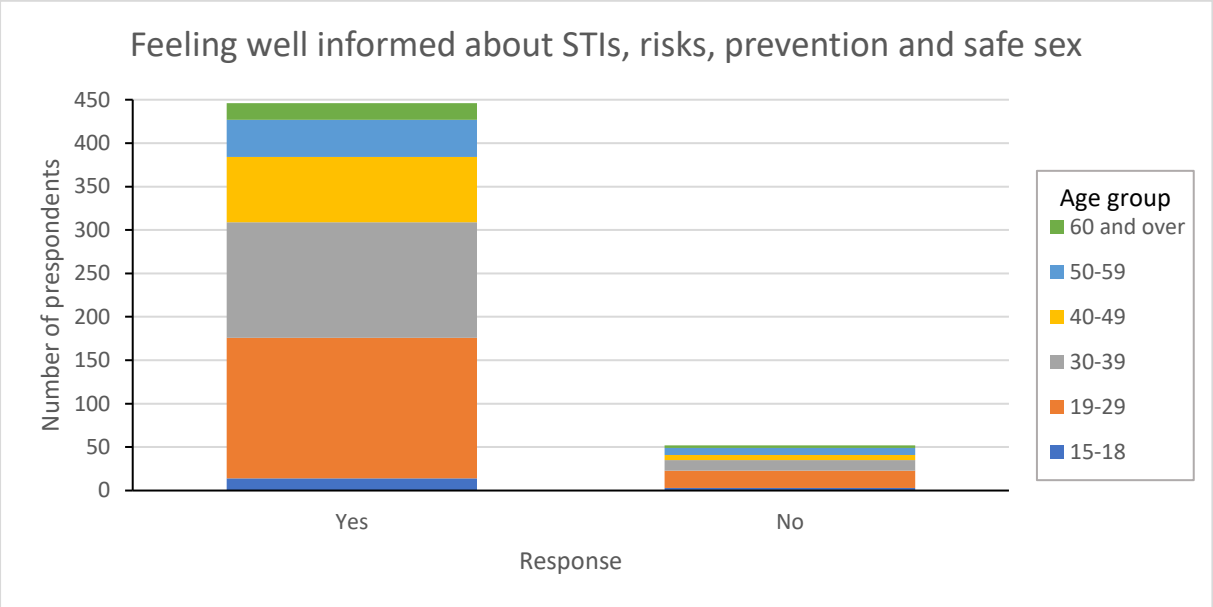

Figure 18: *How well informed respondents felt about STIs, risks, prevention and safe sex.*

'Yes' to feeling well-informed

As shown in Figure 19, for the 155 participants who felt well informed and provided further comments, the top reasons identified were: independent research and good health literacy ; school sex education; discussion with healthcare provider; professional working background in health, youth or women's rights; sufficient knowledge for own needs; keeping updated about health is a priority; and from public health campaigns from the government, community or university (n=16, 10.32%).

"We are well informed consistently from year 5 to year 10 during mandatory courses on health, I am aware of risks of unprotected sex and make informed decisions accordingly. I am also well aware of preventative behaviours to lessen my risk of unwanted pregnancies or STIs" (15-18 age)

"I am very interested in the topic of sexual health and so have done a lot of research myself, but Sex ed in school has benefitted my knowledge too." (15-18 age)

"I had decent sexual health education at school as well as friends who were open about their sex lives and experiences with STIs. I am also a Midwife so familiar with sexual and reproductive health." (19-29 age)

"Before having sex I went to the drop-in centre at the hospital in Woden and got advice on contraception. I went to a Christian school that failed to give any information so i made sure I knew what I was doing myself" (19-29 age)

"Experiences, accumulated conversations/'women's knowledge', …. realising there are risks no matter how careful and being able to follow up with doctor if needed." (30-39 age)

"Extensive education when younger - I was in my teens during Grim Reaper HIV campaign and we had a lot of information and education about HIV and other STIs in school." (40-49 age)

"I thought I did before doing this survey. Will consider discussing with GP, even though I have had same partner for 30+ years and no symptoms." (50-59 age)

"I've tried to keep myself informed by reading about the risks and prevention so that I can educate my daughters." (50-59 age)

"Well educated in general. Had to talk to teenage children mine and others so responsible for their well being. Read written material, watch television and search the internet. Talk to friends and family." (60 and over age)

"I have never had an STI, so must be reasonably well informed. I read a lot about health and try to keep up to date with what's happening." (60 and over age)

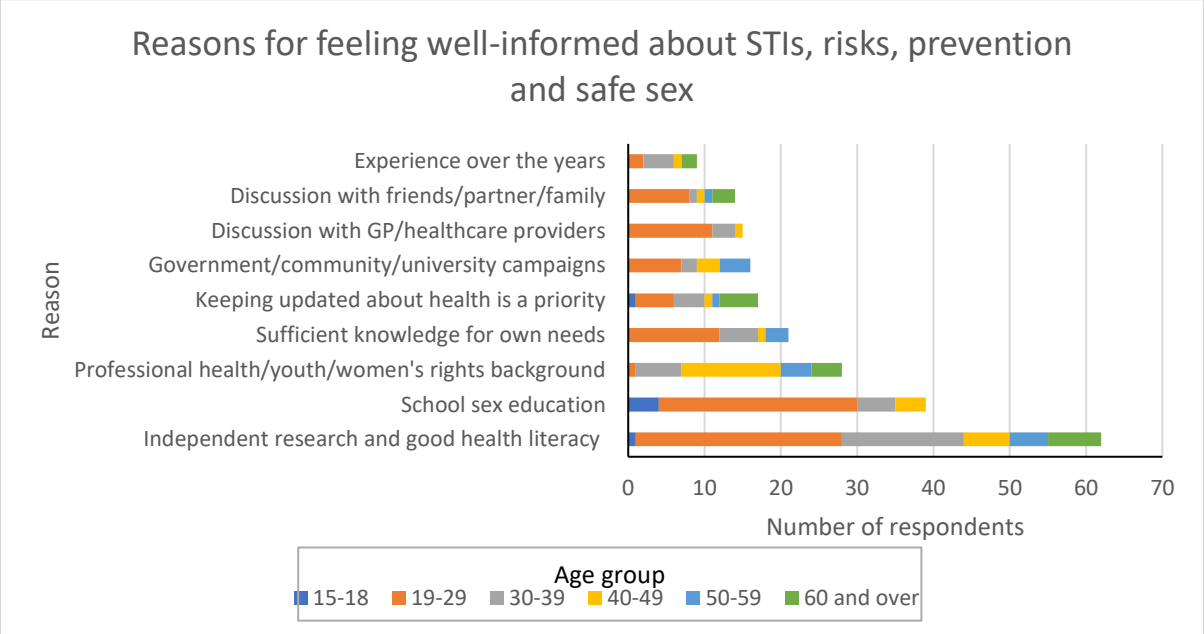

Figure 19: *Top reasons why respondents felt well-informed about STIs, risks, prevention and safe sex.*

'No' to feeling well-informed

A total of 25 participants who stated that they did not feel well-informed about STIs, risks, prevention and safe sex, provided further comments. The top reasons identified were: could be better informed; not proactive in seeking information; and insufficient school sex education.

"Growing up it wasn't really focused on enough. I didn't learn until my 20s that oral sex could get STIs as well" (19-29 age)

"Because, while I know a lot now, I'm in my mid 20's and I feel I should have been taught a lot more before I turned 18." (19-29 age)

"I feel I could know more information as I have HPV and do not know how my checks change with the current amendments to pap smears." (19-29 age)

"As an adolescent I had no idea about safe sex or risks associated due to lack of education by parents, GP, and school. I had to find out for myself how it all worked." (19-29 age)

"I do in a general sense but have no idea on safe sex etc for non-heterosexual women" (19-29 age)

"Not as it applies to me as same sex attracted." (30-39 age)

"Poor sex education at school Stigma" (30-39 age)

"Likely my knowledge is outdated. but as it has not been a practical need, it has not been important to keep up-to-date on information regarding STIs." (40-49 age)

"It's never been a major concern - I never had unprotected sex prior to marriage. I have had the same partner for 20 years. I do from time to time talk to my kids about unprotected sex and the risk of STIs. Possibly should be a bit more aware." (50-59 age)

"It has been many years since I have read anything about this, so I have forgotten most of it. All I know is that men should wear condoms as a precaution, but this does not guarantee protection from transmission of STIs, because the condom could break, or they can be transmitted other ways as well." (50-59 age)

"Not addressed towards more mature women" (60 and over age)

Health screening and services

There was a total of 494 respondents to the section about health screening including cervical screening, mammograms, termination of pregnancy, and breast checks.

Cervical screening

The majority, within the age criteria for cervical screening (21 years of age and over prior to December 2017), indicated that they had regular pap smears. As shown in Figure 20, 360 women (72.87%) responded 'Yes' and 134 women 'No' (27.13%).

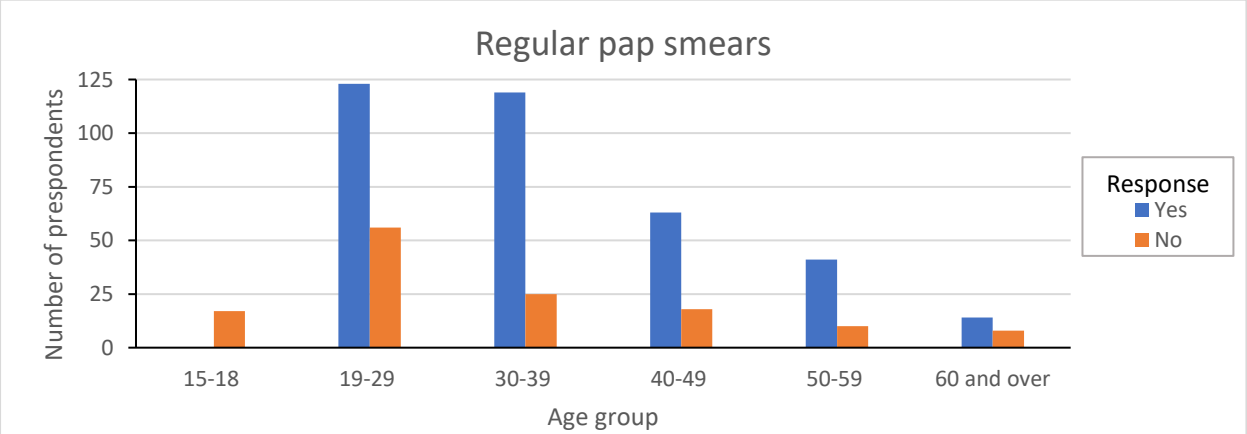

Figure 20: *Number of respondents who have regular pap smears.*

For the 115 respondents who had advised 'No' to having regular pap smears and provided further explanation the most common reasons were: experience is uncomfortable or painful; forget, lazy or not prioritised; no cervix; fear or nervousness about the pain; hassle about finding time, costs and booking; and their age, as shown in Figure 21.

“I haven't had a pap smear as of yet, I only became sexually active two years ago, and I am planning to have one in the near future.” (15-18 age)

“I've been too afraid and haven't have the money to do so” (15-18 age)

“I think it is recommended only to have a pap smear a year after being sexually active, which I am approaching but have not hit yet, or over the age of 18, which I am not. I aim to get one soon.” (15-18 age)

“I was informed I don't need a Pap smear until I turn 25. I'm only 19. But I will get regular screenings once I hit that point.” (19-29 age)

“I never knew when I needed to start having them. I had my first one at the start of the year. I still don't really know how current they need to be.” (19-29 age)

“Unusual amount of pain and no one takes me seriously” (19-29 age)

“Have just started: had my first a few months ago. (I am 22). I knew I was supposed to get them earlier but didn't want to pay to go to doctors, didn't know how to book it without it being awkward. Didn't know what it involved and what would happen if it would be painful etc. Now I've done it I'll go more regularly because there's nothing to be scared of” (19-29 age)

“Previously my GP clinic stopped providing them for free. So they become less regular.” (30-39 age)

“I feel uncomfortable with them. I also find it difficult to find time to get them as I have two small children and don't really want to take them with me” (30-39 age)

“Only when they can be done under general anaesthesia and it's a very long waiting time, sometimes years” (30-39 age)

“Survivor of sexual abuse and don't have a female GP who can do home visits (I'm too sick to leave home).” (30-39 age)

“One of those things I keep putting off due to time pressures, and it's not a pleasant experience.” (40-49 age)

“I have had a hysterectomy and no longer have a cervix” (40-49 age)

“Because I have an elongated cervix and retroverted womb (likely that is the incorrect terminology now). And every time I have a pap smear done, I inform the person doing the smear and say they will need the longer speculum. They inevitably don't listen, insert the wrong one and have to do it again with the right one. Also a couple of doctors have not been able to "find" the cervix. (it's definitely there). It is an entirely uncomfortable exercise. It has been for 20+ years and I don't expect that to change. I did once think perhaps it was a male/female doctor issue and went to a female doctor once and ended up bleeding.” (40-49 age)

“They usually cause me excruciating pain. I have been instructed to advise the people doing the pap smears to use the largest child's speculum, because of the requirements of my body, but sometimes staff refuse to do that, so I put off having them until a medical problem arises that means I have to have one.” (50-59 age)

"Service withdrawn for non-minority groups in ACT Health and I am very upset about this" (60 and over age)

"Told it is not necessary on the basis of my age and health history" (60 and over age)

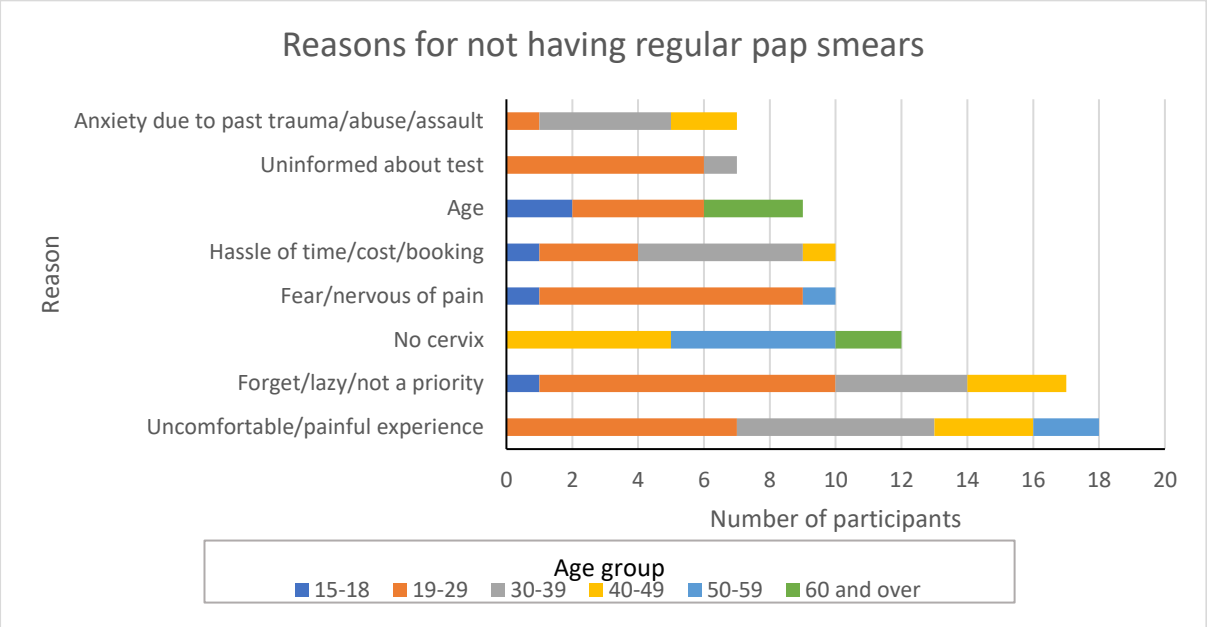

Figure 21: *Reasons respondents identified for not having regular pap smears.*

Mammograms

When asked if they have regular mammograms, a total of 85 respondents (17.21%) reported 'Yes' and 409 (82.79%) reported 'No'. Of the 154 women who were aged 40 years and over and eligible for free mammograms, 74 women (48.05%) advised that they do have regular mammograms.[100] In addition, 11 women between 20 and 39 years of age also indicated that they have regular mammograms.

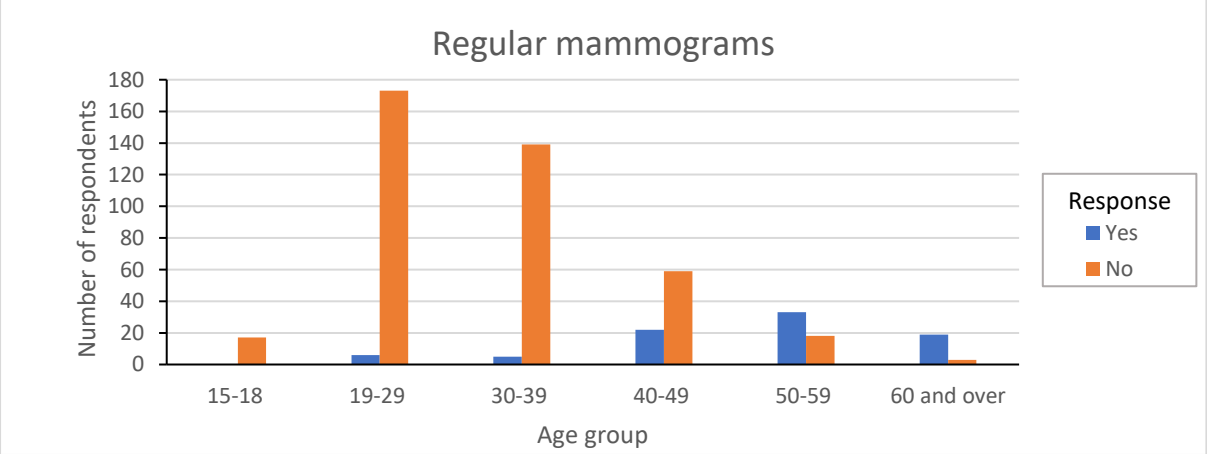

Figure 22: *Number of respondents who have regular mammograms.*

281 respondents who responded 'No' provided a further explanation. They identified being below the recommended age for mammograms as the main reason (n=204, 72.60%); followed by having no risk factors or being unnecessary (n=43, 15.30%); and have never been advised by their healthcare provider (n=28, 9.96%).

[100] Breast Cancer Network Australia, 'BreastScreen Australia', retrieved on 21 June 2018, https://www.bcna.org.au/about-us/advocacy/position-statements/breastscreen-australia/

Knowledge about the difference between medical and surgical termination of pregnancy

When asked if they knew the difference between a medical and surgical termination of pregnancy, 371 women (75.10%) advised 'Yes' and 123 women (24.90%) indicated 'No' as shown in Figure 23.

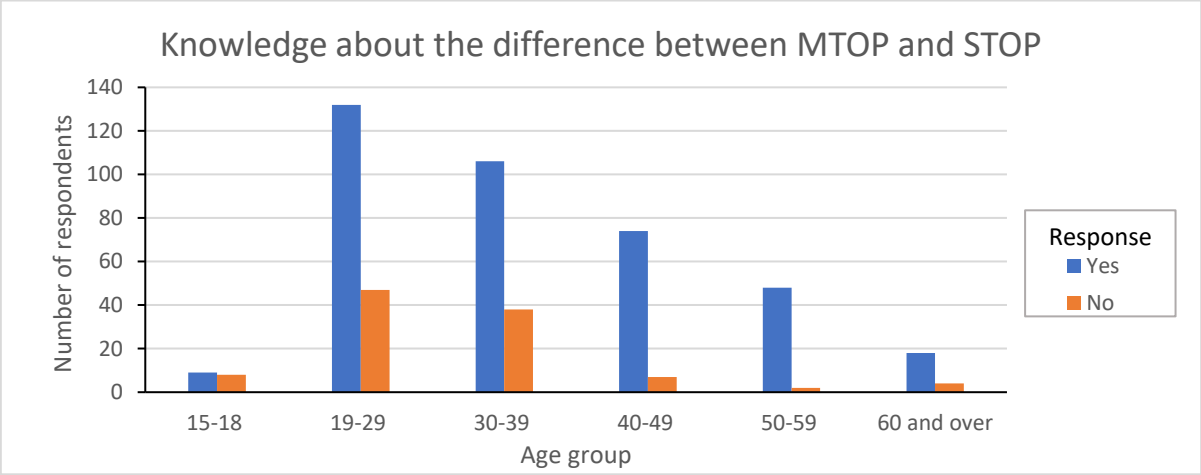

Figure 23: *Respondent knowledge about the difference between medical and surgical termination of pregnancy.*

Knowledge of how to do a breast self-examination

As shown in Figure 24, 389 participants (82.63%) responded 'Yes' when asked if they had been shown or knew how to do a breast self-examination, and 104 participants (17.37%) responded 'No'.

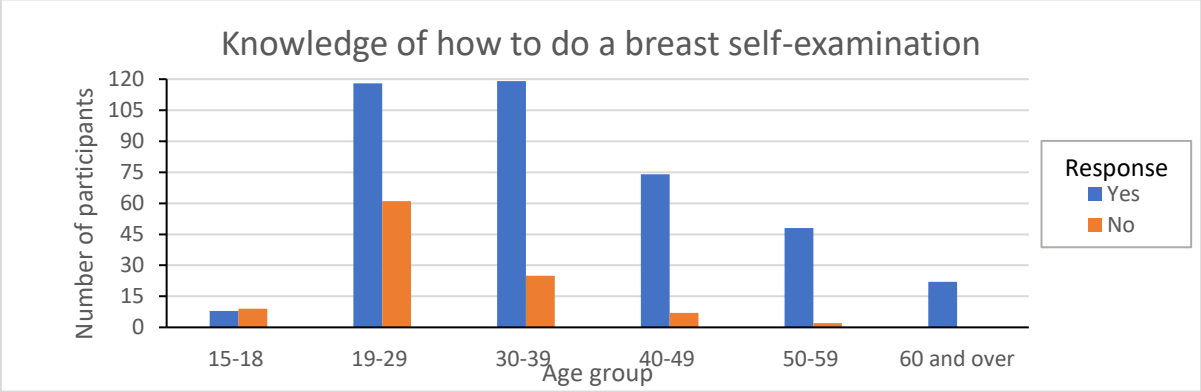

Figure 24: *Participant knowledge on how to do a breast self-examination.*

Contraception

There was a total of 473 respondents to the section with questions about contraception. Table 4 shows the respondents by age groups.

Age Group	Number	Percent
15 – 18	16	3.38%
19 – 29	174	36.79%
30 – 39	140	29.60%
40 – 49	78	16.49%
50 – 59	47	9.94%
60 and over	18	3.81%
All	473	100.00%

Table 4: *Number of respondents to the questions about contraception.*

Feeling well informed about the different types of contraception and their use

When asked if they felt well informed about the different types of contraception and their use, 390 (82.63%) responded 'Yes' and 82 respondents (17.37%) said 'No' as shown in Figure 25.

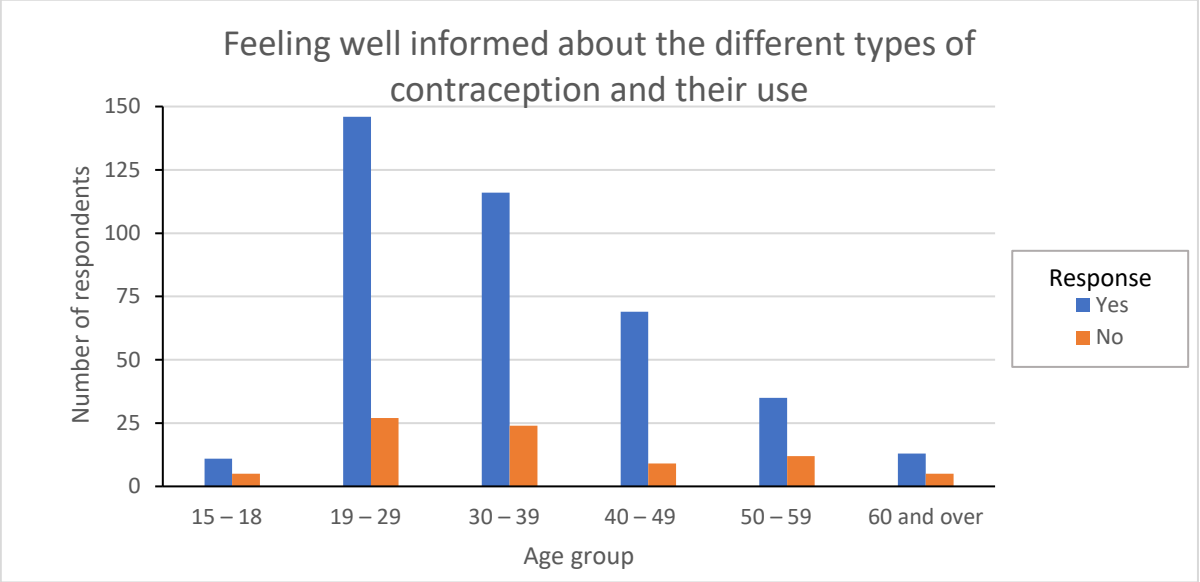

Figure 25: *Number of respondents indicating their understanding of different contraception and their use.*

As shown in Figure 26, of the 152 respondents who provided additional comments about why they responded 'Yes', the most common reasons were: independent research; discussion with a doctor or health professional; having a general understanding or information; and having already trialled various types of contraception.

> *"I have used three different methods of contraception; initially the barrier method of condom use, then the pill and now the implanon. In researching about different contraceptives I have learned a lot and understand them well for the most part."* (15-18 age)

> *"Due to my own experiences, my family's experiences, doctor's advice, and the sex ed program at school."* (19-29 age)

> *"I recently read up a lot about contraception as I have just changed what I am doing. I also talked to the staff at SHFPACT and they gave me a lot of information and pamphlets."* (30-39 age)

> *"Personally - I am confident enough to ask questions to my GP & she is open enough to provide diverse & appropriate options based on my individual needs/medical history Also, working in the youth sector it was always handy to know what's available & how it works, and who it might work for. I always preferred providing options & supporting choice rather than narrowing the field of info for them."* (30-39 age)

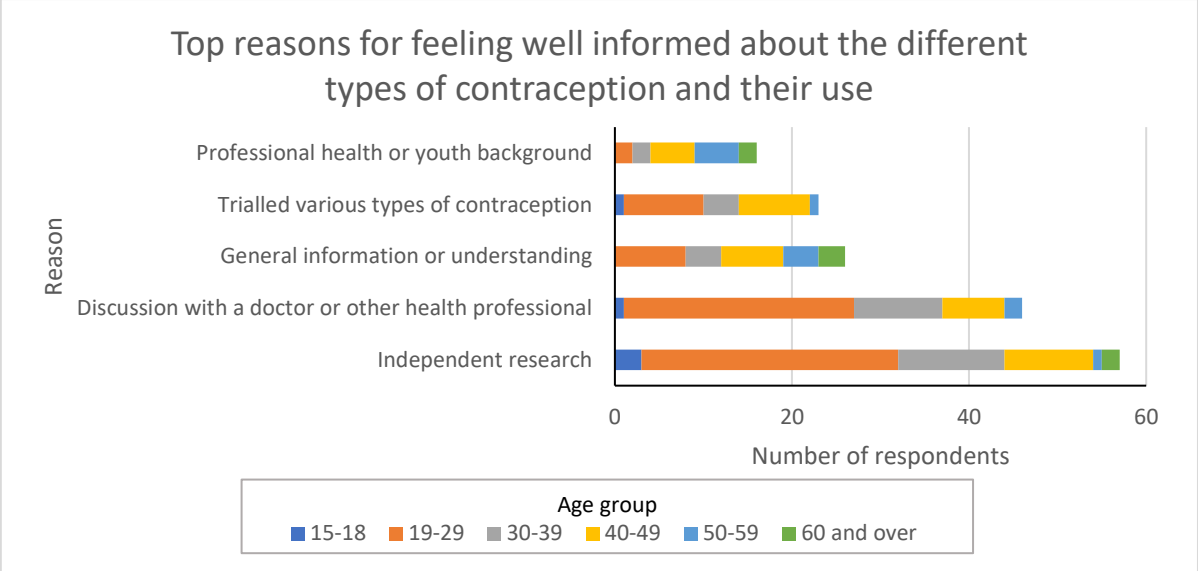

Figure 25: *Top reasons that respondents gave for feeling well informed about different contraception types and their use.*

Many of the respondents also commented that they had experienced having poor discussions with doctors about the different types of contraception or side effects, or felt that their knowledge was not up to date because information was not readily available:

> *"It can be difficult to find correct, up to date and accurate information regarding contraceptives. Particularly when seeing male GPs who will just happily prescribe the pill in one of its forms without actually examining what might be best for the particular situation"* (19-29 age)

> *"I had a conversation with my GP about it and they explained everything. However, the one very important piece of information I never got was that you shouldn't be on the contraceptive pill if you have a family history of blood clotting. I wasn't told this, went on the pill for 2 years, and subsequently developed severe blood clotting in my leg, which now has a lifelong impact on my mobility."* (19-29 age)

> *"I have never been confident about contraceptive options offered by GPS and have taken upon myself to figure out which one I will ask for."* (30-39 age)

> *"Most women are just put on the pill. When I tried the pill and it turned me into a harpie or cried non-stop, the medical sector just wanted me to try other brands. Not ok. There are many other options. The Women's Health Service put me onto diaphragms and showed me how to use them. I also learnt about my mucus and temperature. It is much more empowering to learn about my body and how it works than be"* (40-49 age)

> *"information in Magazines and health leaflets but I am past menopause so not needed"* (60 and over age)

As shown in Figure 27, 67 respondents advised that they did not feel well informed about different types of contraception and their uses The most common reasons provided were: they did not use contraception or that it was unnecessary so they did not need to be well informed; their knowledge was not up to date due to information not being readily available; poor discussions with doctors about the different types of contraception or side effects; having a general understanding or information but could be better informed; and difficulty finding correct information:

"I know the basic types but have not used anything other than condoms and the levlen pill. I wish I knew more about different types of pills but initially went to a busy bulk bill practice when I first went on the pill and it was given to me without much information. I have gone to 4 different GPS for my birth control and have never had the different types of oral contraceptives explained to me. I struggle with this often because I have recently had hormonal changes which really bother me and my to go hasn't raised the impact that my pill could be having. I feel unable to bring it up myself because I don't know much and assume they are taking it into account." (19-29 age)

"I am generally aware of different types but haven't considered it a priority to be well informed as I am a lesbian and so pregnancy is not an issue for me." (19-29 age)

"My friends and I talk and that's really the only way I know about some types on contraception. I wish I had known earlier about some types." (30-39 age)

"I only used the pill and condoms. At 40, my doctor told me I was too old for the pill. Realised I didn't know anything else!" (40-49 age)

"A few new ways I don't really know - contraceptives aren't important at my age" (50-59 age)

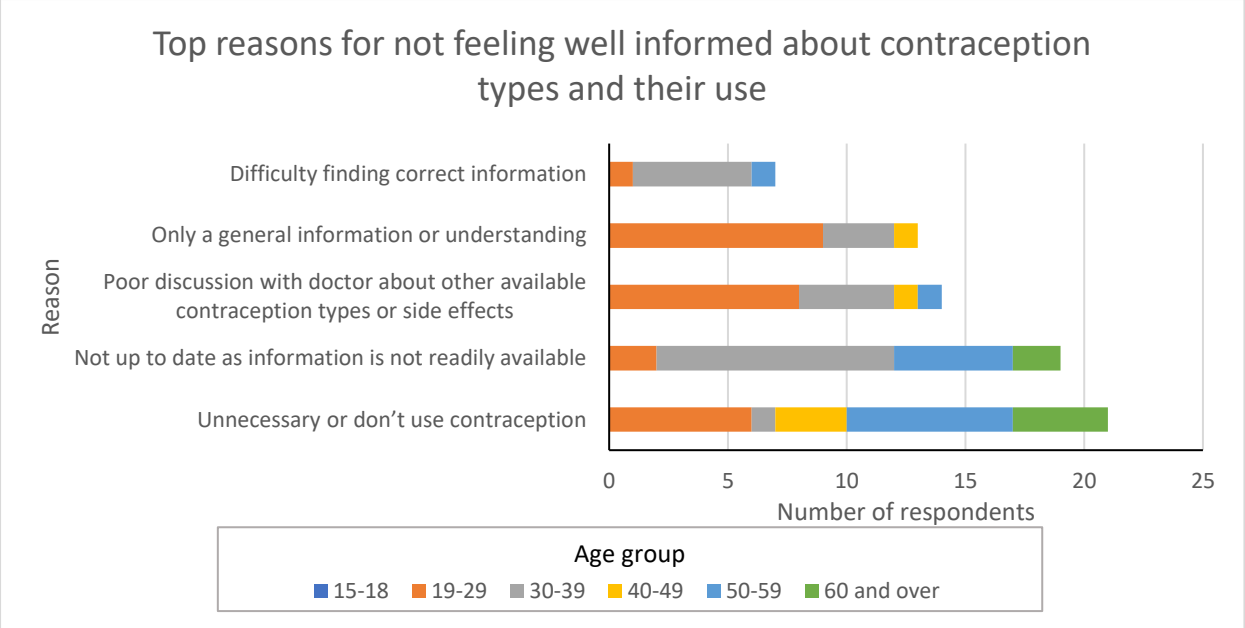

Figure 27: *Top reasons respondents provided for not feeling well informed about different contraception types and their use.*

Comfort in talking to sexual partners about contraception

When asked if they felt comfortable talking to sexual partners about contraception a total of 472 respondents answered. As shown in Figure 28, 84.96% (n=401) responded 'Yes'; 4.03% (n=19) selected 'No', and 11.02% (n=52) advised this was not applicable (N/A).

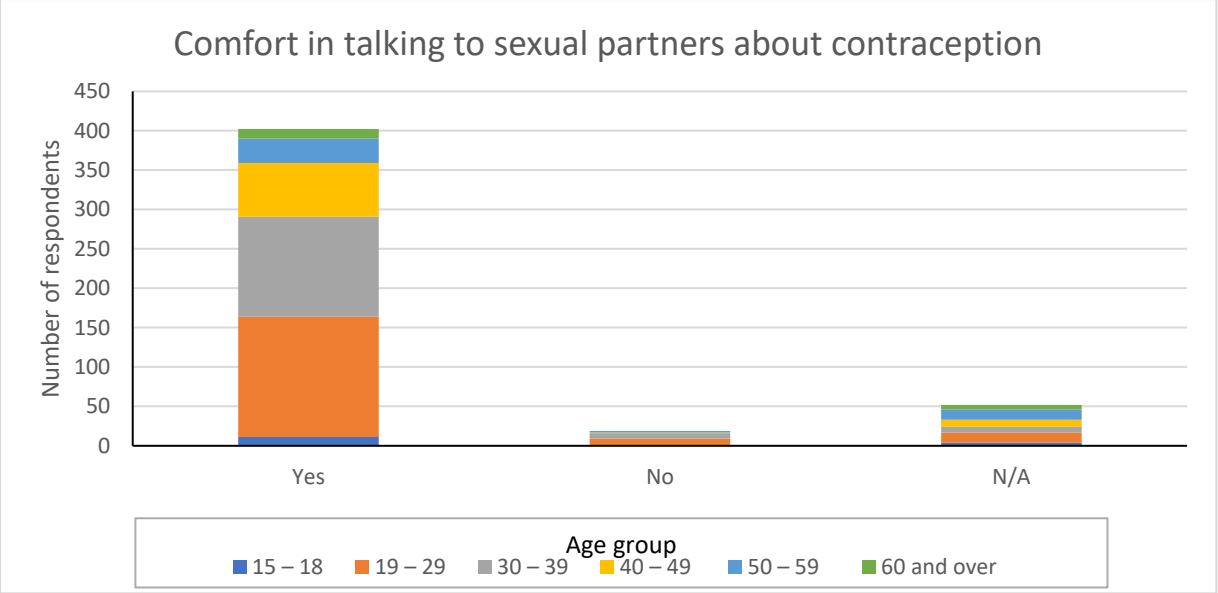

Figure 26: *Comfort in talking to sexual partners about contraception.*

For those respondents who provided a comment about their reason for advising 'No' the reasons included: feeling uncomfortable or awkward about discussing contraception; feeling it is the individual's responsibility and not the partner; feeling pressured by their partner or their partner does not care; and due to past trauma or abuse:

> *"Most of the time I do, but sometimes I feel pressured not to use it or they try and take the condom off during sex"* (19-29 age)
>
> *"When in the moment I feel uncomfortable asking"* (19-29 age)
>
> *"There is an assumption that the female will 'take care of it'.* (30-39 age)
>
> *"Past trauma has caused difficulties with relationships and intimacy"* (30-39 age)
>
> *"Most men that I have been involved with just want to have sex for their benefit, not for mine, and it is a selfish experience on their part, so they usually do not want to use contraception, and I find it hard to push for my needs, including contraception, to be met."* (40-49 age)

The reasons provided by some respondents who said 'Yes' included: being in a long-term relationship; to not have a discussion would be a deal breaker; mutual responsibility; and being in control of their personal health:

> *"Absolutely - it's a two person deal and responsibility. Any form has impacts on both parties, good or bad."* (19-29 age)
>
> *"I am in a committed long term relationship, it is very important to me that both my partner and myself are comfortable and willing to talk about contraceptives to ensure we are both looking after our sexual health"* (19-29 age)
>
> *"When entering a new sexual relationship if it's not on, it's not on!"* (30-39 age)
>
> *"I think it's important to practice safer sex and that belief outweighs any feelings of awkwardness"* (30-39 age)

"Only have sex with people I know well and communicate comfortably" (60 and over age)

For respondents who advised this was 'N/A' the reasons included: not having a partner; their partner having had a vasectomy; and being in a lesbian relationship.

Forms of contraception used

A total of 472 respondents identified the types of contraception they currently use. Each participant was able to select multiple types. As shown in Figure 29, the male condom was the most used contraception (n=136, 28.81%); followed by the oral contraceptive pill (n=114, 24.15%); the Intrauterine Device Mirena (hormonal) or Copper (non-hormonal) – (n=71, 15.04%); the contraceptive implant (Implanon) (n=40, 8.47%); the withdrawal method (n=40,8.47%); with a partner who has undergone a vasectomy (n=21,4.45%); other natural methods such as lactational amenorrhea method, and fertility awareness based methods (n=19,4.03%); the emergency contraceptive pill or ECP (n=9,1.91%); have had a tubal ligation (n=9, 1.91%); the vaginal ring (n=4, 0.85%); the contraceptive injection Depo-Provera® & Depo-Ralovera® (n=3, 0.64%); the female condom (n=2, 0.42%); and the diaphragm (n=1;0.21%).

A total of 69 (14.62%) respondents advised that they used no contraception and 80 (16.95%) participants responded N/A.

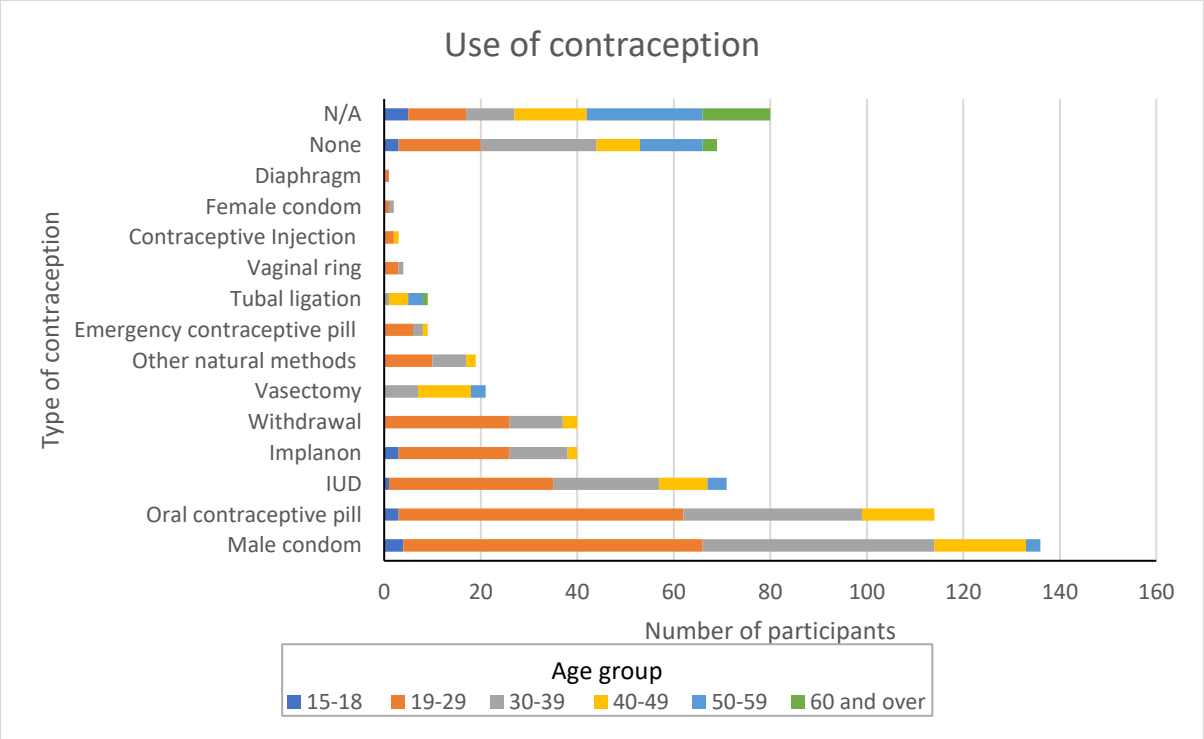

Figure 27: *Number of users by form of contraception used.*

A total of 392 respondents provided their reasons for their choice(s) of contraception. These reasons were coded and the most prominent themes for each contraception type are presented below.

Reasons for using the male condom

As shown in Figure 30, of the 136 respondents who advised reasons for using the male condom, 38 (27.94%) identified because they had no side effects from use; 37 (27.21%) advised ease of use and convenient; 29 (21.32%) indicated effectiveness in STI prevention;

21 (13.97%) was advised it was most suitable for their sexuality, current relationship, age or situation; 18 (13.24%) advised the effectiveness in pregnancy prevention; and 12 (8.82%) noted that the male condom was the best option after trying other contraceptive methods:

> *"Allergic reaction to oral contraceptives, and not in a relationship status where I would be contemplating sex without a physical barrier to STIs"* (19-29 age)
>
> *"Condoms as an added STI barrier with new partners"* (30-39 age)
>
> *"Prevents pregnancy and STIs for the most part, and I don't like taking false hormones in the pill."* (40-49 age)
>
> *"only safe one for my medical issues"* (50-59 age)

Other reasons included affordability and ease of access:

> *"It is the one me and my partner are most comfortable with and it is widely available with no prescription needed"* (19-29 age)
>
> *"It's the only one I know how to get access to"* (19-29 age)
>
> *"Easy and cheap. Haven't bothered to look into something else more reliable"* (19-29 age)

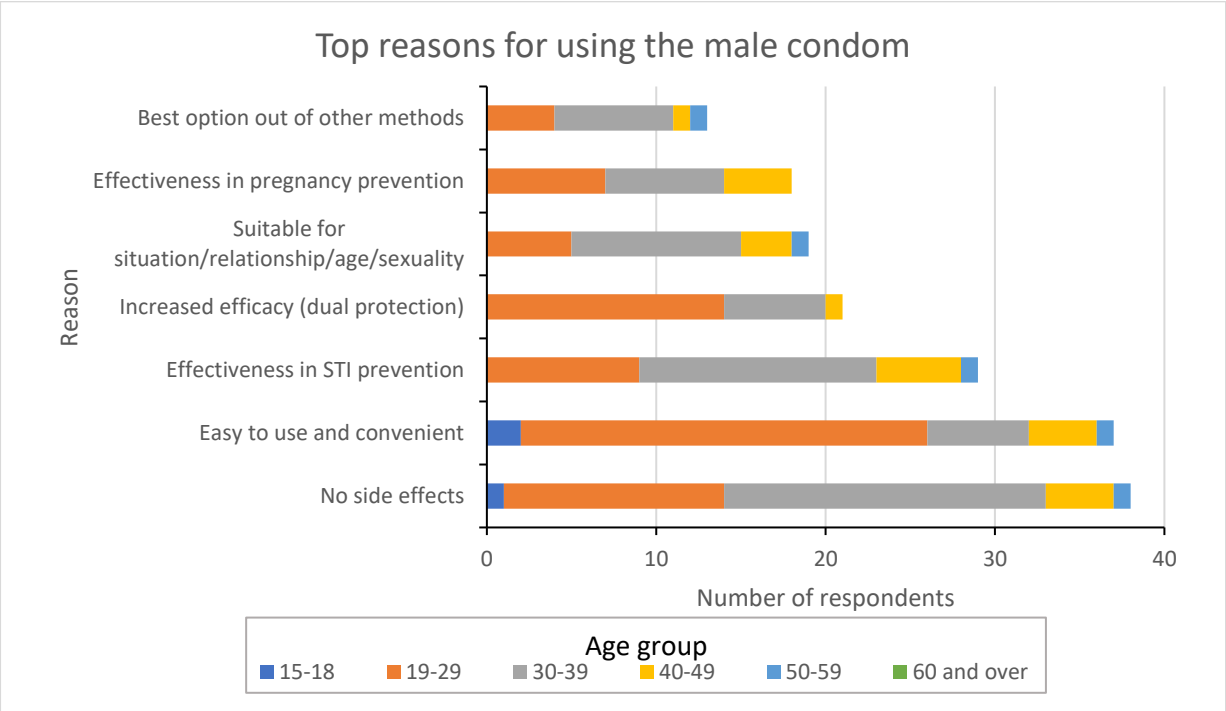

Figure 30: *Top reasons for using the male condom.*

Reasons for using the oral contraceptive pill

Of the 110 respondents who provided their reason for their choice of the oral contraceptive pill for contraception, as shown in Figure 31, the most common reasons were: ease of use and convenience (n=47, 42.73%); used to manage health issues (n=33, 30%); benefits other than as a contraception (n=24, 21.82%); effectiveness in pregnancy prevention (n=16, 14.55%); no side effects (n=13, 11.82%); suitable for current situation, relationship or age (n=13, 11.82%); and reliability (n=9, 8.18%):

"To help with other problems as well as it being easier for me" (15-18 age)

"Convenience, doctor's recommendation, being able to manage my period" (19-29 age)

"Initially went on the pill to help with period cramps and stayed on it because it's mostly effective. We also use condoms to increase the level of protection" (19-29 age)

"Other benefits for depression and PCOS. hormonal regulation" (19-29 age)

"The OCP works well for my lifestyle, I use it to regulate my periods and to help with menstrual symptoms, it's also cleared up my skin. I choose using the pill alone at the moment because I am in a monogamous relationship and my partner and I have both been screened and cleared of STIs." (19-29 age)

"To control Endometriosis" (30-39 age)

"Easy to use, minimal reaction to them, not invasive" (30-39 age)

"I need a temporary easily reversable form as considering another pregnancy and I am not concerned about STI" (40-49 age)

Other reasons for using the oral contraceptive pill were: affordability, accessibility and availability; familiarity from many years of use; recommended by a health professional, the control of fertility; and the best option out of other trialled methods:

"Due to hormonal disposition it has been the most successful of Nuva ring, implanon and normal pill" (19-29 age)

"It's the only type of contraception that's been discussed with me by GP's. It's also easy to use." (19-29 age)

"I use what both the pill and condoms (at the same time) to get a good level of protection against unwanted pregnancy. I don't want to have something added/stuck in my body because i want complete control day to day and the side effects of the pill and condom are well known and they are historically proven as effective)" (19-29 age)

"Because the pill is not invasive and easy to get hands on" (19-29 age)

"easy, cheap, I can control it myself (not rely on someone else) and been with same partner for a long time" (30-39 age)

"Been on contraceptive pill for years and afraid to try other methods" (40-49 age)

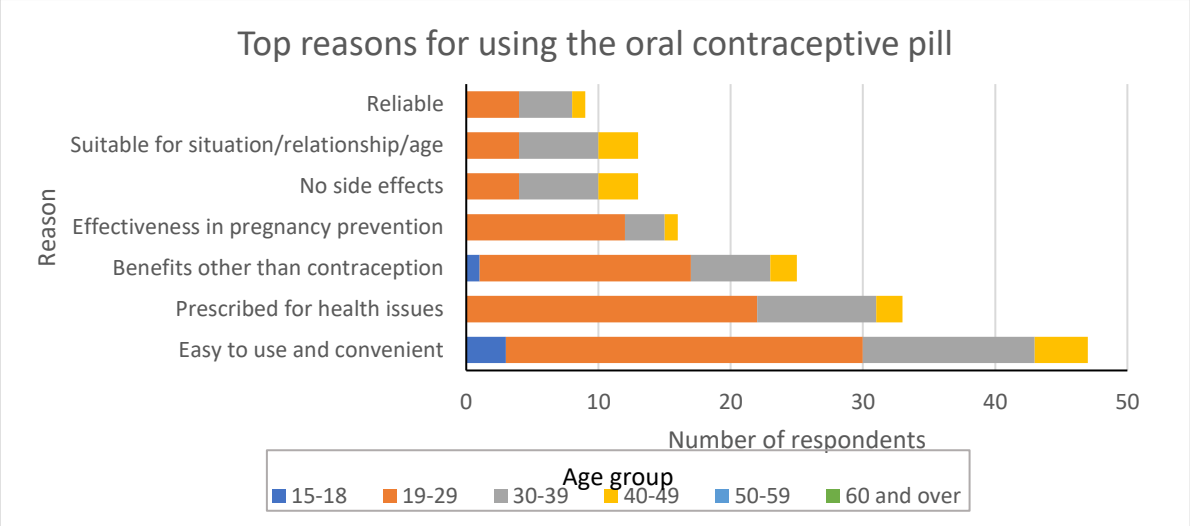

Figure 31: *Top reasons for using the oral contraceptive pill.*

Reasons for using the intrauterine device (IUD)

A total of 70 participants provided an explanation of the reasons for their use of the IUD. As shown in Figure 32, the top reasons identified by respondents for using the IUD were: no side effects (n=29, 41.43%); prescribed for health issues (n=21, 30.00%); long-term contraception (n=19, 27.14%); easy to use and convenient (n=16, 22.86%; benefits other than contraception (n=10, 14.29%); suitable for current relationship, age or situation (n= 9, 12.86%); and the best option out of other methods (n=9, 12.86%):

> *"I can't tolerate hormone"* (15-18 age)
>
> *"The Mirena does not give me the same mood problems that I faced when using multiple variations of the oral contraceptive pill"* (19-29 age)
>
> *"Works on a longer time scale than other alternatives, can be removed without procedure, doesn't feel invasive, high protection rate, cheap over time and not dependent on having to remember to use regularly (like the pill)"* (19-29 age)
>
> *"I have a long-term partner and we are not ready to have children yet. I have had numerous problems with the pill including depression, weight gain and mood swings. Previous GPs had never suggested an alternative, but rather insisted I have all hormones checked and an internal ultrasound. I finally found someone at SHFPACT who was able to discuss different options that would work for me. IUD is low-hormone directly into uterus so has less side-effects than the pill. I don't have to worry about taking anything everyday at the same time. It allows me to be protected from pregnancy without ever really worrying about it, except for self-checking it once a month. It has also considerably eased period pain and heaviness"* (19-29 age)
>
> *"I wanted a method that was non-hormonal but also reliable (withdrawal/condoms are much less so)"* (30-39 age)
>
> *"Because it alleviates some of the symptoms of Endometriosis for me."* (30-39 age)
>
> *"Long term contraception is very convenient."* (40-49 age)
>
> *"Stroke risk, on warfarin, this is best option for contraception and also to reduce excessive bleeding from warfarin"* (40-49 age)

Other reasons that users of the IUD identified were: recommended by a health professional; effectiveness in pregnancy prevention; cost-effectiveness; reversible contraception; and reliability:

> *"My doctor recommended non-hormonal contraception to avoid risk of blood clots"* (19-29 age)

> *"I have had 3 children and do not plan on having any more but we feel too young to have tubes tied or get a vasectomy"* (30-39 age)

> *"Recommended by my gynaecologist after bleeding on Pill. I have been his patient for over 20 years & trust him implicitly"* (30-39 age)

> *'the fact that it's a single outlay that is relatively expensive but is cheaper in the long run versus being on the pill which is getting a prescription every couple of months or three months. It was just not – that time versus effort and energy and money factor.'* (19-29 age)

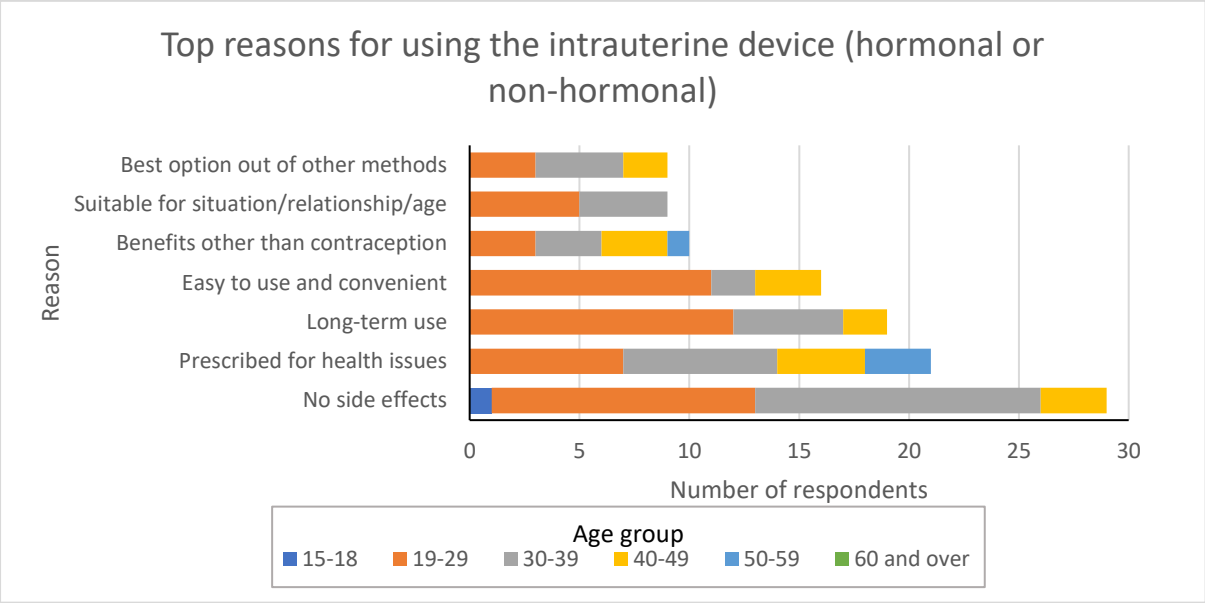

Figure 32: *Top reasons for using the intrauterine device (hormonal or non-hormonal)*

Reasons for using the contraceptive implant

A total of 39 participants described their reason for using the contraceptive implant (Implanon). The top reasons were: long-term contraception (n=19, 48.72%); easy to use and convenient (n=16, 41.03%); no side effects (n=8, 20.51%); and effectiveness in pregnancy prevention (n=8, 20.51%):

> *"I cannot mess up the rod. The pill, or condoms are often used incorrectly, and while well-educated I am scared of this. The rod was the most effective and cheapest next option."* (15-18 age)

> *"Lower dosage over longer period of time, low cost, doesn't require daily pills."* (15-18 age)

> *"With a stable partner we have both been Stu checked so not worried about that. Implanon is reliable and also stops my period from being so painful. Don't have to remember to take it and it's a few years before it has to be changed "* (19-29 age)

"Using implanon and condoms protects again pregnancy and STIs. Implanon suits me more than the pill due to the reduced hormonal component and the fact I'm not relying on my memory to take pills consistently" (30-39 age)

"Long term. Easy. Less side effects. Don't get my period whilst using it" (40-49 age)

Reasons for not using a type of contraception

Some respondents provided comments about why they did not use some types of contraception. Hormonal contraception including the oral contraceptive pill, implanon, NuvaRing and the hormonal IUD were the most commonly avoided because participants had experienced side effects or feared experiencing side effects:

"I've given up on hormonal contraception, as I couldn't stand the side effects on multiple types of oral contraceptive, Nuva ring, and Mirena. With a history of anaemia, I was advised not to try the copper coil (plus my Mirena got lost and had to be removed by a gynaecologist after a transvaginal ultrasound). We'll use barrier methods until my husband can get a vasectomy." (19-29 age)

"I have very bad reactions to hormonal pills and don't think it is worth it for me to put myself through the negative side effectives of a hormonal contraceptive. None hormonal contraceptives are few and far between and have their own side effectives. Male condoms work out to be the best option" (19-29 age)

"I wanted a method that was non-hormonal but also reliable (withdrawal/condoms are much less so)" (30-39 age)

"I have reacted badly to all types of hormonal contraception that I've tried. I had a copper IUD inserted after my last child but after a year it went missing and I had to have general anaesthetic surgery to search and retrieve it! Condoms feels like the only option left. Vasectomy not an option just yet as I'm not 100% sure we are done." (30-39 age)

"Used implanon for years in past and switched to condoms because implanon caused low libido and strong anger" (30-39 age)

"I'm allergic to lactose which is in all the pills, the injection isn't long term, the implant in the arm gave me worse symptoms so the only option was the IUD." (30-39 age)

Some respondents mentioned the "invasiveness" of LARCs:

"Because the pill is not invasive and easy to get hands on" (19-29 age)

"Anxiety over medication and use of things inserted. I have never wanted these options. However I became pregnant from the withdrawal method." (19-29 age)

"Easy to use, minimal reaction to them [condoms], not invasive" (30-39 age)

Other respondents mentioned avoiding the long-term use of a hormonal contraception because it might affect fertility and instead opted for natural methods:

"Free of adverse side effects, associated with very low divorce rates, easy reversibility and highly effective when used correctly" (19-29 age)

"I have been on the pill and the implanon, I decided I wanted to try and go natural to make sure that I won't have any issues having children later on" (19-29 age)

Some participants advised that contraception affected sexual pleasure:

> *"Neither of us enjoy sex with a condom"* (19-29 age)

> *"It [condom] is the one me and my partner are most comfortable with and it is widely available with no prescription needed"* (19-29 age)

> *"Originally because one time we just didn't use a condom and it felt heaps better. I get pain during sex so anything to reduce pain is good. I don't want to use hormones because I'm scared it will affect my mental health. I'm considering a diaphragm but haven't investigated it fully as it doesn't seem to be a method that is used very often by people anymore. Plus my partner thinks its icky!"* (30-39 age)

> *"Best method [vasectomy], no pregnancy, no need to 'be prepared' (allows spontaneity), comfortable"* (50-59 age)

<u>Barriers to accessing contraception</u>

A total of 413 respondents answered the question about whether they experienced any barriers to accessing contraception in the ACT, with 78 (18.16%) reporting that they had experienced barriers, with some listing that they encountered more than one barrier. The main barriers identified were: affordability (n=26, 33.77%); time barriers (n=18, 23.38%); incompatible contraception (n=9, 11.69%); confusing information about contraception (n=9, 11.69%); and limited services available (n=5, 6.49%).

Affordability

The survey respondents who identified affordability as an issue mentioned the combined cost of the contraceptive item and appointments with the service provider to obtain contraception, the impact of those upfront costs, the lack of eligibility for subsidised pricing, and the lack of bulk billing services as barriers:

> *"Having to afford doctors to just get a prescription for a pill I've been taking for 2 years. Costs are also expensive, so I have to factor this in as a Uni student."* (19-29 age)

> *"It's hard to access bulk billing GPs."* (19-29 age)

> *"It's ridiculous that I need to pay so much to see a doctor to get the script then to pay for the medication I have taken daily for over 20 years. Often I put it off as i don't have the time or money to see a doctor. Men don't incur this expense."* (30-39 age)

> *"Getting to the GP is a hassle and expensive with two little kids."* (30-39 age)

> *"Financial constraints of doctor's appointment to get contraception and then cost of contraception."* (19-29 age)

> *"Without having had a child, women are recommended to be sedated while the IUD is inserted. The cost of anaesthetic + procedure is around $300. While this is cheaper than the pill over the life span of the IUD, this up-front cost may deter many from using the IUD as public waiting lists can be quite lengthy."* (19-29 age)

> *"Not eligible for Centrelink low income card so have to pay more Parents stopped me initially"* (19-29 age)

> *"I was able to get the IUD for free because of my age, but if I get any check ups, removal or another one inserted I will have to pay full price"* (19-29 age)

"Cost of device and multiple Dr appointments (to get script, buy implanon, additional appointment for insertion)." (30-39 age)

"The ring is not cheap. I am fortunate I have private prescription cover on my extras. Even then, it is $30 for three months and the GPS don't prescribe more than 8-months worth - so extra GP fees need to be factored into this obstacle as well" (30-39 age)

'I have to pay $100 to see my doctor so that they can give me a script for the pill. They know I'm already on it and I've used it and haven't had any problems.' (30-39 age)

Time

Those respondents who listed time as a barrier mentioned the inconvenience of having to renew their oral contraceptive pill script:

"Time actually booking in to get the pill" (19-29 age)

"I understand the need for a prescription (to ensure I'm being monitored and receiving comprehensive sexual health care, not just a pill), but sometimes it's inconvenient to obtain a prescription. Perhaps a longer term prescription would help? (1-2 years worth of repeats?)." (19-29 age)

"I have to get a script from my GP - with small children and working it is very hard to get an appointment if I need my script updated yet they won't give me an emergency script if there are no appointments available." (19-29 age)

'I was unable to see my doctor when I went off it because it was the weekend. So what that meant was that I had to wait for the following week to get an appointment with my doctor, to get the script, to get the pill. I even tried to all an after-hours doctor and they said it was a matter of rule that they don't provide any prescription for contraception.' (30-39 age)

'The biggest pin point for me, is the waste and drawing out of time. I don't like paying money but I'm in a fortunate position where I can pay. But I at least want timely access to services.' (30-39 age)

Respondents also noted the time spent booking and attending appointments to obtain the preferred contraception:

"It was a little bit expensive and I had to take an afternoon off work after having my IUD inserted. My regular GP didn't feel confident doing the procedure and recommended I have it done at SHFPACT. I felt embarrassed giving my (male) boss a medical certificate from SHFPACT." (19-29 age)

"Just that you have to go to the doctor to discuss options which is annoying, time off work and affordability." (30-39 age)

" time, amount of time needed to book ahead to get it fitted, needing to take time off work to do it,….." (30-39 age)

'With implanon you need to schedule an appointment to have it removed and inserted…." (30-39 age)

Incompatible contraception

Some respondents commented on the side effects of contraception that leave them with few or only one option available:

> *"Cost of the pill, I pay $75 for mine but it is the only one with no adverse side effects that has really helped my endometriosis"* (19-29 age)

> *"I think my contraceptive pill is way too expensive and the cheaper version does not work as well"* (30-39 age)

> *"Bad experiences with taking the OCP (it had a strong effect on my mood, increasing my depression and PMT)."* (30-39 age)

Confusing information about contraception

Finding correct information about contraceptive types and side effects was described by some survey respondents as challenging:

> *"The different pills and other options are a bit confusing/ it's hard to know which is best for me /my situation."* (19-29 age)

> *"Lack of information of new contraception and newer technology that is available"* (19-29 age)

> *"Another GP tried to talk me out of getting the Mirena because it's not for women who haven't had children - this is incorrect."* (30-39 age)

> *"Difficulty accessing reliable practical information or advice. Not being able to talk through options with a trusted person."* (30-39 age)

Limited services available

Some survey respondents identified difficulty with finding service providers who could insert or remove contraceptive devices:

> *"Having a qualified GP who is trained in insertion - I had to see a male doctor to have it inserted as my usual GP can't."* (19-29 age)

> *"Getting an IUD inserted in Canberra was difficult and costly. Very few accessible healthcare providers offer the service, and rules were strict"* (30-39 age)

> *"Finding clinicians trained to inset Mirenas was initially an issue. Have one now."* (30-39 age)

> *"Not all GPs do implanon because they need specific training. There's a different barrier for that particular contraception. I'd wasted a referral going to my GP, they said I had to go to this different provider. I had to book in and wait two weeks until they were free and then get that done. So yes, I've seen sexual health and family planning for a range of things along that continuum. I've found them to be great, because they are specialists. It's what they do."* (30-39 age)

Awareness of access to free condoms from SHFPACT and AIDS Action Council

When asked if they were aware that they can access free condoms from Sexual Health and Family Planning ACT (SHFPACT) and AIDS Action Council, 253 out of 467 (24.18%) survey respondents said 'Yes' and 214 said 'No' as shown in Figure 33.

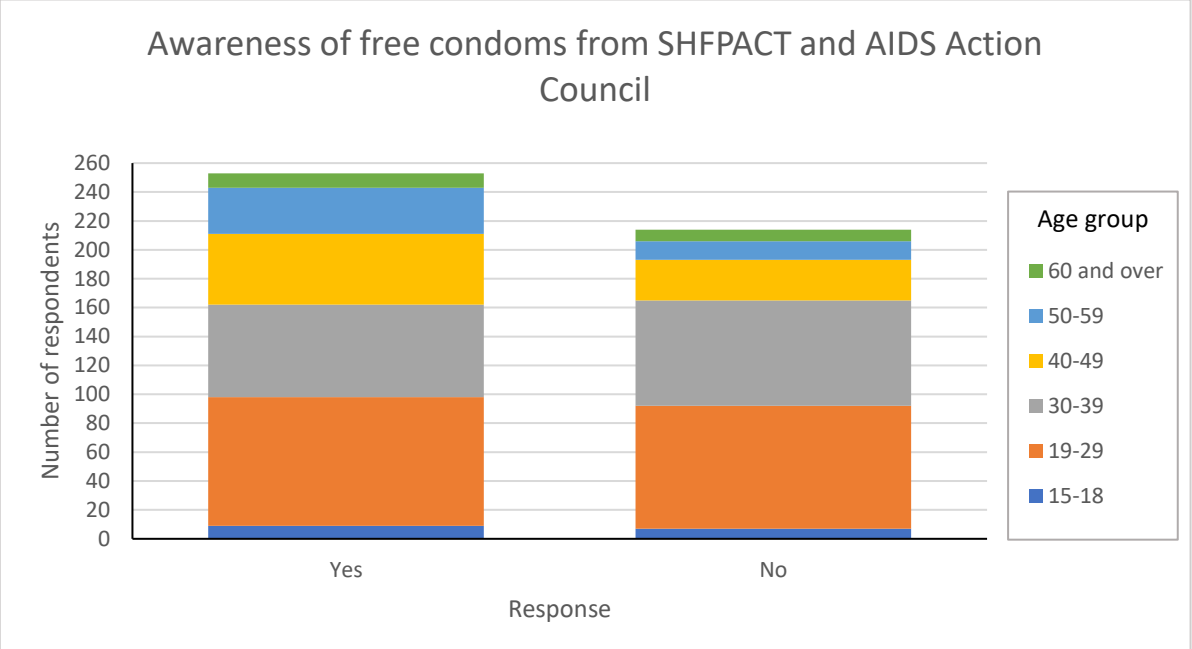

Figure 33: *Awareness of access to free condoms from SHFPACT and AIDS Action Council.*

Awareness about the effectiveness of the emergency contraceptive pill for between 90 and 120 hours after unprotected sex (depending on type)

A total of 472 respondents answered the question about awareness that ECPs that can be effective between 90 and 120 hours after unprotected sex. As shown in Figure 34, 345 (73.09%) respondents said 'Yes' and 127 participants said 'No' (26.91%).

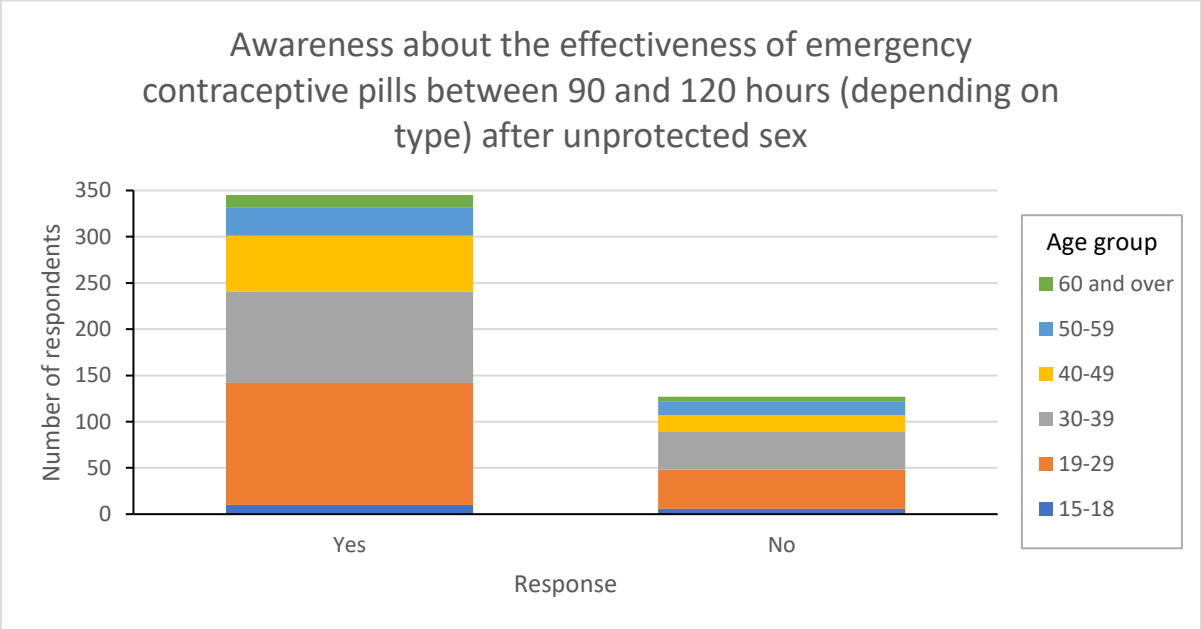

Figure 34: *Respondent awareness about the effectiveness of emergency contraceptive pills between 90 and 120 hours (depending on type) after unprotected sex.*

Awareness that the emergency contraceptive pill is available from most pharmacies without a prescription

A total of 473 participants responded to the question about awareness that the ECP can be accessed at most pharmacies without a prescription. As shown in Figure 35, 72.09% (n=341) of the participants advised 'Yes' and 27.91% (n=132) advised 'No'.

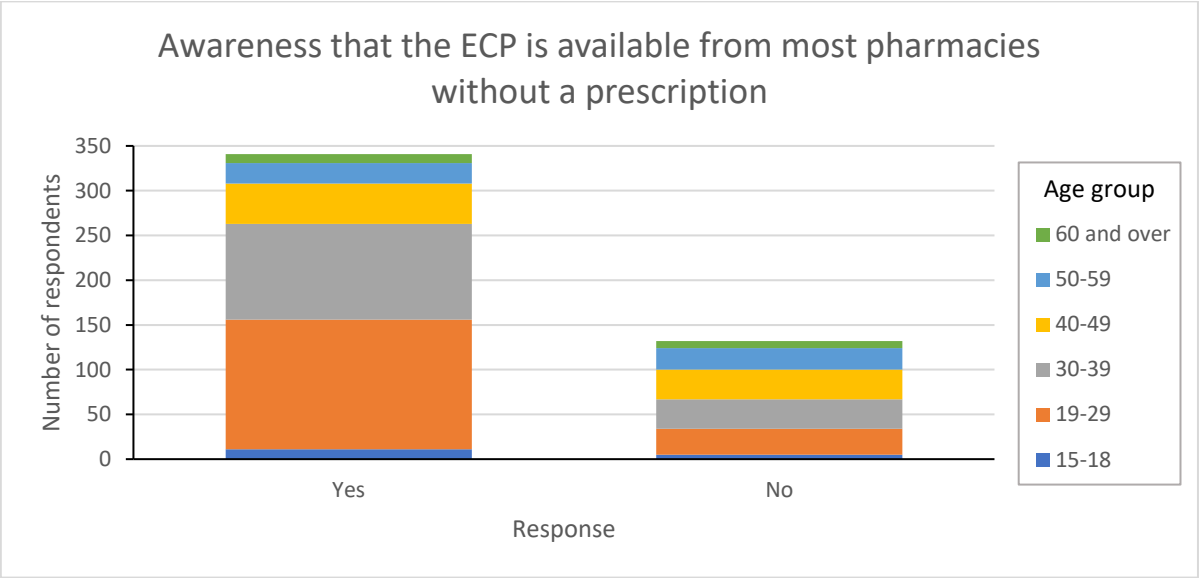

Figure35: *Respondents' awareness that they can access the emergency contraceptive pill from most pharmacies without a prescription.*

Termination of pregnancy

Information about pregnancy termination

Forum participants were asked where they would access information if they required pregnancy termination services. Responses included the internet, a regular GP, a termination clinic, gynaecologist, family planning clinic, and online support group.

> *"In terms of the actual steps, source 1. was the Internet and source 2. was Marie Stopes and looping in any other professionals as I saw fit.*" (30-39 age)

> *"I called Sexual Health and Family Planning as my first port of call and it was no sorry we don't do any services like that." (19-29 age)*

> *"I'd go to the GP and I would do some Googling as to where termination services are available in the ACT so I would at least in my mind know what and where et cetera. and then I'd go to a GP to start the process."* (30-39 age)

Some women emphasised avoiding the internet due to the contentious nature of abortion could bring up not only unreliable information but also emotionally distressing material.

> *"I would start with my doctor or any doctor. There's a waiting period for my doctor. Maybe the 7 days medical centre in Belconnen. To get information. Or even a pharmacist. They might know where I should go to get that information. I wouldn't google, I would try not to, I think that I would end up with a lot of conflicting information that would make me more confused."* (19-29 age)

Other women advised that they would personally seek out a website made locally about women's health and some in felt that WCHM should have the latest information online for women in the ACT and surrounding areas.

> *"If your agency is one of the peak representations of women's health then wouldn't it be great to have something on your website for women who are looking for a medical termination of pregnancy that they could have a page they could go to where the different options and where they can go? I don't know, unless that information is in a centralised place elsewhere in another health service, it would be neat and tidy to have it if you guys do as well."* (30-39 age)

Women who reported that they have experienced a TOP discussed feeling isolated and would like to have known about the prevalence of TOPs:

> *"I felt like I was walking in blind into this real shameful, dark secret. It is, the way its practiced now but it shouldn't be. Because if it's one in three, that's almost everyone. We talk about domestic violence as one in three and that's come from a place where 15 years ago we couldn't talk about it publicly, now we can talk about it in a café or in the workplace. How do we get abortion to be a similarly open topic?"*

> *"I know statistically it's not just younger women, its 1 in 3 and that many women are married or have a partner or they already have children."*

> *"You had to figure out what was going on and how that you went through it and dealing with the fact that it was quite a taboo that now years on since talking about it a lot – so many people have been through the experience, but you would never know when you're actually going through it. It's still quite people go through it quite silently still. So it was really just trying to find out on my own and going through that."*

<u>Comfort in speaking with a regular healthcare provider about pregnancy termination</u>

A total of 463 participants responded to the question asking if they would feel comfortable talking to their regular healthcare provider about pregnancy termination. As shown in Figure 36, 68.47% (n=317) answered 'Yes', 30.02% (n=139) answered 'No' and 1.15% (n=7) answered 'N/A'.

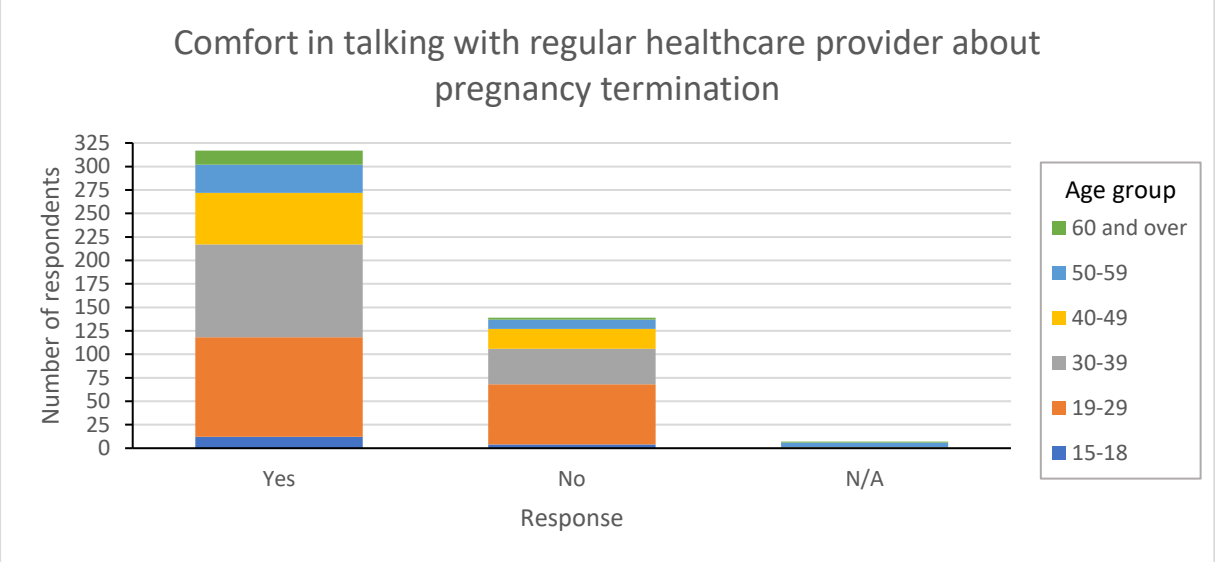

Figure 36: *Respondents views on whether they would be comfortable talking with their regular healthcare provider about pregnancy termination.*

A total of 116 participants who answered 'No' provided comments on their reason. As demonstrated in Figure 37, the most common reasons were: prefer to seek specialised care from a family planning, women's health or sexual health clinic (n=27); fear of stigma and judgement (n=25); personal objection to seeking a TOP (n=23); an uncomfortable and sensitive topic (n=17); unsure about healthcare provider's view (n=16); don't have a regular healthcare provider (n=11); regular healthcare provider would not be able to provide adequate information and support (n=11), and prefer to speak with non-regular healthcare provider for anonymity (n=10):

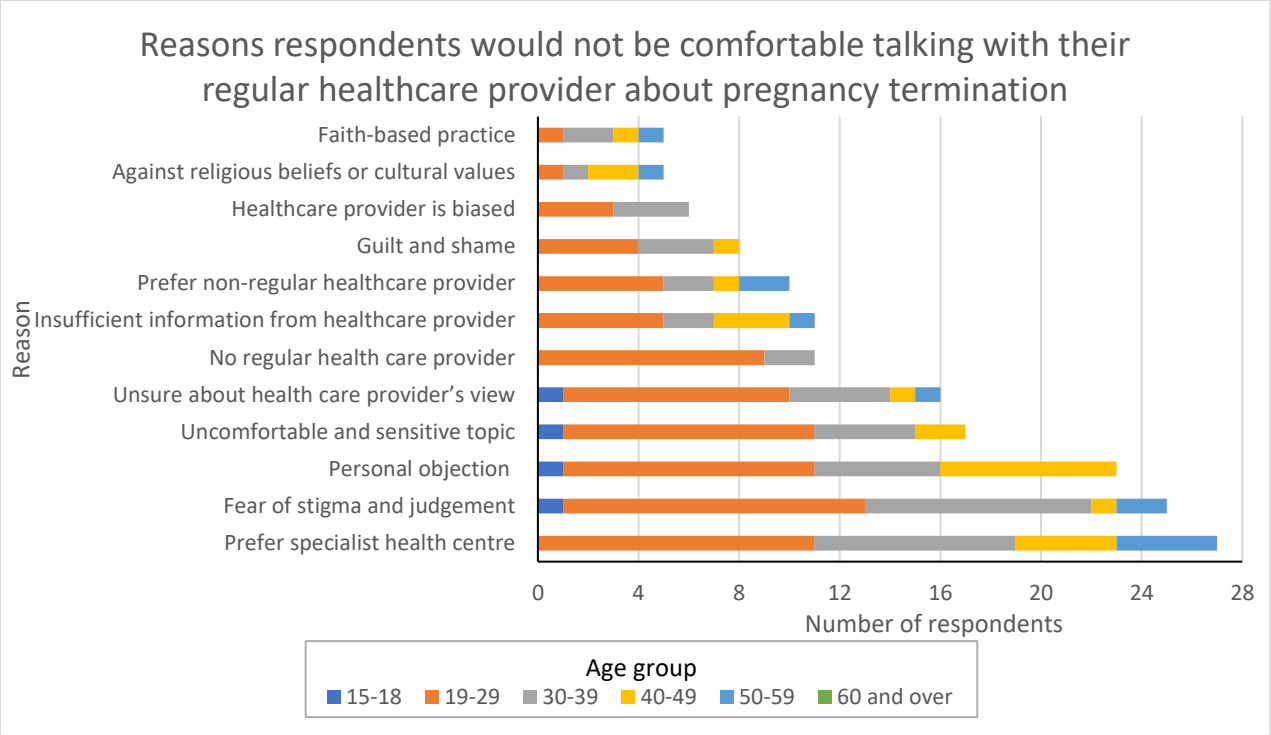

Figure 37: *Reasons identified by respondents about why they would not be comfortable talking with their regular healthcare provider about pregnancy termination.*

> *"I would feel more comfortable talking about this with a health care provider who I knew and who I had developed a level of trust with. However, I have only lived in Canberra for 2 years and have gone lengthy periods without having to need to see a GP. As well as this, due to financial pressure and the fact that a few GPs I have visited have had to stop bulk billing students, I have had to move around to various different GP practices. Because of this, I haven't been able to find a good doctor to develop that level of trust with. So if I did need to talk about pregnancy termination, I would visit somewhere like a hospital or a walk-in centre - somewhere with a degree of anonymity, who would know the best kind of advice to give, and I also wouldn't run the risk of starting to form a good relationship between me and a new doctor before having to move on to another GP yet again."* (19-29 age)

> *"GP is thorough but not very sensitive to sexual health, and I feel that a moral judgement would be place on me and that that would make me uncomfortable, and act as a barrier to asking questions etc because I am young and single- there is more judgement on unplanned pregnancies for single people than couples"* (19-29 age)

> *"I currently do not have a set GP and feel slightly uncomfortable talking about sexual health and pregnancy related issues with someone who I don't know and am unsure about their own ethos surrounding sexual health etc."* (19-29 age)

"I would probably feel more comfortable talking to a professional who deals with cases of unwanted pregnancies on a more regular basis. I feel more certain that I would be treated with respect and provided unbiased information in such an environment." (19-29 age)

"I've known him since I was a child. I don't know that it's something I would be comfortable discussion with anyone" (19-29 age)

"I would prefer to speak to someone at SHFPACT or similar. I don't know if my GP shares my values around termination but I would trust a women's health organisation" (19-29 age)

"Risk of being judged/GP not having up to date information/GP doesn't listen very well. Would go to specialist women's health clinic." (30-39 age)

"I previously had an abortion and my regular GP told me they didn't feel comfortable referring me, as a result I attended a women's clinic for a referral. Should I ever need a referral for this in the future, I'd attend the women's clinic first off to save the judgment and hassle." (40-49 age)

"It is the only area of health that I am not comfortable talking with him about." (40-49 age)

"Because I don't feel this is something that would need to be entered onto my general medical records. I would be happier to talk to someone at SHFPACT" (50-59 age)

Many women spoke about feeling guilt and shame about TOP:

"Feel it's shameful and fear that doctor will judge me/ reject my suggestion for termination" (19-29 age)

"Social stigma. Heard too many stories of medical professionals who've guilted the pregnant person into not terminating." (19-29 age)

"Scared of retribution" (30-39 age)

"I've done it in the past when I wanted to pursue a termination. Unfortunately the doctor I saw at the GP clinic in Phillip was very catholic and was very judgmental about our wish to pursue an abortion. She didn't want to give us any information about our options, tried to talk us into keeping the baby when we weren't ready, and the whole ordeal was incredibly traumatic." (30-39 age)

"It's socially unacceptable to want an abortion, especially in young teenagers. Of course your doctor doesn't judge but you never really know" (15-18 age)

"I feel like there is some judgement when talking to a GP about it largely because I'm at an age when people are choosing to have families and that continuing with pregnancy is the "right" choice because I'm not dumb and young. This might just be a reflection of my GP though." (19-29 age)

Some women who had commented 'Yes' about feeling comfortable talking with their regular healthcare provider still mentioned that they would prefer speaking to a family planning, sexual health, women's health specialist or clinic:

"Because they are my long term gp, it would be beneficial for them to know. I trust my gp. I would, however, feel even more comfortable going to a sexual health clinic because they would have more experience in dealing with these situations." (19-29 age)

"I'd be more inclined to discuss this with SHFPACT than my GP. My GP is wonderful but I would feel more comfortable speaking to specialists." (40-49 age)

Impact of the cost (approximately $500) on decision about going ahead with a termination of pregnancy

Survey respondents were asked the question if they needed to access termination services would the cost (approximately $500) impact their decision about going ahead with the procedure. A total of 462 participants responded and 107 (23.16%) identified that it would, and 352 (76.84%) advising 'No' as shown in Figure 38.

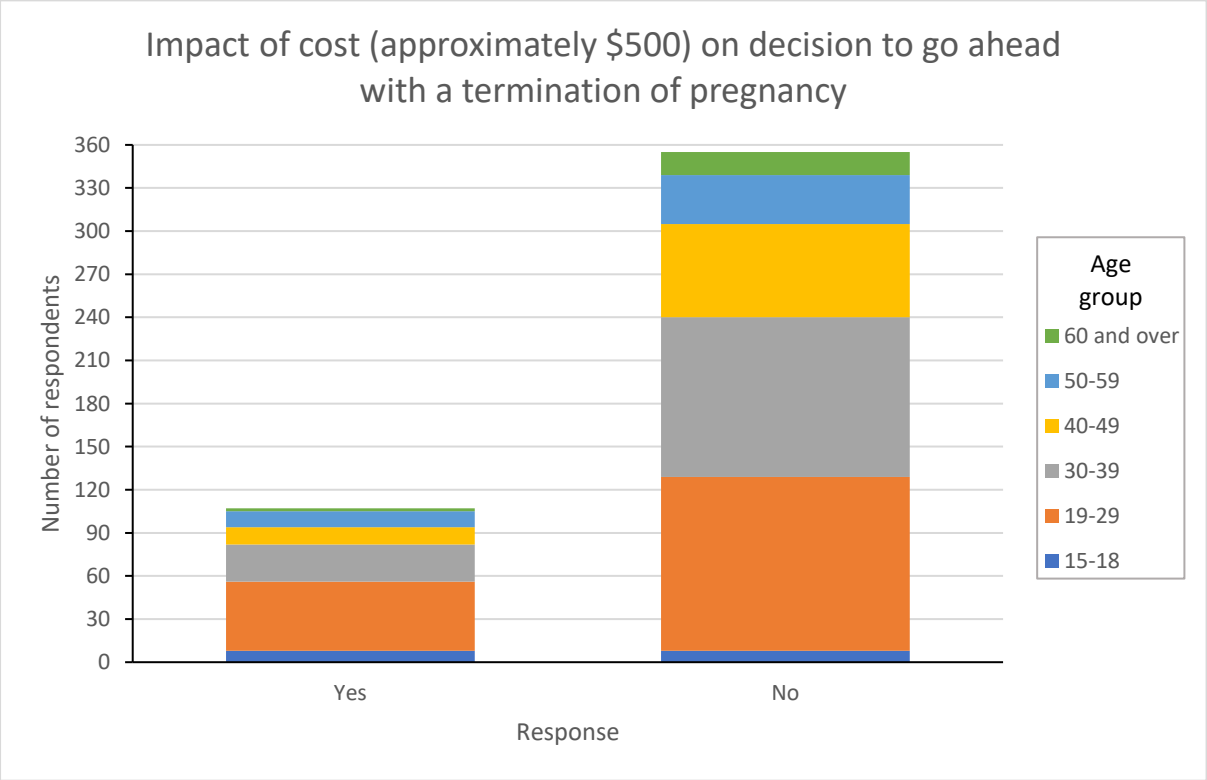

Figure 38: *Respondents' answers to whether the cost of approximately $500 impact their decision on going ahead with a termination of pregnancy.*

As shown in Figure 39, 71 respondents who answered 'Yes' explained why the approximate cost of $500 would impact on their decision. The main reasons identified were: Too expensive (n=37); insufficient personal funds (n=27); stressful budgeting would be required (n=23); and no budgeting capacity (n=14).

"I work for minimum wage which is only $10.40 an hour, with the hours I get, I get $200 a week and $100 from that goes to trying to support me and my mother. Of course I can save up but it would take a while" (15-18 age)

"It is a lot of money to come up with, even for myself in a stable financial situation. Especially given that you are not intending on having to spend $500, don't have the opportunity to save for this and generally comes out of the blue. There is a very small time frame in which you have to make your decision, for me it was a matter of days,

and it was stressful and added pressure having to come up with $500 in a short period of time." (19-29 age)

"I've have never had $500 at once, that's a fortnights disability payment for me, and I can barely afford to live off it let alone get a procedure done." (19-29 age)

"I'm a student, supporting myself on a part time wage. I would struggle to pay to see my regular GP to discuss getting a termination, let alone paying upwards of $500." (19-29 age)

"I guess if you're just bordering on not being able to use the MTOP having to find the time to come up with $500 you might have to end up getting the STOP. Yeah, nah, I wouldn't have that money to fork out." (19-29 age)

"In the current situation I'm saying loud and clear, that is not accessible to the wider population. The cost, the access, physically the transport – that is not accessible to me… I'm lucky to have my parents who help me buy my text books, who if I'm running out of money and I need medication, I never going to go without food or shelter. But I literally don't have that kind of money." (19-29 age)

"Because $500 is a lot of money - for someone on minimum wage, that's almost a whole week's pay. I'm not saying that it should be free, the doctors involved deserve to be paid fairly, but the procedure should be covered by Medicare to increase accessibility." (40-49 age)

"Coming up with $500 in a short period of time without getting a loan would not happen." (50-59 age)

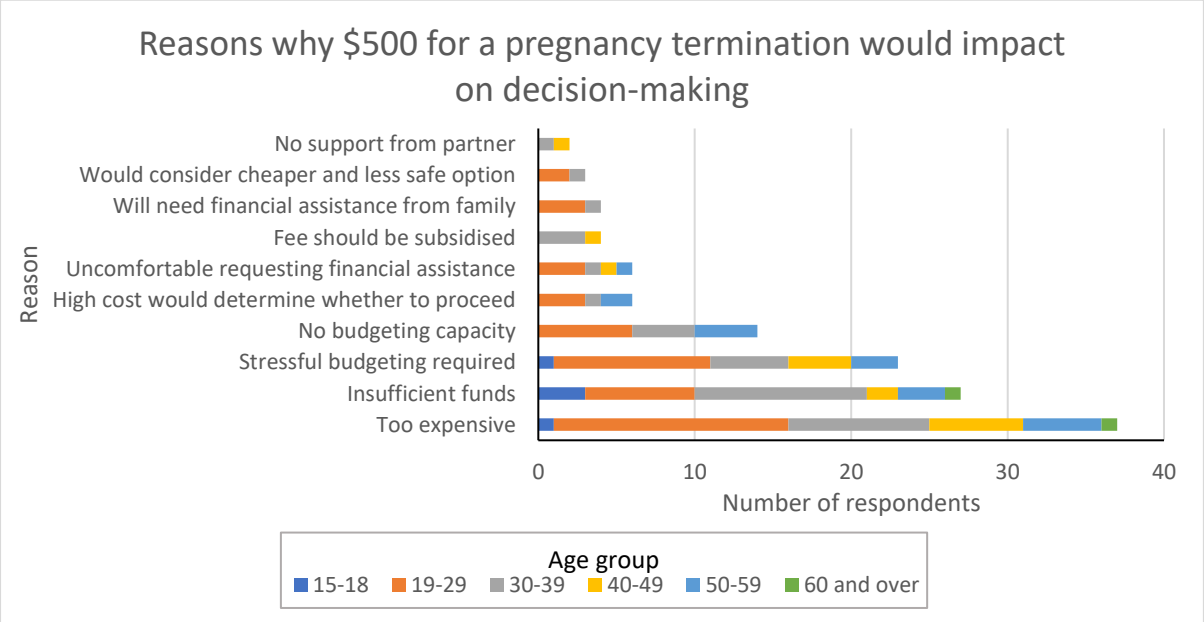

Figure 39: *Reasons reported by respondents about why $500 for a pregnancy termination would impact their decision to go ahead with the procedure.*

Other reasons mentioned were being uncomfortable about seeking financial assistance from partner, family or friends, or seeking out a loan, or having to request financial assistance from family or partner:

"Absolutely, if I was unable to afford it then I wouldn't have it. I would do everything in my power to afford it but at the end of the day if I didn't have the fund I wouldn't. It would be difficult to borrow the money and explain why." (19-29 age)

"I am a student who has considerably little finances and there is barely a week where I don't have more than $20 in savings. However, I also know that continuing a pregnancy would cost considerably much more money and time in the long run, and I do know that my family back home might be able to help with finances in the case that it did happen, but still, the cost would play a significant factor in whether or not I go ahead with the procedure." (19-29 age)

"I don't have heaps of money, and while it wouldn't change my decision it would make it harder to have to find the money. Beg, borrow (but not steal)." (30-39 age)

"Not all women have access to that money. For my case my husband didn't support it so I couldn't access our money and had to borrow from a family member. I'm lucky I had this resource. What would have happened if I didn't? The fee should be subsidised by ACT government to make it truly accessible" (30-39 age)

"Not having stable employment, being casual, having to miss shifts etc" (30-39 age)

"Yes, but if I can't afford $500 then I definitely can't afford to have a baby. I have a mortgage to pay and $500 is a lot of money." (30-39 age)

"I would have to do it using cash so my partner wouldn't see it on my Medicare record. It would not be easy to find that amount of cash without him knowing. I wouldn't want to lie to him anyway, but if I really felt I had to do it the two big problems are cost and worrying about people seeing me going into the clinic. If I could go to my regular GP that would be better." (40-49 age)

"I would not be able to afford that, so either I would not have it (if I was considering, which I am not because I am past reproductive age), or the man who got me pregnant would have to pay." (50-59 age)

Alarmingly, three participants also noted that they would seek out less safe termination options to reduce costs:

"I don't make a lot of money so would have to consider cheaper and unfortunately less safe alternatives" (19-29 age)

"Way too much money, should be under Medicare, for that much money I would just do it myself" (19-29 age)

"Depending on what money I had I might not have enough to go through it safely" (30-39 age)

Another 43 participants who had advised 'No' commented on the impact of the costs on themselves and on the choice of others.

"That's super expensive for a lot of girls who may need that procedure. If I girl can't afford $500 now, how can you leave them with a child who will cost much more? I am lucky enough to be in a situation where I have savings, a job and a supportive partner but obviously not everyone does." (19-29 age)

"I would still go ahead with the procedure but it is a hefty cost for low income earners such as myself" (19-29 age)

"But the cost would affect my quality of life. I would need as much time as I could to get the money in order and take time off work for the appointment." (19-29 age)

"No because a child is more expensive but it would be a significant barrier to actually accessing the procedure" (19-29 age)

"For some women though this wouldn't be affordable…… Even though $500 isn't a lot if you have it, pregnancy being a time dependent issue is where I think the difficulty lies." (30-39 age)

"At first I was surprised at the cost as I thought I could just get the medication from the GP and then go ahead. The process has been a little slow as the only clinics in ACT are 2-3 and Marie Stopes although amazing only funded to operate Thursday and Friday with high demand. Looking forward to GPs getting the formal education, qualification and authority to diagnose and prescribe the medicine for termination in the very near future." (40-49 age)

"But I am aware for many women it would - it should be free" (40-49 age)

"It would have at any other stage in my life so far, however am now in a secure job and could pay or access." (30-39 age)

"I have the ability to pay. However, I know many women that do not and have to beg or go through humiliation to ask for help, sometimes from men that do not care about them and that abuses them. They also need to ask for help from friends and very few trusted women's organisations." (50-59 age)

Comfort in accessing medical termination of pregnancy with the support and care of a regular GP or qualified health practitioner

A total of 459 participants responded to whether they would feel comfortable taking the medical abortion pill with the support and care of their regular GP or qualified health practitioner rather than accessing a surgical termination in a clinic if they required pregnancy termination services. As shown in Figure 40, 81.48% answered 'Yes' (n=374) and 18.52% answered 'No' (n=85).

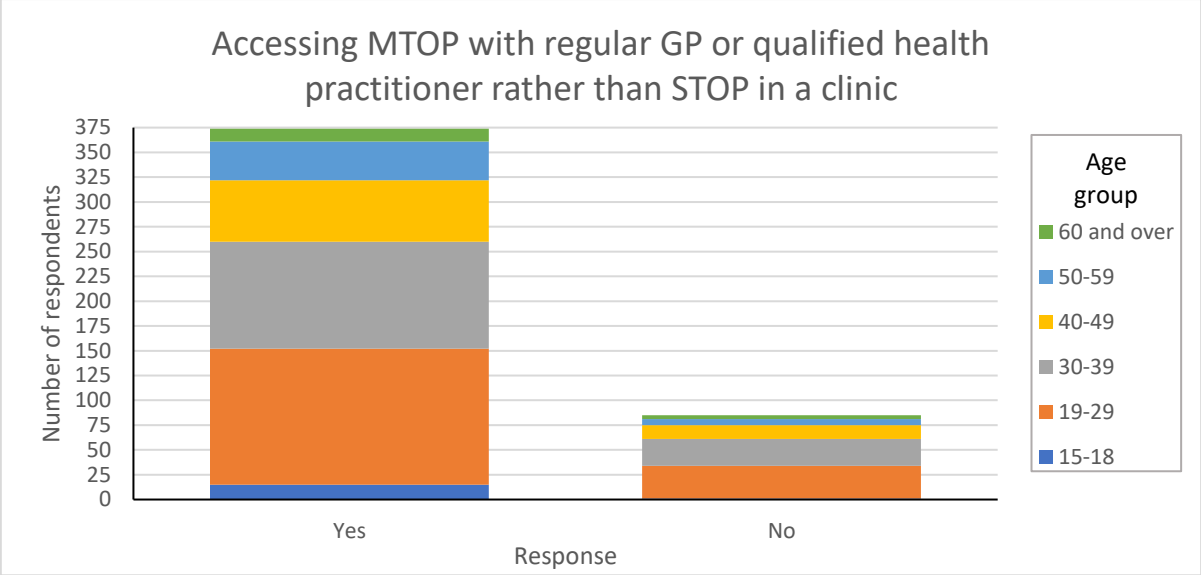

Figure 40: *Number of respondents who would feel comfortable accessing medical termination of pregnancy with the support and care of a regular GP or qualified health practitioner rather than a surgical termination of pregnancy in a clinic.*

A total of 67 out of the 85 women who answered 'No' commented on their selection. The most prevalent reasons identified were: would not terminate a pregnancy (n=20); MTOP has complications (n=18); STOP is quicker (n=15); prefer support and supervision from specialists than at home alone (n=10); have heard negative stories about MTOP (n=8); and emotionally confronting (n=6):

> *"Actually not sure, I would, however, rather get a surgical termination. Although it is an invasive procedure, I would feel as though it was more controlled, even though I am aware both are safe procedures."* (15-18 age)
>
> *"I don't like this option, as I was advised it causes pain and was described to me as "bringing on an abortion"* (19-29 age)
>
> *"Would prefer the surgical option as it is quicker and I have heard the cramps from a medical abortion can be painful."* (19-29 age)
>
> *"Anxiety around medication use and trauma of seeing blood/pregnancy"* (19-29 age)
>
> *"I think a medical termination would be more traumatic and risky."* (19-29 age)
>
> *"Not sure it would be as effective or 100% work"* (30-39 age)
>
> *"I have only heard horror stories, it not working, infections, surgery required etc."* (19-29 age)
>
> *"Far less messy and less traumatic. I once had a D&C* [dilation and curettage] *for a missed miscarriage. It was all handled quickly and I didn't have to worry about heavy bleeding and passing the embryo or foetus. I think it would be traumatic to have to do that on your own."* (30-39 age)
>
> *"I've miscarried before and the bleeding was terrible. I don't want to go through the bleeding process again would rather have it all removed in one clean sweep"* (30-39 age)

"Not sure - would want all information & medical supervision/family or friends support when taking the abortion pill I think. Never know unless in that situation." (30-39 age)

"That's why I keep saying GP, GP, GP because I trust them, I think they're great and it's neat and tidy to have everything under one roof." (30-39 age)

"Wouldn't want to drag it out. Would want to get it over and done with as quickly as possible. Would worry that the medical method might not work effectively or properly" (40-49 age)

"Personally, I would have trouble trusting a medical termination to be successful and I wouldn't want to be alone when cramping / passing the material. With a surgical termination, I feel more confident because a doctor performs the procedure and you're in a medical setting with nurses for support." (40-49 age)

"Less confident in its effectiveness and some (slight) concerns about possible side effects" (60 and over age)

Although not required, some of the respondents who selected 'Yes' also explained their choice. The most common themes were: greater trust in their regular GP than a surgical clinic, less time spent off work or study, and that a surgical clinic is more confronting:

"Less intrusive - don't have to take time off work/uni." (19-29 age)

"This would have been so much easier than having to put my health in other people's hands who I did not trust" (19-29 age)

"That's why I keep saying GP, GP, GP because I trust them, I think they're great and it's neat and tidy to have everything under one roof." (30-39 age)

"Surgery appears scary. My GP (and the medical practice) is so lovely I would feel very cared for." (30-39 age)

"It would have been much easier. I had to wait a couple more days to get into the clinic. This meant more days off work when I got treatment. So it would have been fabulous to have been able to go to GP and get treatment all in the same day and have it over with quicker. The waiting has made it more emotional and costly for me." (40-49 age)

"Yes - having had two surgical terminations I feel they can be a confronting environment. In some ways, being able to experience a termination at home with personal support would be preferable." (40-49 age)

Several participants in the discussion groups also described their preference for MTOP:

"Whereas if you had the ability to get RU486 through a GP or another form of professional help. At least it's someone with a bit of a holistic care model or someone who knows and understands a bit more about you than you are X who is X when is pregnant, who is seeking a termination, who is there with or without a partner."

"In that circumstance my ideal situation would have been that I could have obtained RU486 through a GP with a ultrasound being undertaken in a private setting rather than the $500 Marie Stopes option."

"…rather than taking a day off work of sick leave and dealing with it in your own house and dealing with that without having to be in a medical setting per say."

"I think the benefits of putting it through a GP service is that you can do a mental health plan through it. Then at least someone is aware of the fact that that might be something you need to look through and being able to access that as a free service. I think all of the issues about women needing additional services kind of go away if you put it through a holistic care or through Sexual Health and Family Planning that already has contraceptives, regular STIs free STI screenings, all of those kind of things."

"I think also for women maybe going through domestic violence situations where there's safety going to a doctor and very obviously going to an appointment and that sort of thing could put them at risk. Having that kind of service, having the ability to go to your local GP instead of taking the day off and going all the way to the city, walking through the big scary city and going "I know what I'm going to do." I think safety-wise that's a really good service to be able to offer as well."

"Yes, much rather that. I would much rather be able to access a provider that I'm familiar with. I know my GP, my GP knows me. Someone that I know rather than having to confront another stranger. And there's again that vulnerability and power play. That's the health professional they hold the position of power and you having to admit… admitting something. I would feel really uncomfortable having to ask someone I've never asked before "Can you please give me medication to terminate the pregnancy?" and the following questions I'd rather answer them to someone I knew."

Some respondents advised that although they would not personally opt for a MTOP, they would like other women to be able to access MTOP via their GP or healthcare provider:

'100% yes, absolutely. I think women should be able to get misoprostol from their GP. Easily managed. I've been through both, it's the same thing. Someone sits you down, they give you information, they talk to you about the possible consequences, what to expect then you take the pill. Come back and take another. It's entirely manageable by a GP. Yes, that would make it so much more accessible. A hospital setting is not required to take misoprostol. D&C yes. It's really important for women in vulnerable situations or violent relationships too, it's lot easier for them to say they are just going to see a doctor and that could see a doctor for a range of different things. But for them to get a referral somewhere else, to make a booking, to find several hundred dollars etc to make that next step there are just so many barriers. Whereas a woman can just go to a GP as a one-stop shop for something like that. And I think it would help to remove the stigma as well. For many women too, it would help to be getting that information from a trusted professional assuming that many women or clients have a relationship with their GP ……... I think that would provide more options for them to consider information and decisions.'

The views of ACT women who considered a termination of pregnancy in the last three years

Respondents were asked whether they had considered a TOP in the last three years, and 37 (7.86%) women said 'Yes', as shown by age group in Figure 41. Of those who answered 'Yes', 1 woman was aged 15-18 years, 22 women from the 19-29 age group, 9 women from the 30-39 age group, and 5 women from the 40-49 age group.

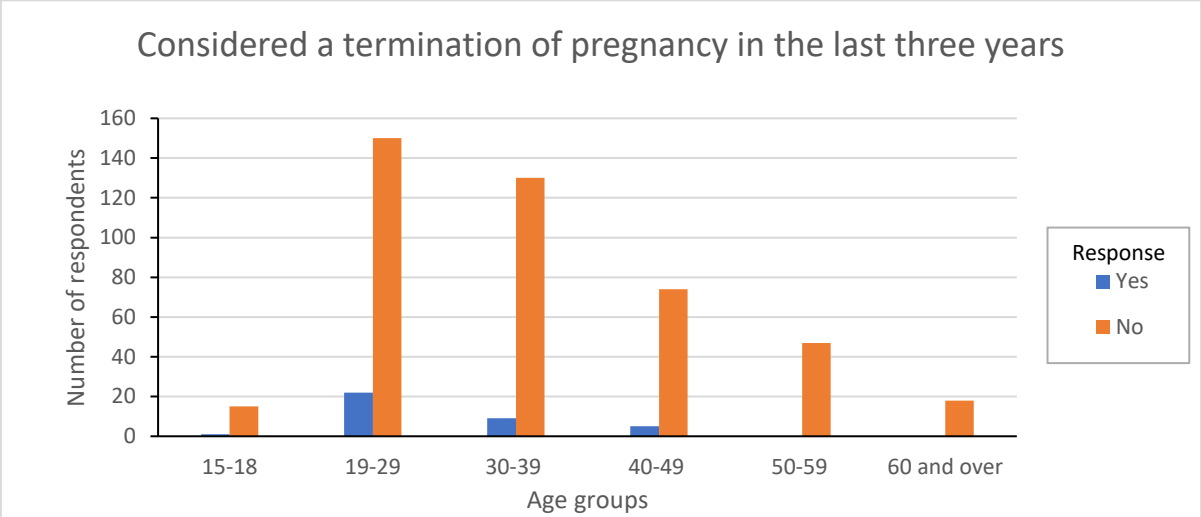

Figure 41: *Respondents who had considered a termination of pregnancy in the last three years.*

Those women who had indicated that they had considered a TOP in the last three years were then asked whether they went ahead with the TOP. Of the total 37 who responded, 19 women advised they had, as shown by age group in Figure 42.

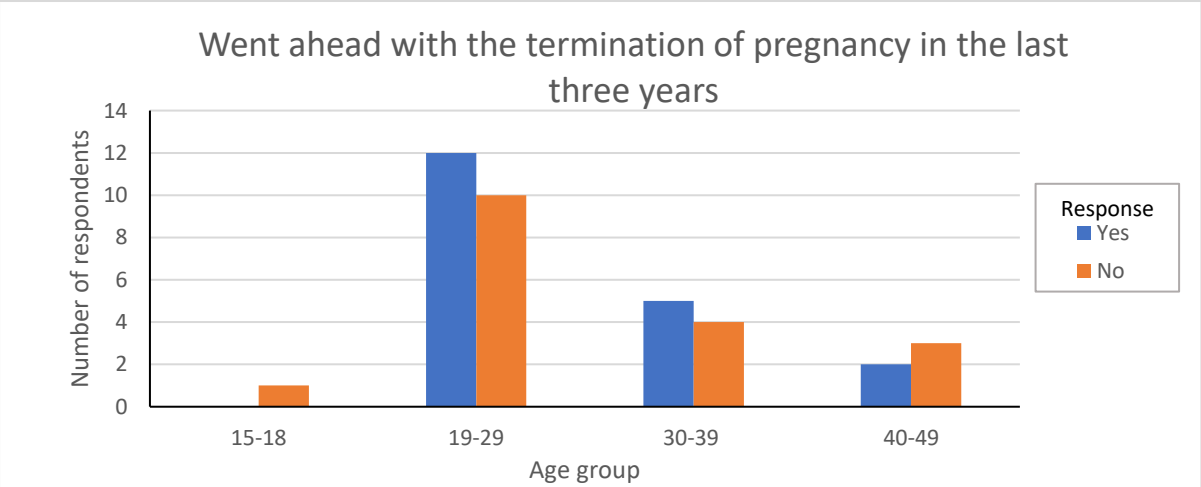

Figure 42: *Respondents who went ahead with a termination of pregnancy in the last three years.*

Of those women who answered 'No' the main reasons were that they were not pregnant, or that they had miscarried:

> *"I didn't get pregnant, but I had very bad PND/PNA* [postnatal depression/postnatal anxiety] *and was determined that if I did I would have a TOP as I didn't feel able to cope with another pregnancy/child"*
>
> *"I was not actually pregnant. Experienced a pregnancy scare and decided termination would be the best option."*
>
> *"The pregnancy was not viable and did not progress beyond 6 weeks."*

"I decided to keep the baby but ended up having a miscarriage"

"Spontaneous miscarriage a few days before termination planned."

One participant indicated she would have gone ahead with TOP if there was a high risk of a chromosomal condition:

"Tested higher risk for trisomy 21. Had further testing which showed negative so did not terminate."

Were there barriers to accessing safe termination of pregnancy services

The survey participants who had gone ahead with TOP in the last three years were asked if they faced barriers in accessing safe TOP services, and 11 of them advised 'Yes'. The top barriers identified were: affordability (n=9), time away from work (n=6) and anonymity (n=2):

"I became pregnant after recently ending a long term relationship, I was completing my 2nd year of a 4 year apprenticeship, living out of home and nearest family were over 3 hrs drive away. I struggled to get time off from work and save up the required $400 in time. I barely ate and walked over 6 kms to work for 4 weeks to save the money in time to have the termination before it was too late to proceed."

"I couldn't really draw from our joint savings. I can accept that $500 is a huge fee for many people to afford. Ideally, I would like to see that compensated or subsidised by the ACT government because that is a significant barrier to be able to make a choice about their reproductive health."

"The first time it was $560 and I was on a low income at the time. I was working in hospitality, it was really it and it was a conversation between me and my partner of how we were going to afford it. The second time I was in a really good place, was earning really well, it wasn't a big concern for me per say. It definitely – a $500 unexpected chunk to the bank account is not great. But I was in a better position at the time, but that's purely luck."

"Fresh 18, I did not have $850, I had to take out a personal loan… the only reason I went to the follow-up appointments was because following that $800 bill there was no way that I was going to go back to anyone that was going to cost a cent more because I had to get a loan out to pay that amount… Thankfully, I didn't actually have to disclose to my bank for what it was that I needed the money for."

"Affordability would have been an issue, I was very fortunate that the man involved supported my decision and was able to pay for the procedure, other women may not always have that support. TOP services are quite expensive."

Discussion participants who had experienced a TOP described the information gap about available local options and understanding the whole process before, during and after TOP.

'That required me to proactively seek it out. Go online and talk with the service providers, doctors, other professionals and friends. I got information from a range of sources. Probably looking back, I would have appreciated if… because it's such a taboo topic, the information wasn't readily known to me. Whereas if we are talking about cervical cancer or breast checks I already have the baseline understanding about the key components and if it affects me I move forward. I barely even had a baseline understanding about abortion because the information isn't publicly, readily, socially accessible… We all know about safe sex for example, we all know about

contraception, we all know about condoms, but we don't all know about abortion, what it looks like or how it's done.'

"And I Googled. Yeah, it's really a confronting thing to type into a Google search and write "How do I terminate a pregnancy" and you get some results that you're not really after. So I did a little bit of research into where it may be available in Canberra. I found that it was really hard to get any information on where those kind of services would do that in my hometown."

"Self-terminating, the pro-life aspect. There's a lot of websites out there that are masquerading as a "pregnancy" and like "planning" but they're not, they're pro-life and they can trick people."

Discussion participants who experienced a TOP also spoke about dealing with social values and the stigma when accessing TOP:

'It did make it a lot more difficult knowing that there were different expectations, whether that's coming from my husband who had a completely different point of view or my friends who might hold onto more conservative societal expectations… the stigma, there aren't many women in my circumstance where they can say they've been through a miscarriage and abortion within a 6-month period. Within a 3-month period they've undergone misoprostol and D&C under the name of miscarriage and then D&C under the name of abortion. For me they are the exact same processes and yet there is a completely different stigma and interpretation for what I have done and for what has happened to me… When it came to me then talking about abortion, there's usually an opposite, standard approach. Which was a shock for me and it was disappointing to see that. There's a level of stigma here for miscarriage and there's an off-the-charts stigma when it comes to abortion. And that's been really disappointing for me because I've been through both and they are just under different labels... Certainly, what I've learnt from a range of people is that there is hierarchy and the most important, innocent or best thing above all else is an unborn child. Which I absolutely disagree with. I'm a living, breathing person, I've been here for 30-something years, I have a life, I have friendships, I have relationships, I have a history and to have all that dismissed for a potential life which hasn't yet had any of that? I found it deeply upsetting.'

"Some of the barriers that you come across – the medical professionals that refuse to talk about it, the ones that have ulterior moral/religious values that they don't disclose to you. So if you go to a bulk-billed medical centre and you get an appointment with whichever doctor they put you with unless you know a doctor there…it can be really traumatising, really damaging and for someone who might be in a situation where their safety is at stake, don't have family close by, these are all barriers that whilst you know that this is the decision that you've made, each blow to it just makes it painful and scarier than it needs to be."

Which service provider was accessed for TOP

Respondents were asked which service provider they went to access TOP. Thirteen women accessed a termination clinic, 3 a public hospital, 3 their regular GP, 1 accessed another GP, 1 accessed telehealth, and 1 accessed a youth Health Service:

"Started with my GP and then referred to the Marie Stopes Clinic in ACT. They are amazing! Only have the very best to say about them. Everyone made the process bearable from beginning to end. So very grateful this service exists."

Accessing termination of pregnancy in the ACT or interstate

Respondents were asked where they had accessed the services for a TOP. Fourteen of the women accessed a provider in the ACT, 3 accessed a provider in NSW and 1 accessed via telehealth (unknown location).

One participant described having to attend a TOP clinic in Sydney due to available opening times.

> *"But I did find one place [in Canberra] that seemed like something they could do. I had just started a new job in Sydney so I couldn't take much time off so I rang to inquire about the opening hours. The woman I spoke to on the phone seemed to indicate they were open on Saturdays and Sundays but not for terminations. And obviously my dismay of that was quite intense because I would much rather be at home [in Canberra] with my family and my friends… So that Saturday doesn't work for me so I guess I'll just have a child. Take that lifelong commitment. So I ended up terminating in Sydney and the practice I went was a women-specific health centre and they provided a range of different services… So I did it on a Saturday and went back to work on Monday."*

Discussion participants discussed the difficulty in physically and emotionally accessing a pregnancy termination service:

> *"I didn't feel like it was as trustworthy or accessible or open. I felt like it was really just hidden away, like being in this old building and having to go upstairs, I understand it can't be absolutely front wards facing because then there would be risks for myself or anyone else accessing the service. But it made it feel like a much more difficult experience for me emotionally when I was walking in, I just felt like all that stigma and shame was building and having to find my way, being in that older building, then sitting in the waiting room."*

> *"…the fact that you have to access something through Queanbeyan because the ACT laws are worked around that way is not ideal as a Canberran. But it's good that there's at least other options popping up in and around that women are accessing."*

> *"The general emotional side of things is something that you've always got to work through and the fact that it's still such a divisive topic. The first time I went through safe access zones hadn't been put into effect which was the worst. But those kind of things where there are so many barriers for a woman to actually get to that point and then you're just putting another barrier in, all of those kind of things."*

TOP option chosen

As shown in Figure 43, 7 women opted for MTOP and 11 opted for STOP. Of this group, 3 women who had selected MTOP indicated they had undergone both options.

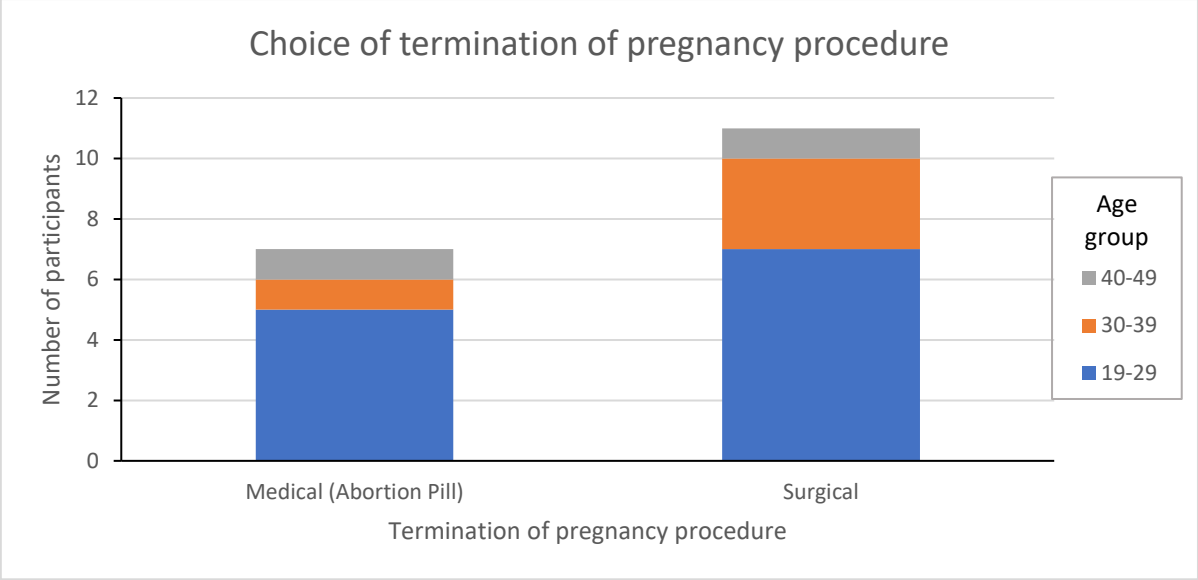

Figure 43: *Number of respondents who selected medical or surgical termination of pregnancy procedure.*

One discussion participant described having experienced both MTOP and STOP:

> *"I first accessed surgical because I'd taken longer than I probably needed to make the decision on the termination and that was the main option. But then when I used the service for a second time RU486 was what after going through and reading a lot and knowing what had happened in the surgical termination the medical termination was …. posed to me to be a lot calmer simpler process rather than full blown day procedure, someone come in with you, someone had to drive me home, all those kind of things that come with it."*

Attending follow up appointment

Respondents were asked whether they attended the follow up appointment with the service provider or with their GP after undergoing either the MTOP or STOP. As displayed in Figure 44, a total of 12 women said 'Yes' and 6 women said 'No'.

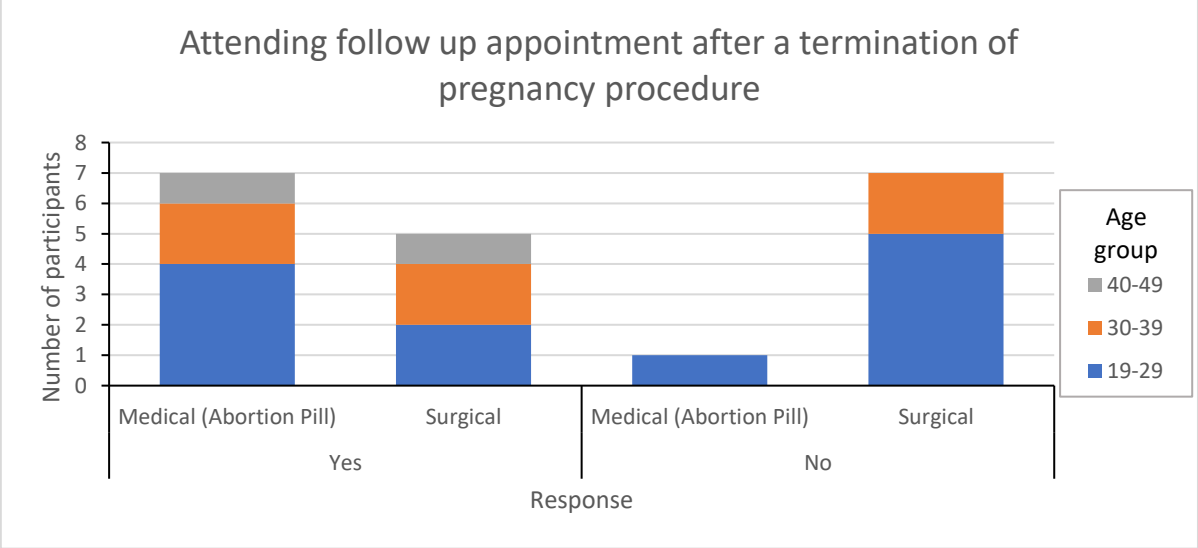

Figure 44: *Number of respondents who attended a follow up appointment with the service provider or with their GP after a termination of pregnancy procedure.*

Some individuals explained why they did not attend the follow up appointment:

"Procedure went as planned" (19-29 age)

"Cost. Shame." (19-29 age)

Receipt of adequate information and support following a TOP

Survey respondents were asked whether they felt that they received adequate information and support following a TOP. As shown in Figure 45, 11 participants answered 'Yes', whereas 7 said 'No.

Of the 7 women who reported that they did not receive adequate information and support following a termination of procedure, 2 had undergone MTOP and 5 STOP.

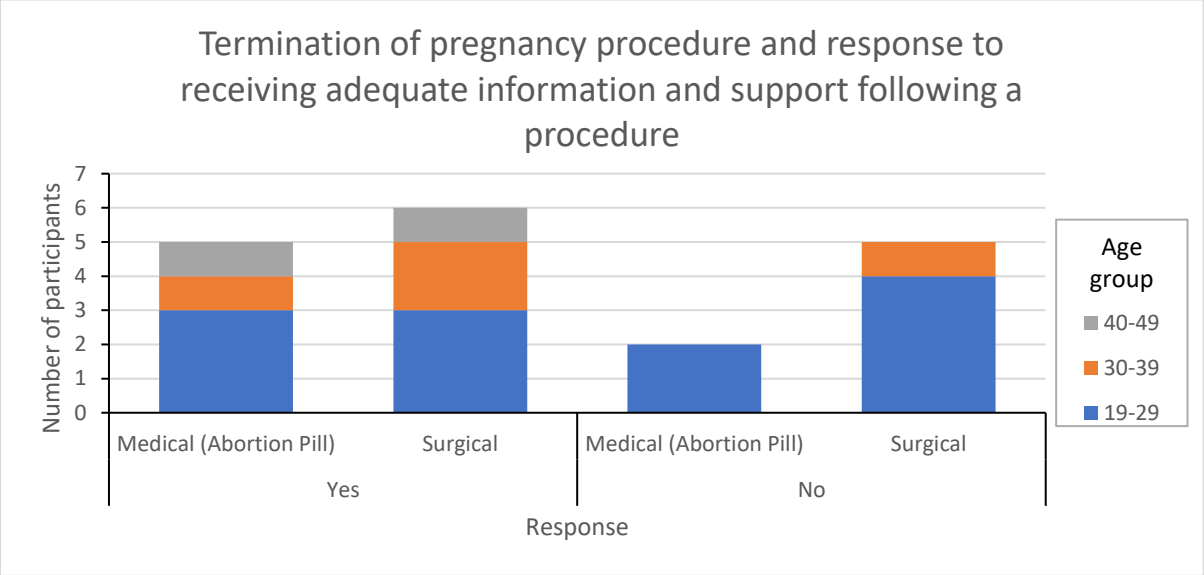

Figure 45: *Number of respondents indicating whether they felt they received adequate information and support following a termination of pregnancy procedure.*

Four out of five women who provided comments about their 'No' selection mentioned insufficient after care:

"Felt like a conveyor belt approach once able to access" (19-29 age)

"No one really went into the emotional distress I would feel for some time after the termination. I was psychologically affected by it majorly for over a year and still breaks my heart to think about. Even though it was the right thing to do, and yes 100% my decision, the staff push you in an out of the clinic and there is no after care. I look back on the experience at Marie stopes Sick to my stomach. I just wanted a support or someone to talk to, and was so hard for a long time as I wasnt comfortable To talk about what really happened, there aren't many people who understand. I don't care what anybody else says.. just because you go through it doesn't mean you WANT to do It. I had to because I had nothing to provide for my baby and no supportive father (split from me when i got pregnant) and I could not Raise a poor baby without a loving father. I grieved for them both, I Was extremely fragile. The clinic almost makes you feel like you don't have a right to be sad about it. I know they are there for a reason but not every one deals with it Easily." (19-29 age)

A discussion participant described her experience of STOP:

> *"If you're going through surgical you go through door four. Kind of get them in, get them out. And I think a lot of that comes from as well that that's – they're a service that is there for that and that's what they tailor in."*

Another respondent provided a positive response for her 'Yes' answer:

> *"Yes the staff were amazing. Nothing left out and they provided me so much help for home and numbers to call if I need anything. So very supported."* (40-49 age)

Complications following a termination of pregnancy

Respondents were asked whether they experienced any complications following the termination of pregnancy procedure, and 5 participants stated 'Yes' and 13 reported 'No' as shown in Figure 46. The reported complications included blood clots in the uterus, retained tissue, blood loss and emotional distress.

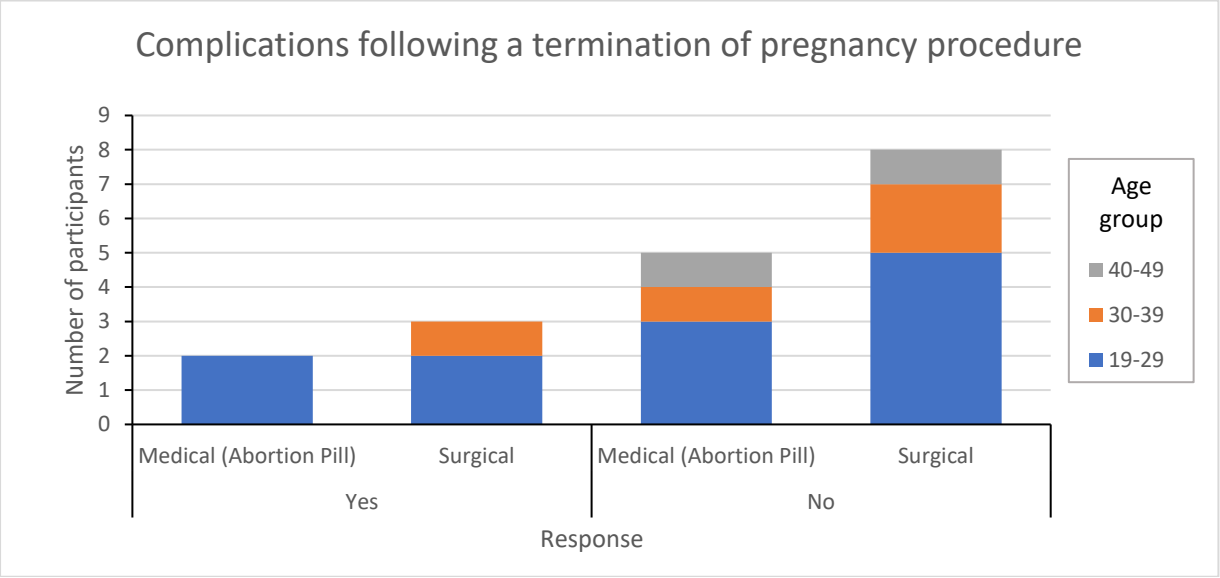

Figure 46: *Participants report on whether they experienced complications following a termination of pregnancy procedure.*

Discussion participants also described complications:

> *"When I accessed RU486 I ended up in hospital but that was that I had side effects from it, but most people don't. Even then I still probably preferred it."*

> *"I ended up hospitalised for clotting and definitely knew that it was probably something that wasn't right and called the helpline and he was yeah go and get checked. But even still that was rather than being knocked out for it and waking up and dealing with coming out of anaesthetic and the hormone rush. It was just this – you just went through the process and it was get your bloods – when I was hospitalised it was get your bloods run, monitor the situation for a couple of hours and move on.."*

Was there discussion or recommendation of contraception at the time of the termination procedure

Survey respondents were asked whether a regular/ongoing form of contraception was discussed or recommended at the time of the termination procedure. A total of 13 women reported 'Yes' and 5 reported 'No'.

A discussion participant described the process of contraceptive counselling involved in their TOP consultation:

> *"I was going for a medical termination on my first appointment they strongly suggested the Mirena. And it was on the second consultation we can fit it if that's what you want to do. So I had two weeks of going and reading through all the materials and going through and figuring all of that out, which was great. And probably if I'd had that material in the first place I would have been using a Mirena a lot earlier.'*

Feedback from healthcare providers

A total of 24 doctors and nurses working in sexual and reproductive health were consulted about their views on the current and emerging issues for women in the ACT.

How women access local services for the sexual and reproductive health needs

ACT doctors and nurses advised that women often attended consultations with some information that they had gathered either online or from word of mouth to clarify with the health professionals. All the doctors and nurses who participated were not restricted by length of appointment and recognised that unlike in general practice they were able to thoroughly discuss with their patients.

> *"You get some that come with a detailed plan in their head of what they want. They've researched it to the minute little detail and you get others that have been dragged in by a caseworker and, "I don't know why I'm here, and I don't know what you can do."*

> *"If you have the time to have a conversation, I do believe that overall, women know what their needs are. They know where their health is lacking and poor and they know where it's good."*

> *"…mentioned some past trauma or some issue or some relationship and you get it and you hear it and you go straight in to have the conversation, rather than, which would happen in general practice when you don't have the time, you would hear it, and you'd go, "Oh, don't have time for that. That could be too big." The fact that we have the time and come from a gendered lens means that we hear those comments and then we open the conversations. And when you open difficult conversations, you build trust."*

> *"In sexual health you are making sure that you talk about pap smears and the change in pap smears. That's a long conversation. If you pick up on the cues when you are doing a proper consultation about reproductive health, it is a long consultation."*

Common misconceptions heard from women

The doctors and nurses described that sexual health education in schools appear to be inconsistent so that young women often have incorrect information about various contraception and STIs, health relationships, and fertility.

> *"I think for young women there's a lot of misunderstanding of emergency contraception and especially on the SHLiRP program when I used to work on that. They would think that they could only ever have it once in their life. They thought it stuffed up their system. They thought all sorts of amazingly strange things about emergency contraception that they felt they didn't want to take it because they thought they could only ever take it once and it might cause problems for them."*

> *"I think another thing, particularly in the younger, like towards the 14 - 15 year group, they don't have a good understanding of when they are and aren't able to give consent for sexual acts and things and they don't have great confidence in negotiating consent."*

> *"I've actually never heard any school talk about relationships. There's consent and then there's what was mentioned before about women not realising that sex should be enjoyable…….but that's not the way it works. Like, two people can say yes and then had a really bad experience and no-one gives you a way of dealing with that."*

"And you ask the question, do you know when you're the most likely to fall pregnant in your cycle, and then the 30 year old is completely mortified that they have to say, "Actually I've got no idea." "

Although the internet has allowed for greater reach of information to the general population, the health professionals also expressed concern about the impact of pornography on safe sex.

"I had a client mention to me in discussion about pornography that generally it's filmed without barrier protection so no condoms, which again may be sending the wrong message."

"People are horrified when they realise you can even get an STI in your throat, particularly heterosexual women, I think that's a completely foreign concept which is really interesting. Actually that's a big thing. A lot of people think that STIs are only genital. They don't understand that you can get an infection in your throat or that you can transmit it to someone else."

The health professionals also talked about the dependency on phone apps as a sole method of natural contraception. They described the false advertising of these apps as dangerous as it led women to believe they were using an effective method of pregnancy prevention.

"I think the problem is everyone sees medicine as this black or white thing and so much of it is grey, and some of those apps drive me crazy with the advertisement on Facebook for them. "Doctors have been telling you you need chemicals for contraception for all these years, and here's this natural free way to make sure that you don't get pregnant." It's like good luck with that. It's called the Billings method and here's my children. Like, it's not a reputable - I mean if you put a new label on it and add an app and all of a sudden everyone thinks my gosh, we've got this great new way of contraception, and I just don't think that they're - I mean the risk is huge. The risk is pregnancy and people don't understand that because it's all packaged up in this nice pretty pink thing that comes to you on Facebook, and those apps really annoy me because there's a lot really well-educated women who should know better who comment on it."

"in some apps, so it's very confusing for women actually because they talk about ovulation and of course that's what they think is their fertile time, so then they're missing this whole window of time that they could get pregnant because they're, "No, no, I'm not," without considering the five days of sperm staying around and so actually when I've looked at the apps there's probably, I would honestly say, two apps out of about 10 that I've seen that actually have it correctly shown according to what we understand fertility is."

<u>Importance of promoting contraception</u>

All doctors and nurses who participated in the study agreed that access to safe TOP should be more available to women in the ACT, however, they stressed that contraception should be the key message promoted to all women and prioritised in relation to sexual and reproductive care. They highlighted that it is an obligation for health professionals to put women in charge of their bodies and avoid unplanned pregnancies and contracting STIs.

"It takes a village to raise a child, but it also takes a village to prevent a child."

"The social cost of that [termination of pregnancy] *versus how cheap it is to provide reliable contraception. It's a no brainer from the government."*

"Termination must be available, not stigmatised. We must say our approach is first and foremost proper contraceptive family planning."

They also identified the need for public health campaigns and resources promoting safe sex to reduce the stigma of condoms and STI checks.

"sexuality is still almost a dirty thing for women whereas it's not, and taking care of yourself is actually going and getting the sexual health check and things like that. It's like, "Well, you must be having a lot of sex if you need a sexual health check," and that's just the wrong attitude. That's not at all what it should be about."

"women who may start new relationships later in life, who are post-menopausal or probably with no chance of pregnancy, but there is a chance of STIs, or those women that are still in their reproductive lives but starting a new relationship and negotiation of that and negotiation of safe sex and rethinking all this again. Lots of different scenarios you can think of, so it's confidence, yeah confidence to go and seek help for contraception or for STI screening."

<u>When healthcare providers don't know</u>

The doctors and nurses stressed that women's sexual and reproductive health is a specialty requiring invested interest to keep updated on the available information so not all health providers are highly knowledgeable about the complex subject matter. Therefore, doctors should be referring on if they are unable to help the patient.

"If you realise the average age of a GP is 53 or 55 in Canberra."

"…doctors are trained that while they may not offer or support that service, it is their job to send them to somebody who can provide that service or information."

<u>Affordability of contraception</u>

Cost of contraception is not only about the contraceptive item, it also includes the appointment and procedural costs for some contraception. The doctors and nurses identified that although some contraception may be more suitable for a patient's stage of life and relationship, the variable costs across different types and the associated costs impact on the decision-making and therefore women no longer have a real choice about their preferred method of contraception.

"Sometimes cost is a real barrier for people with options. So, it's, "I'd like the option of choosing from all of the range, but really I can't because I can't afford half the range currently."

"And of course the pill we can [prescribe it] *but that's not as reliable and it runs out. If it runs out on Saturday and the chemist isn't open till Monday …."*

"…access to contraception is limited because of domestic violence… getting to the GP, with those barriers, makes it harder, because you have a context behind you of - either you don't feel comfortable at the GP, you don't know how to go to the GP, or you just go to the GP and say, "Actually, I can't pay for this consultation and I can't pay for my contraception because I have no control over my money," which raises a whole new conversation when really you just need contraception."

"that cost barrier being quite prohibitive for people and so limiting their choices of where they can access low to no cost contraceptive advice."

Time barriers of obtaining contraception

Due to siloed services in the ACT, the doctors and nurses emphasised that accessing contraception is not as easy as just paying for it. Time is also spent to find appropriate services, obtain a consultation and prescription with a doctor or booking for an insertion time, childcare issues, and travelling to services within opening hours. Each of these are barriers are amplified for vulnerable women.

> *"There's a vulnerable teenager in Gungahlin, today at 3pm when school finishes, she will get a bus and just make it and they will listen to her and say here's the script, trek all the way back to where you came from, get the script filled and then come back to us."*

> *"Often that* [postnatal contraception] *will happen at the 6-week mark. That's traditionally when contraception gets discussed. But in actual fact if you don't come back for 6-week check or if you say yes I will go on mini pill. But you don't fill script."*

Location of services and opening hours

The doctors and nurses worked in practices that were in the city centre or at Canberra Hospital and realised that their services are not easily accessible for vulnerable women who have restricted access to transportation such as young women and women experiencing domestic violence.

> *"I think young people, specifically under 25, access is harder for those groups. I think access is also a challenge because of geographical - I think services are centred in the city, but that are often are focused on those specific either age groups or specialty areas, so the Junction, focuses on young people, Women's Health Service and SHFPACT are both located here in the city. So, I think those populations are at greater disadvantage, and they're a large population that are disadvantaged for access for contraception"*

> *"from my experience we seem to see the college students who have their licence and are able to come in a free period to a walk-in clinic, but most of them seem to be local to the south side and I think that's because those young people who don't have access to a car and the ability to drive find it really hard public transport wise, getting here outside of school hours from north side with the bus system and things, so we'd see that that would be a barrier to them receiving care."*

Some of the providers include outreach services and afterhours services to break down these barriers but they are often project-based due to limited funding.

> *"So every now and then there is a little bit of money available to do something external and that's where the walk-in centres have come in and we're trying to engage people that don't have a GP in those services and they are afterhours and it's twice a month at each service. But that's a six-month period and there hasn't been a huge amount of advertisement around that, so that limits the amount of people we're actually getting through that service as well. We rely more on word of mouth and the clinicians at the walk-in centres to engage patients in that service too…"*

Constraints

The healthcare providers discussed that it is sometimes difficult to provide women with real contraceptive choice due to financial and legal restraint of storing contraception within the practice. The providers explained that women with Healthcare Concession Card can access contraception at a subsidised cost from a chemist but this requires multiple steps to insertion of the LARC and providers can lose the opportunity to provide LARCs at any of these steps. Establishing an approach of a women's sexual health advice centre/system where any individual with a female reproductive system can safely access for all their sexual and reproductive health needs would be ideal.

> *"What we are then talking about is a proper service of family planning and contraception sexual health advice. Let's just set them up. Within the centres there are counsellors available."*

> *"They're the most disadvantaged, where the whole prescribing is an issue and the costs in that. It's not just the cost; it's the whole - the action of having to go to a pharmacy and get back here and attend for an appointment. We put all those together. You'd be much better off have a system where you have Implanon right here, right now, and you said, "I have this that I could pop into you." Not without consent, but access is - for some women access is if it's right here, right now, they'll do it. And if it's not, it loses the priority. It's not an issue. It's an immediate, because for a lot of drug users, for example, it's in the moment."*

> *"We, in terms of stock, probably have more stock than other places would, for some of that stuff, or at least access to them. You've just got to get to the chemist, but in terms of - even the morning after pill, so emergency contraception, you've got to get there to do it and have a - if you have sex Friday night, you've really got to get to somewhere Monday morning. Well, that's a whole lot of organisation. If it's off pay week and it's not somewhere that doesn't - that isn't going to charge you for it, you've got to have 20 bucks for it. So, you've got a number of steps along the way that just people just fall through the cracks on. But it also means that by default, if we're using the here and now method, it is something like an Implanon, which isn't giving a woman a choice."*

> *"…it's about having certain services that recognise that the immediacy of the action - and that's what they do. A lot of quick smart - there's policy on how to do quick smart and the whole reason is because we know that if you walk out that door, we won't see you again."*

> *"Particularly for a young teenager, the whole ability to get to a pharmacy, to understand how you do that, how much money they will want. It's a difficult thing to do, so if we could provide it, it would be much better."*

> *"People to come to a women's health centre, expecting that they're going to see women and it will be a safe, supporting environment. So, just by the nature of the centre, I think that helps."*

Although time-consuming, some services described accompanying women to the chemist to pick up a contraception to ensure the patient returns to have a LARC inserted or implanted.

> *"Yeah, and if you're having to accompany people to the chemist and back, that's time that your staff is spending doing that instead of what they - well, we do it happily, but it would be probably more time efficient if you didn't have to go to the chemist… And cost wise, as a service, it's still cheaper for us to walk to the chemist with them, because that's on the PBS, whereas when we have it in stock, that's our budget.* "

They also described the importance of building rapport and continuity of care to promote good sexual and reproductive health.

> *"You get used to the same GP and then another GP takes their place. It takes time to learn about the culture and we are very opportunistic. If you've got a patient in there you do everything you can then. There's a good chance when they say they'll some back, they wont."*

Lack of affordability of TOP services

All the doctors and nurses commented on cost as barrier impacting on women's decisions about TOP. This was particularly raised for young women who they had witnessed continue a pregnancy due to inability to afford the high upfront cost of a TOP.

> *"Costs are definitely a barrier. … It's* [termination of pregnancy] *a costly procedure to have done. Finances can be hard. We have noticed the numbers* [of TOPs] *have dropped enormously. Because of Implanon particularly. Some Mirena. That's access to contraception."*

> *"I tried to work out the economics of an unplanned pregnancy that then continues to be a baby. All the costs associated and the welfare. They become very welfare dependant and often never get off that."*

Discussion

Australia has an obligation, as a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), to ensure equity in access to health care services, including those related to sexual and reproductive health and family planning.

The 2010 National Women's Health Policy recognises the priority of sexual and reproductive health for Australian women and that it is highly complex across women's diverse lives. The Policy explored the gendered nature of sexual and reproductive experience and behaviour and of strategies to improve systemic, structural, social, and cultural issues impacting women of different ages, backgrounds, and abilities.[101]

The findings of this report are consistent with previous research undertaken by WCHM in 2010 and 2018 which demonstrated that women's access to health and wellbeing services and supports are affected by their social and economic circumstances - the social determinants of health. In 2010, ACT women said they wanted information to be "*available, affordable, accessible and appropriate".* [102]

This current research shows that ACT women want to be able to make informed choices about their sexual and reproductive health, and to access relevant services and support.[103] But women of all ages in the ACT are still experiencing barriers to accessing information and services to help them maintain their sexual and reproductive health and to making informed choices. These barriers included availability, accessibility, affordability and appropriateness/acceptability of services as factors affecting their ability to manage their sexual and reproductive health. Women also expressed frustration that although general information is available to those who have the capacity and willingness to search, information can be unclear and require lots of time and effort before informed decisions can be made.

Access to information

"You don't know what you don't know."

This recurring phrase in the findings is consistent with previous research by WCHM and reinforces the importance for women of access to local information that is reliable and trustworthy. In this research women still talked about the need for local information so that they can understand the options available, know where they can go, and to support them to make decisions based on trusted and credible information.

> *"And if you haven't gone and done that research or have that information provided to you sometimes you go in there .. and they ask if you have any questions and you say a million but I don't know what they are." (19-29 age)*

[101] Australia Government, 'National Women's Health Policy 2010', *Department of Health and Ageing*, Canberra, ACT, 2010, retrieved on 20 August 2018, https://www.health.gov.au/internet/main/publishing.nsf/Content/3BC776B3C331D5EECA257BF0001A8D46/$File/NWHP_access_final.pdf
[102] A Carnovale and E Carr, *It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010, pp. 47.
[103] M Murphy, B Murphy, & D Kanost, *Access to Women's Health Information: A Literature Review of Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 8.

Information sources

The sources of sexual and reproductive health information for women in the ACT were explored among forum discussion participants. Women described accessing credible websites from the government and reputable organisations, their GP, trusted friends or family, a specialist service, and trawling online through blogs, forums, Facebook groups and other social media outlets. Few women also sought journal articles. In summary, the women wanted information that was reliable, quick to access, straightforward, and non-judgemental and therefore the internet was often quoted as the first but not as standalone source of information. The regular GP was also quoted as one of the first source of information.

> *"That's something I still feel like even though I've had a few conversations with health professionals, I still feel a bit confused and I'd probably go, I sometimes go to Facebook groups and forums of women online people and talk with them about it."* (19-29 age)

> *"I use the internet for a lot of mine as well because it is instant information that I can access and over the years I kind of developed the research skills so I know what a reliable source is – but I had to seek out that information myself."* (19-29 age)

> *"…So that really put me off going to my GP for that advice for a really long time because I'm like I don't know what the norm is and I don't know what sort of service I should expect from a GP which* is why *I sought out specialised services because I know that's what they're specialising in, that's what they're going to offer me, and I'm not going to be put in the situation again where I'm not given the right services for myself."* (19-29 age)

> *"So I guess that's why it's important to have things like government websites because people know in Australia for the most part that the government is reliable and very accountable, and the information they're going to put forth is hopefully going to be true. So you can go to forums for the anecdotes, but for fact checking you can go to the government."* (19-29 age)

> *"…one of my degrees was in medical science, so it's probably more like journal articles than Doctor Google, and the doctor. Actually, it depends on which doctor. The ones at the clinic in University Avenue, Sexual Health and Planning are a really good resource as well."* (19-29 age)

> *"I find I'll use the internet more for kind of a second piece of information. Or if I'm waiting to get in to see a doctor with a question then I'll Google something or if I have been to a doctor and just want to double check something or not double check but get more information I'll generally go online… I feel like there's so much scope for things to go wrong or the wrong information online."* (30-39 age)

> *"I think the nurses that work in the sexual health clinic at Canberra Hospital and at the Women's Health Centre in Civic are fantastic. And I had interaction with them in a work capacity as well as private, and like I tell people all the time to use the services, especially if they've got – it's low income. They're good services and they're good sources of information. I just don't feel like I should take a position that someone else may need."* (40-49 age)

> *"I look at the source so I see where's coming from. If it's coming some kind of medical professional organisation or something then I'm going to trust it more. Online communities, like I was saying before, there's Facebook pages with a kind of feminist and health and social pages, tend to put questions up there or see questions up there that interesting and trust that information."* (40-49 age)

"I would seek out the GP because I would still expect that they would have their hand on the pulse for local services and things that would be relevant for me, I would hope. I think if there was something that I needed, like my particular example, I had to go to the GP anyway. So they were my first port of call. It was like the one stop shop to get all my answers I thought to start with." (40-49 age)

The forum participants discussed the benefit of walk-in centres as youth-friendly free information hubs for adolescent women who can discuss any sexual and reproductive health concerns confidentially with nurse practitioners and as a port to local specialist sexual and reproductive health services.

"I want to know a place where my daughter can go, a nice safe place, unpolitical place, a non-political place where she can go and get information and she can talk about issues.…it would be good if somebody could turn up to a desk and get information, for example that they could get sexual health information or actual tests and resources there as well, and that they're all co-located, so you're not having to go to one destination for one piece of your sexual health. You can just go to one spot, and whether that's – that could be linked in very clearly to a medical centre that deals with relieving minor ED issues as well." (40-49 age)

"So you hope that the 16-year-old goes online and comes up in the first few search engines, and then when they see the homepage, they can see, oh, the flowchart [about available information]*, I love that, I know it sounds daggy but they can see a flowchart. Need information about abortion, Pap smear, blah, blah, blah, and it's all ticked off, and they go, that's me, I'm the person that needs that, and then they can go there, before they go there –"* (40-49 age)

"I feel like I could definitely go to the walk-in 'cause like no one knows what you're there for. And then they're really nice there. As well so I feel like I'd be fine going there. We love the walk-in centre." (15-18 age)

Information about contraceptive options

Most the women in our study who have used contraception, stated that they had used or are still using the oral contraceptive pill. This is consistent with a multinational survey demonstrating that besides the condom, the pill is most frequently used in Australia.[104]

Although, the pill was reported as one of the most preferred methods of contraception, many of the women in our study still expressed concern about the lack of information they received and how this impacted on their understanding about the efficacy in pregnancy prevention if taken irregularly or taken with other medication, and of possible side effects.

"I read a little piece of paper, the booklet they tell you on what to do if you accidentally miss a pill and I was like shit, it's so easy to get pregnant while on this drug, and I was like this is not ideal for someone like me who will occasionally forget to take a pill." (30-39 age)

"When I went off the pill I was – I didn't have my period for over three months and I went to the doctor and I was like, is this normal and they're oh, it's fine. It will go back to normal soon and I think it was actually a year until my period came back, after going off the pill." (19-29 age)

"The amount of research and talking to my doctor and stuff I did on my own and freaking out and the basically if you don't take it within the same hour every single day its

[104] K Gemzell-Danielsson et al., 'Use of contraceptive methods and contraceptive recommendations among health care providers actively involved in contraceptive counseling — results of an international survey in 10 countries', *Contraception*, vol. 86, no. 6, 2012, pp 631-638.

effectiveness just goes down…15, I went onto the pill and I think I put weight on when I went on it. I know that there was other reasons than me forgetting that I went off it. I just never liked it." (19-29 age)

Past studies have shown that the knowledge about contraception is not consistent and accurate across healthcare providers and that this inability to provide comprehensive and quality care for their patients can be a barrier to women's ability for pregnancy prevention.[105] Other studies have shown that healthcare providers (physicians, nurse practitioners, physician assistants) and GPs who were older and graduated more than 10 years ago are more likely to have gaps in knowledge and misinformation about contraception.[106, 107]

ACT women told us they wanted accurate contraception information from doctors and services but spoke about the lack of information they were given about options other than the oral contraceptive pill. The women in our study spoke about having had some formal sexual health education in their adolescence in which the condom and the oral contraceptive pill were explained and which may have been the most suitable contraception during that time. Many described having difficulty in discussing with their GP what other modern contraceptive types were available for their personal and changing needs.

And many of those who reported they found the pill incompatible expressed frustration in the lack of information about alternative and more suitable contraception.

Richters et al. demonstrated that IUD use is more prevalent in Australian women over 30 years of age who are well-educated, high earning and cohabiting with regular partners and suggested that LARCs are replacing permanent contraceptive methods as the contraceptive choice for older couples.[108] This suggests there needs to be expanded effort in education and resources for women as well as GPs to increase the proportion of women using IUDs and implants. Particularly given that LARCs are very effective at preventing repeat, unplanned, and unwanted pregnancy, and are more affordable in the long term.

"Well I fell pregnant three times taking three different pills" (40-49 age)

ACT women in this study described that not only did they encounter GPs who were relaying outdated information about the IUD, but that this information was also communicated in school sex education.

"So for example they said the IUD was only for women who had given birth and was unsafe for anyone else to use." (19-29 age)

Women also spoke about doctors who did not fully talk about or understand the potential side-effects of contraceptives, and the lack of understanding about why women might be seeking contraception. Furthermore, and like observed by Wigginton B et al., women told us that this meant they were driven to change contraception not only due to unwanted effects, but also to seek wanted effects such as an attempt to improve skin, menstrual control, mood swings, and help with existing medical issues.[109]

[105] C Dehlendorf et al., 'Health care providers' knowledge about contraceptive evidence: a barrier to quality family planning care?', *Contraception*, vol. 81, no. 4, 2010, pp 292-298.
[106] Ibid.
[107] K Gemzell-Danielsson et al., 'Use of contraceptive methods and contraceptive recommendations among health care providers actively involved in contraceptive counseling — results of an international survey in 10 countries'ibid., vol. 86, no. 6, 2012, pp 631-638.
[108] J Richters et al., 'Contraceptive practices among women: The second Australian study of health and relationships'ibid., vol. 94, no. 5, 2016, pp 548-555.
[109] B Wigginton et al., 'A qualitative analysis of women's explanations for changing contraception: the importance of non-contraceptive effects', *The journal of family planning and reproductive health care*, vol. 42, no. 4, 2016, pp 256-262.

> *"I started the pill when I was 13 for period pain and it was never about sex so I didn't worry about that – "Take it and you won't have your period." … I know I've gone on antibiotics but no doctors have said how to use it right."* (15-18 age)

> *"…sex is actually always an issue I've had migraines all my life and I ended up having two terminations because I was on the mini pill because you can't have the full pill when you get migraines. I would've preferred obviously for that not to happen so better access to contraceptive information much earlier would've been useful in my life. Particularly advice around like health issues that affect taking contraception and the impact of that itself."* (40-49 age)

There is no contraception that is 'one size fits all' and this was strongly expressed by younger women and is consistent with past literature.[110] Some young women reported frustrations about the choice limitations that were imposed by doctors, which was perceived by these women to be due to their young age. This was similarly observed in a study by Goldhammer et al.[111] who reported that young women want consistent and accurate advice from their GPs and perceived that their contraceptive choices were limited by an apparent reaction to their (young) age.

> *"I went to my doctor and said, "Look this* [the oral contraceptive pill] *isn't working is there some other option, something else I can do?". And the response was "there must be something wrong with you. There must be something wrong with your hormones, with your body. So we're going to do all these tests." So I got an internal and external ultrasound, I got all my hormones tested and in the end everything was fine, and the answer was "Well, the pill doesn't work for you"."* (19-29 age)

Many women reported seeking information and advice online, ranging from credible websites to forums and support groups. They described credible websites as sources for fact-checking whereas online forums were useful to interact with other women and read other's experiences. However, many of the participants warned that reading online forums required a good level of critical thinking to discern fact from an individual's opinion.

> *"So for instance if I was looking up about people's experiences with a certain type of birth control or contraceptive or experience with X that isn't a, "This many percentage of people reported this kind of effect", and just wanted to know what it was like for people, I'm not going to take it as fact but I might look into forums for that."* (30-39 age)

> *"I would Google a specific question and then I would look at all the different responses which might be a combination of forums, health organizations, foreign health, government health, the NHS in the UK is really good, just to get a broad view, a very mixed view, a balanced view I think if you're looking at lots of different outlets."* (30-39 age)

> *"I think the Facebook groups, they are interesting to get experience but there are a lot of people on there who take it very seriously to the sense where it's like – these are just people's experiences, we don't know if this is actually something that happens to everyone. Yes. Just people who, yes, it's getting stuck in an echo chamber, basically. But not a whole lot of critical thinking from some people."* (19-29 age)

Women in this study were found to have a high level of awareness of the ECP but inadequate knowledge of how and when to use it, strongly suggesting that more information and education are required, especially in clarifying the different types of emergency contraception, and the difference between the ECP and MTOP.

[110] SC Dixon et al., "As many options as there are, there are just not enough for me': Contraceptive use and barriers to access among Australian women', *The European Journal of Contraception and Reproductive Health Care*, vol. 19, no. 5, 2014, pp 340-351.
[111] DL Goldhammer et al., 'What do young Australian women want (when talking to doctors about contraception)?', *BMC family practice*, vol. 18, no. 1, 2017, pp 35

Most of the women in the study were not aware of the existence of the ulipristal acetate ECP and its effectiveness up to 120 hours after unprotected sex, and fewer women were informed that the most effective emergency contraception is the non-hormonal copper IUD inserted within 5 days of unprotected sexual intercourse.

Discussion participants who did not work in sexual and reproductive healthcare were surprised that there was more than one form of emergency contraceptive available and that the efficacy of the most common ECP (levonorgestrel), licenced for use up to 72 hours after unprotected sex, was dependent on the stage of the woman's menstrual cycle. The women noted that participating in the survey and discussion was itself informative for improving their sexual and reproductive health knowledge, and that they did not realise the number of times they had taken risks with their health after learning about other more effective emergency contraception. These findings are reflected in a national survey by Hobbs et al. revealing that Australian women aged between 16 and 35 years have a high awareness of the ECP, but their knowledge about correct use of it is inadequate, thus the risk of becoming pregnant is higher than perceived.[112]

> *"You have just shattered my belief that I didn't take any risk. The morning after*." (40-49 age)

Local healthcare providers advised that misconceptions about ECP prevented women from necessarily accessing the ECP. Young women were reported to either believe the ECP was highly dangerous for their body, confused with the abortifacient mifepristone, or that the likelihood of pregnancy was low due to the current stage of their menstrual cycle. This is consistent with a previous Australian study found that only one third of the women had specific knowledge about the mechanism and time frame of ECP and that the main barrier to use of ECP was the low perception of pregnancy risk.[113]

> *"I think for young women there's a lot of misunderstanding of emergency contraception and especially on the SHLiRP* [Sexual Health, Lifestyle and Relationships Program run by SHFPACT and the Canberra Sexual Health Centre] *program when I used to work on that. They would think that they could only ever have it once in their life. They thought it stuffed up their system. They thought all sorts of amazingly strange things about emergency contraception that they felt they didn't want to take it because they thought they could only ever take it once and it might cause problems for them."*

> *"…there seems to be like a "Don't worry, it's within a few days after my period," or it's during a period. They don't get that they can get pregnant then. They're like, "Yeah, but you can't ovulate." People don't really understand that sperm can just hang out for a while. That's probably a really important one is people are horrified when they realise that they could still have sperm in them from a few days ago. They don't get that it's just waiting to pounce."*

<u>Information about STIs</u>

More than half of the participants who indicated that they were sexually active in the last 12 months stated that they were in monogamous relationships and that the main reason they were concerned about contraception was for birth control reasons rather than STI prevention.

Many participants in this study who were in long-term monogamous relationships considered themselves less at risk from STIs and their reasoning for no longer being updated about STI prevention was because they felt there was no more need to seek and take such precautions. For many, STI testing was only undertaken obligatorily as part of pregnancy check routine rather than

[112] MK Hobbs et al., 'Pharmacy access to the emergency contraceptive pill: a national survey of a random sample of Australian women'ibid., vol. 83, no. 2, 2011, pp 151-158.
[113] Ibid.

by their own request. The assumption that being in a committed relationship means being safe from STIs and free of disease has been found in past studies to be deceiving.[114]

> *"Not something that either my husband or I - we'd be very shocked if we got an STI, because we'd be like, where did you get it from?... So, we haven't even thought of that."* (40-49 age)

Monogamy can be seen as a safe sex strategy, however, this is if both partners (a) agree to be monogamous before engaging in sexual activity, (b) postponing sexual activity for several months for any infections that any partner may have acquired in previous relationships to surface, (c) undergo complete STI testing, (d) engage in sexual activities with one another after testing negative to STIs, and (e) remain sexually exclusive.[115]

However, few women in monogamous relationships also reflected that they should be or are cautious about the risk of contracting a STI because they can never be certain about their partner's sexual activity.

> *"Despite being in a long-term monogamous relationship, I get tested every 6 months because I put my health first."* (19-29 age)

> *"Only if I'm worried about something. I should do it more, I guess."* (30-39 age)

> *"I used to get tested regularly (every 2-3 months) but now I am in a monogamous relationship it's only once a year. Because you never know!"* (19-29 age)

> *"Partner occasionally strays"* (60+ age)

Interestingly, older women talked about their friends recently becoming single after a long-term monogamous relationship as those who needed up to date information about safe sex and STI testing. They identified that although older women have less to worry about in relation to pregnancy than younger women, STI prevention should always be on the radar but older women are never reminded enough of this because public information about STIs seems targeted towards young women.[116]

> *"It's an easy service to access if you know it's there, because you just rock up. I've got friends who have been married for 25 years and now they're looking at starting new relationships or wanting to check things out, so I just tell everyone about it. Because it's a bit of a secret." (40-49 age)*

Younger women were able to discuss in detail about STIs such as chlamydia, gonorrhoea, herpes, HIV/AIDs in a clinical manner due to formal school education. With the male condom being reported as the most commonly used contraceptive type, one of the main reasons for it's high use was its effectiveness in protection against STIs and the fact that it can be used simultaneously with most other contraception as extra preventative measure from pregnancy.

However, younger women, and older women speaking of their earlier experiences, described their lack of understanding about the actual act of prevention of STIs.

> *"I was 18 or 19 and someone mentioned something about catching STDs from oral, to use a condom while doing oral as well and for some reason that just never clicked…Over*

[114] TD Conley et al., 'The fewer the merrier?: Assessing stigma surrounding consensually mon-monogamous romantic relationships', *Analyses of Social Issues and Public Policy*, vol. 13, no. 1, 2013, pp 1-30.
[115] Conley, Terri D., Ali Siegler, Amy C. Moors, et al. 'A critical examination of popular assumptions about the benefits and outcomes of monogamous relationships', *Personality and Social Psychology Review,* vol. 17/no. 2, (2013), pp. 124-141.
[116] S Hinchliff, and M Gott, 'Seeking medical help for sexual concerns in mid and later life: A review of the literature', *Annual Review of Sex Research*, vol. 48, no. 2, 2011, pp. 106-117.

the past year I'd only just learned about dental dams for oral sex with protection. But I'd never heard it discussed by doctors or sexual health or anything. I found out about that through friends." (19-29 age)

Many younger women mentioned that there was little education on HPV as an STI so due to this disconnection they did not understand the importance of the Gardasil vaccine when it was being administered at school during their year 7 (aged 12-14 years).

"You're not really told what shots they are unless you look at the card they give you or if you asked your parents when you got home or the day beforehand." (19-29 age)

Women who identified as queer stated that they found it especially complicated to seek information specific for their protection from STIs and have sought blogs and forums because formal sexual health education and credible websites only focus on heterosexual women. School sex education appeared to be highly variable, resulting in adolescents receiving little to no information on sexual health and sexuality, especially information relevant to sexual minorities. As adolescents matured into adults, they are faced with navigating the health system themselves, and queer women were equipped with less accurate information than their heterosexual peers, thus increasing the health disparity.[117]

"…for me realising I was bisexual at 14 I tried to ask my teacher at a private Anglican school questions about lesbian sex and they were just like, "Well you're not going to do it are you?" and I was like, "Well that's absolutely my choice isn't it?" There was just no information for me about same sex relationships and I had to find it out online on forums where the information wasn't reliable and not always safe." (19-29 age)

The current health system and public health education are built around heteronormativity which fails to recognise women are of diverse sexual orientation and sexual behaviours possessing unique sexual and reproductive health needs compared to women who are exclusively heterosexual.[118] Therefore, participants reported that service providers assume that women accessing sexual and reproductive health identify as exclusively heterosexual and mostly monogamous.

"I'm in a polyamorous relationship I struggle to find either doctors who I trust to talk to me - who I feel have a good enough understanding about what that actually means to have thought through the issues, and that's where experiential stuff on the internet is good because you get people who are also in polyamorous relationships with manage STIs from that perspective" (30-39 age)

Studies have shown that this narrow assumption of sexual orientation and behaviour for women is problematic as the burden is placed on women to disclose.[119, 120] When women did disclose their sexual identity and/or behaviour, they are then advised that they did not need to consider STI testing.[121, 122] This was also found in our current study, with some participants reporting that their request for a STI test after engaging with different partners was considered unnecessary unless they worked in the sex industry.

[117] RD Hubach, 'Disclosure matters: Enhancing patient-provider communication is necessary to improve the health of sexual minority adolescents', *Journal of Adolescent Health*, vol. 61, no. 5, 2017, pp 537-538.
[118] K Baker and B Beagan, 'Making assumptions, making space: An anthropological critique of cultural competency and its relevance to queer patients', *Medical Anthropology Quarterly*, vol. 28, no. 4, 2014, pp 578-598.
[119] K Baptiste-Roberts et al., 'Addressing health care disparities among sexual minorities', *Obstetrics and Gynecology Clinics*, vol. 44, no. 1, 2016, pp 71-80.
[120] S Munson and C Cook, 'Lesbian and bisexual women's sexual healthcare experiences', *Journal of Clinical Nursing*, vol. 25, no. 23-24, 2016, pp 3497-3510.
[121] Ibid
[122] J Power, R McNair and S Carr, 'Absent sexual scripts: lesbian and bisexual women's knowledge, attitudes and action regarding safer sex and sexual health information', *Culture, Health & Sexuality*, vol. 11, no. 1, 2009, pp 67-81.

"Yeah, just the lack of information around gay sex and stuff. I don't know how to protect myself socially if I have interactions with a woman ….. In school there was just nothing on gay sex and I know that that's a stigma but I'm not sure where I would go to get that information." (15-18 age)

"I know I should, but I don't put myself in a high-risk category. I talk about STIs before engaging with new partners, and those partners have always also been people with vaginas" (19-29 age)

"My partner has been tested and have only ever had sex with her." (19-29 age)

"I haven't actually had penetrative sex, therefore my GP says my risk is lower." (30-39 age)

"Regular female partner, so STIs unlikely" (50-59 age)

Information about appropriate contraception services

In relation to contraception there was then an observed trend amongst women about the difficulty of accessing suitable services to enable an informed choice of effective prescribed methods and having to search for a practitioner certified to provide their preferred contraceptive type.

The women in the present survey often discovered LARCs and TOP service providers through the internet, their friends and/or specialised healthcare providers in sexual and reproductive health. This is consistent with findings from Rowlands et al. who observed that young women experiencing stigmatising or sensitive issues were more likely to search the internet for information as it offers anonymity, affordability, and availability, this was then followed by consulting with doctors, then family members[123] Not many women recounted learning or being advised about LARCs from their GP unless the participant themselves raised the question in their consultation.

"I've had bad advice from GPs in the past and judgemental advice from GPs in the past, so I tend to do my own research if there's an issue and then I'll go to the GP. If I like her advice I'll follow it and if not then I'd follow up with a specialist or do some more research myself." (40-49 age)

"And she [GP] *finally referred me to a gynaecologist, a male gynaecologist, who said, , "You can have it* [IUD insertion] *done under sedation." My GP hadn't even mentioned that I could have it done under sedation."* (40-49 age)

Many participants, particularly younger women, explained that they bypassed the GP and sought specialist care from the Canberra Sexual Health Centre, SHFPACT, Women's Health Service or women's health specialists because obtaining information relating to sexual and reproductive health from a GP was for 'general' health and often 'hit and miss'. Some women advised that they were unsure about their GPs' beliefs and would be uncomfortable with the potential of being judged so they preferred to save time and money from trialling different GPs and directly visit a specialised service for women's health where it is certainly safe from judgement and importantly knowledgeable on the subject matter.

"For my daughter and son, I would take them to an adolescent-friendly sexual and reproductive health centre. I wouldn't necessarily take them to the GP, they're pretty conservative GPs." (40-49 age)

[123] IJ Rowlands et al., 'Seeking health information online: Association with young Australian women's physical, mental, and reproductive health', *J Med Internet Res*, vol. 17, no. 5, 2015, pp e120.

Adolescent women highly recommended the walk-in centres for advice as they had had firsthand experience of the ease of communicating with nurse practitioners to obtain useful information.

> *"Can go there for anything. We've all been there together. We've all been there together. We're like family excursion to the walk-in centre anyone?"* (15-18 age)

All respondents who had visited SHFPACT, Women's Health Service, Canberra Sexual Health Centre, Marie Stopes Clinic, the Junction Youth Centre, and/or Winnunga Nimmityjah Aboriginal Health and Community Services (WNAHCS) spoke positively about discussing contraceptive choices at these clinics. Women's Health Service, Canberra Sexual Health Centre, and WNAHCS were especially commended for their free or affordable access to specialist services in women's health, sexual health, and culturally appropriate care.

However, many women described how being aware of these local and specialised clinics required searching the right places online, consulting with the right GP or hearing about them from a friend. The women reported that they were fortunate to have found these services and wished that they had known about them earlier and that they were publicised more in school, university, work places, and other public areas.

> *"There was a lot going on with my ovaries and everything, everything just down in that area generally at that time and me, it took me having a breakdown in one of the doctor's offices for them to bulk bill me and then refer me to an ultrasound place that would bulk bill me as well. But it wasn't an easy fee. And then I found, being Indigenous, – the Indigenous Healthcare Centre and that's bulk bill."* (19-29 age)

This is consistent with findings from Dehlendorf et al. who discovered that practitioners who were obstetricians, gynaecologists, female and/or those who perform IUD insertion in their practice were most knowledgeable about contraceptive types, eligibility of use, and ability to provide contraceptive counselling.[124] This was especially evident from women who accessed safe TOP reporting that they all received comprehensive contraceptive counselling with time to decide what would be most suitable for them as part of process and some women even took up the opportunity to pay an additional fee to have LARC inserted immediately after TOP procedure.

> *"I went to the doctor and was just given like this the pill – Levlen Ed I think. Just the standard like "there you go" not going to ask anything about your lifestyle or anything else, we'll just give you this one right of the bat. And I was really bad at taking it. I suck at getting up at the same time. I was a shift worker for years and years and years, so I was sometimes finishing at 4 in the morning, I didn't want to wake up at 7 to take the pill… When I was 21 I became pregnant and we went to Marie Stopes and I got a termination. And they were the ones that were like "implanon, have you tried it?" And I got it and it was fantastic! I didn't get my period at all, I wasn't pregnant anymore, I was really really happy about it. Coming off the implanon for the first time I went straight back on it for another round."* (19-29 age)

Healthcare providers in our study reported discussed the importance of having the 'luxury of time' in face-face consultations as very important in building trust and rapport especially with vulnerable women who live transient and chaotic lives impacting their compliance and ability to return for multiple short appointments.

The ACT has a highly transient population, and participants who were newly arrived in the last 18 months describing difficulty in navigating the ACT services in terms of sexual and reproductive health. Some of those who were new to the ACT discussed delaying professional consultation about their sexual and reproductive health needs until they returned to their homes interstate

[124] C Dehlendorf, et al. 'Health care providers' knowledge about contraceptive evidence: A barrier to quality family planning care?', *Contraception,* vol. 81, no. 4, 2010, pp. 292-298.

where they were more familiar with the system that they find simpler and more affordable to navigate than the ACT health system.

Information about MTOP and STOP

Participants were equally split in their opinion about initially accessing information about pregnancy termination online, or through a service provider. Those who stated they would access the internet advised that they are able to critically analyse their sources, whereas those who would avoid the internet discussed that they were afraid of being emotionally overwhelmed from filtering for reliable, accurate and local information. Some participants also mentioned avoiding their GP if they felt their GP would have a conscientious bias on abortion matters.

Three quarters of the survey respondents stated they had a general understanding of the difference in procedure between MTOP and STOP. However, approximately half of discussion participants demonstrated that they had a basic awareness of the existence of the two methods, but little was known about gestational stage, side effects, costs and laws surrounding provision of abortion in the ACT. This suggests that many individuals do not think about having an abortion until needed, and thus there is a greater pressure to obtaining reliable, accurate and local information in a timely manner.

Clinical studies have demonstrated the efficacy of MTOP and STOP at 9 weeks of gestation is similar with success rates of greater than 99% for both procedures.[125]

However, participants in this study showed greater preference for STOP because they felt it is faster, the patient is unaware of the procedure as it is occurring, and they had concerns about the potential side effects of MTOP. Whereas, the smaller proportion who stated they would prefer selecting MTOP advised this was due to fear of surgical procedures or of being unaware of the procedure occurring, and because MTOP allowed greater flexibility in time and is more private experience as it can be taken in the home environment.

Some participants advised they would avoid MTOP due to 'horror stories' they had heard from their friends or their GPs.

> *"I did a bit of reading about the pill because they gave me those two options and it sounded like - and I spoke with a friend who had recently had a D&C* [dilation and curettage] *and she'd tried the pill on a previous miscarriage and she had a really bad experience."* (30-39 age)

Healthcare providers observed that women made decisions that best fit with their other commitments and activities, but that improved availability and accessibility of safe options and accurate information regardless of circumstances is a necessity towards improving choices and autonomy for women.

> *"Women actually know what they need when they need it."*

Health screening

STI testing

Most study participants demonstrated an understanding of the importance of STI testing after unprotected sex and/or when symptoms appear, but many felt that some GPs judgemental attitudes made accessing STI testing prohibitive. With 23% of survey respondents who stated that they had sexual activity with another person/s in the previous 12 months but had never been

[125] LD Ireland, M Gatter and AY Chen, 'Medical compared with surgical abortion for effective pregnancy termination in the first trimester', *Obstetrics and Gynecology*, vol. 126, no. 1, 2015, pp 22-28.

tested for STIs, this is a clear indication that there needs be improved education and outreach campaign to reduce this rate for ACT women.

The sexual health professionals stressed the need to reduce the stigma for women in requesting STI testing, and for GPs to keep updated on their contraceptive knowledge and become more comfortable in bringing up and performing STI testing in consultation, especially for young women.

Pap smears

All women in the study were informed about pap smears and most women who had engaged in sexual activity over the age of 19 had undergone at least one pap smear in their lifetime. At the time of the survey the routine for pap smears was every two years and women in the study were aware of this due to reminders from the national register.

However, many women advised they were not able to keep up to date with their pap smears due to difficulty in making time to attend an appointment for a physically uncomfortable process. Some women described the experience of pap smears as so traumatising that they have avoided and past their due date. This indicates the importance of health practitioners in being sensitive about their communication and performing of pap smears to reduce fear of the important procedure.

> *"My first pap smear here* [Canberra] *was probably one of the worst experiences of my life. The doctor, who apparently is quite infamous for not having great bedside manner - I didn't know that. I wasn't that excited about it anyway, it was only my second. She was just like "Oh there's something wrong here", which is not something you should say to someone. Especially in that situation, I was so vulnerable. I was getting pretty stressed out and worked up. So, she sent me off to get a pelvic examination, there was nothing wrong. At the time I was really stressed out. I started crying and she was like "Why are you crying?" and I was like "Well I'm pretty stressed out about this discussion we've just had." She said "Your stressed? You should see how many patients I've had today." It was pretty bad. I never want to see that woman again*." (19-29 age)

Due to the introduction of HPV vaccine in Australian schools, a new cervical screening test has been implemented in December 2017 whereby, cervical screening involves the same procedure but only requires a test every five years for women 25 years and over. Half of the women 19 years and over were aware of this and all received this new program positively.

However, specialist providers raised caution that this may mean women will make less frequent health appointments. Reduced continuity of care means there may be less opportunity for practitioners to inform, support and advise women timely and appropriately to manage their sexual and reproductive health.

> *"We have screening not starting till the age of 25. I'm not sure that there is a shared model across young women, across health care providers around what good sexual health engagement is like for that 18 to 25 year old group. At a minimum that should include annual chlamydia testing, but I think that message is really lost in all the public changes that have happened"*

Breast examination

The majority of the respondents advised that they knew how to do a general breast check. They were also generally aware of the starting age at which risk of breast cancer is high and aware when they were eligible for free mammograms. However, there were some women who believed they were of high-risk and wished that early detection tests could be more financially accessible.

"I know I'm at a risk, but to go and get genetic screening is, it's quite a difficult process, so that pathway is difficult, plus $500, $600 yearly to get an MRI is also quite dear. I know it was my own fault because I went and had implants, but it would be good to have that pocket of women, preventative, early detection testing made more available, cheaper, more accessible. I reckon that avenue is a big gap because then further down the track to say our pocket of society ends up getting it, then you're dealing with a lot more healthcare outcome problems." (40-49 age)

Affordability

Cost of contraception

Many contraceptive types exist for women today, however accessibility to them are hindered by the cost of obtaining certain types based on whether the contraceptive item is subsidised and the cost of procedure.

Women in this study mostly described the oral contraceptive pill as being affordable due to the small upfront cost for each script. However, when forum participants were informed about the average costs of LARCs, they all agreed that the approximate upfront cost of Implanon (including insertion) at $150 for use of three years or the Mirena (including insertion) at $300 for use of 5 years would be more cost-effective in terms of time and money in the long run. The participants also calculated the cost and time of attending non-bulk-billed GP appointment for renewed scripts on top of purchasing the pill. For those who are prescribed oral contraceptive pills which are not listed on the PBS, the cost difference was even larger with women reporting that they pay their prescription entirely out of pocket between $70 and $90 for a three-month supply.

"Yeah, the one [oral contraceptive pill] *I take is like $77. … So, my dad pays for it at the moment, but I'll probably have to start paying for it soon. And I have loads of other medications I have to pay for."* (15-18 age)

Subsidies for those holding a Healthcare concession card were also variable according to contraceptive type. Healthcare providers in women's health described that although there were many types existing for a woman to find one that is most suitable to her, the reality is that this decision can significantly be influenced by cost as also identified by Dixon et al.[126]

"Sometimes cost is a real barrier for people with options. I think there are a number of women that would prefer things like a NuvaRing to a pill, but the pill on a health care card is $6.30. A NuvaRing is 40 bucks a month. So, it's, "I'd like the option of choosing from all of the range, but really I can't because I can't afford half the range currently."

Although the cost of the hormonal IUD, Implanon and Depo-Provera are clearly presented in the PBS, women reported being quoted variable costs from different services for the consultation and the procedure to remove and insert or implant LARCs.

He [GP] *actually didn't charge me at all, so he bulk-billed the whole thing. At the .. Medical Centre, just pay for the implanon. I don't pay for the insertion or the removal or anything like that. But yeah, call in that "women's specialist doctor", they're like "$480… I had to get a consultation appointment for $130 and then I had to come back and that would cost me $350 to have it removed and another one put in and I would also have to buy the implanon so an extra $30 or so.* (19-29 age)

[126] SC Dixon, et al. 'As many options as there are there are just not enough for me: Contraceptive use and barriers to access among Australian women', *The European Journal of Contraception and Reproductive Health Care,* vol. 19, no. 5, 2014, pp. 340-351.

This clearly indicates that total costs for a procedure can be dependent on the presenting consumer and the provider, and this ambiguity of costs can be very inhibitive on choice for women in the ACT whose decision-making is highly dependent on what is affordable.

> *"Came back for the next appointment and when I went to the counter they almost charged me almost $500 or something. And I said, "The person on the phone said that it* [IUD] *would be free because I was 25 and I wouldn't be charged"* (19-29 age)

Free male condoms are available from SHFPACT and the AIDS Action Council, however, many of the women in the discussions were surprised that male condoms were not freely available at more accessible places such as universities.

Respondents were glad that the ECP is available over the counter without the need to spend extra time and money in obtaining a script from a doctor, however, because the ECP is often only used at a time of panic or if there has been error in contraception, women are left with little choice to shop around for the most affordable retailer. A healthcare provider described witnessing young people risking an unintended pregnancy due to the high cost of ECP.

> *"The morning after pill is between $30-55. The actual cost of them, the cost price is $4.00 each. So the mark-up is obscene. And whilst I understand that there is an element of professional intervention in that you have to have a pharmacist giving you the morning after pill, most of the time, it's not $55 worth of intervention that happens there, and that cost, ….. If you've got a 16-year-old who could avoid the termination scenario with a morning after pill, and decides, no, $55 is too expensive and just decides to wing it for whatever. That happens. I saw so many people leave the pharmacy after realising the cost of it."*

Cost of TOP

Because ACT residents generally have higher weekly earnings than the national average, those who don't can experience issues that can impact negatively on their health service access and equity of access due to cost barriers.

A quarter of Australian households have less than $1,000 in cash savings and one of the worst-affected groups are young people under 30 year of age and students who are particularly insecure about their level of savings, living expenses, and lack of ability to handle a financial emergency.[127] This suggests that the $500 base cost of a TOP, either medical or surgical, at a standing clinic accessible to women in the ACT and surrounding areas is not financially accessible to young women.[128]

Most women younger than 30 years of age in this study stressed the starting upfront cost of obtaining a TOP would be out of reach and significantly impact their lives. Some women suggested the stress of the high costs could be relieved if payment plans were available, as well as noting that having an unwanted child would be of greater health, emotional, and financial burden to the woman, the child and the community.

> *"It's one of the biggest things that could happen in your life. And the mental health that goes with it. You would think at the very least there would be some kind of payment plan that means you could get the termination and pay after. But surely there should be some acknowledgement of socio economic status. If you can't afford it, maybe you shouldn't have to pay."* (19-29 age)

[127] ME's 14th Household Financial Comfort Report (2018) https://www.mebank.com.au/getmedia/2046702b-39c0-457b-8950-80d75e716bcd/ME-s-14th-Household-Financial-Comfort-Report_August-2018.pdf
[128] M Shankar et al., 'Access, equity and costs of induced abortion services in Australia: A cross-sectional study', Australian and New Zealand Journal of Public Health, vol. 41, no. 3, 2017, pp 309-314.

Women over 30 years old mainly stated that they could afford the $500 however most also added that they were in a fortunate position with a stable income and supportive network that can provide emotional and financial assistance. They understood and witnessed other women in less fortunate positions, such as those experiencing domestic violence, financial hardship, and those with young children who would face great difficulty in acquiring an abortion with such a high upfront cost that can only rise with delay.

> *"For a woman who was on a very low income, unemployed, or was experiencing financial hardship due to domestic violence or a controlling partner et cetera then I could imagine that $500 for some people would be too much, but I'd imagine it's the minority of women who were seeking an abortion would need financial assistance, but I believe that it should be made freely available to those women who cannot pay that $500."* (30-39 age)

> *"It really should be massively subsidised by government if that's the actual cost. Women should be able to choose whether they have children regardless of whether they're poor or not."* (40-49 age)

> *"And there may be a lot of women that are in difficult situations and they don't want to have more children but for whatever reason they've become pregnant again and they can't do anything about it because they don't have the money for a termination and then the cycle continues. They don't have a choice. There's a choice between that and paying rent or feeding their children."* (30-39 age)

> *"Again I naively thought those kind of places* [payment plans] *existed. Touch wood, I've been fortunate enough that I'm not in a position where – there are people I can ask money for if I didn't have it myself, but there's a lot of people out there that just don't have those options and I'd like to think there's some safety net for them but it's terrible that there's – Nope, maybe not… that is a social issue that affects everybody in the community around that person if they have to drop out of work and look after a kid or now that there's another kid that requires schooling –"* (30-39 age)

All participants who underwent a TOP in the last three years of the study accessed the Marie Stopes clinic in the ACT and emphasised that although cost of TOP did not influence their decision to undergo an abortion, they certainly were surprised by the high cost and most struggled with budgeting and accruing sufficient funds by borrowing from their support network to proceed with the procedure.

> *"It was really financially stressful for my partner and me that month, it was just a bad month. We've both got okay jobs so normally – and because I didn't want to tell anyone about it. Normally in an emergency I could ring up my dad and ask for $500 and say, "I'll pay you back next month" but I wasn't interested in lying to him and I still haven't told my parents."* (30-39 age)

> *"On one hand it was very easy because I knew what I could and couldn't do, but it was still a very difficult choice. Just having to go through all those different processes. So I think making it as easily accessible as possible, removing those barriers is really really important. Especially when it comes to decisions that have a time frame. For me, I still had to borrow money and that's because my husband didn't agree with my choice."* (30-39 age)

> *"it was so expensive. But I was like whatever, like this is happening. But again I was lucky enough that I could just put it on my credit card, again if I wasn't in that position. I don't know like I wouldn't have been able to go and borrow money off my parents or anything for it, like I would never tell them."* (30-39 age)

Low number of bulk-billing GPs

A significant issue was the low number of bulk-billing GPs.[129] For new arrivals to Canberra who were accustomed to never making a patient co-payment for an appointment with a GP, it was particularly not an easy adjustment and costs easily piled up when regular GP visits were necessary.

> *"That's one of the reasons why I don't enjoy going to the doctor here, I will just save it all up, go down to Sydney and just go bleugh, here's all the things, give me all the drugs, kind of thing. It's super expensive to get in here. I have a good job, it's fairly well paid, like average, but I have X amount of expenses and with everything at the end of the day I've only got $500 for two weeks of disposable income…. So that's how I operate and going to the doctor every X amount of weeks or every so often just to get a check-up or to say, "I need this script written. ..", $80 for a piece of paper isn't worth it. So, if I spend $40 and take the bus down to Sydney I get to see my parents, I get to see my grandparents, I get that piece of paper for technically free…"* (30-39 age)

Accessibility and acceptability

Safe & non-judgemental

Many of the women discussed the importance of seeking sexual and reproductive healthcare where they can express their concerns without fear of judgement and that their experiences are validated. In research that focused on healthcare professional behaviour and attitudes, patients were more receptive and felt more welcome in seeking advice when they were comfortable with their healthcare provider. Similarly, for some of the study respondents, the 'embarrassing', 'shameful' or invasive nature of sexual and reproductive health was a barrier for women to seek proper care. The barrier was heightened when women received poor treatment, especially for young women seeking care for the first time and those who have had traumatic experience of sexual abuse or assault.

> *"Your blood test is in. You know we can't give it to you over the phone, you have to come into the medical centre", walked in, the receptionist called the doctor, "Yep, yep, yep, you're pregnant!", click, room full of people! It was horrifying! Hence, complaining. He's still practicing. But yeah, it was a really horrible situation and again I had to turn to the internet… But yeah, it was a really horrible experience with that doctor and then having to kind of "how do I get an abortion?", was really awful too."* (19-29 age)

Some women described that although there were times they felt uncomfortable they were determined to find appropriate care for their sexual and reproductive health needs. Some women mentioned that being proactive in requesting a STI test was not enough with their GP and they were left to convince and justify why they were making a request. Worryingly, many women also recounted that a negative experience led to delaying or avoidance of the next visit.

> *"I told that story at the* [Canberra] *Sexual Health Centre when I went in for an STI check and the man who was the nurse was horrified. He said, "Well look you are here now we can just do it* [pap smear] *quickly if you are comfortable." I actually hadn't gone in for that. I was pretty scarred from the previous experience. So I had one then and it was absolutely fine. So in that instance I had 2 polar opposite experiences. One horrible one and one where I would have put it off except I had just gone in and he gently encouraged me to take advantage of the fact that I was there. So, getting a good doctor can be a barrier."* (19-29 age)

[129] The Department of Health, *Annual Medicare Statistics*, (Canberra, ACT: Australian Government, 2018), retrieved on 5 September 2018, http://health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics

"Even if you know logically it's not scary, you can't fight your brain sometimes. It is uncomfortable and it's weird having someone examine you and your genital in a non-sexual clinical way, sometimes it can be quite uncomfortable. And I think the person doing it makes a really big difference and because it's all they do! They have a really positive manner about the way that they talk about things." (19-29 age)

"I've had friends who have had horrible pap smear experiences and not necessarily just from males either. One friend, she's put off, I don't know if she's gone back to have one, she put off of getting a pap smear for ages because she went to a doctor and afterwards the doctor threw a box of tissues and said "clean yourself up" or something, I mean it was some awful thing and my friend was just traumatised by it and didn't want to go back for another one." (19-29 age)

Confidentiality & privacy

Because sexual and reproductive health matters can be a contentious issue in society stigma and discrimination influence the participants' decision-making.

Some women recalled seeing protesters outside of Marie Stopes clinic before the 50-metre exclusion zones were introduced in the ACT in 2016 and commended the implementation of this law which improved women's safety and privacy in accessing sexual and reproductive health services in peace without being intimidated.

"Exclusions, and I know that has helped significantly, …. Regardless of how people think about that I think that still is an issue is that people feel like they're being watched and judged and physically can't get in the door, that can be an issue." (19-29 age)

Although, the safe access zone surrounding TOP clinic has been an improvement for women and their reproductive rights, women highlighted the importance of confidentiality and privacy to be able to comfortably discuss their options and make meaningful and well-informed choices. They stressed that all individuals, regardless of age, cultural, social, and economical background, have the right to access a health professional or service for any health concern without the risk of being in public.

"I guess whatever range of services she wants frankly and it's not so cost-prohibitive that she can't access it. If you have an unplanned pregnancy it could be related to your own whoops carelessness "Oh dear, I've got an unplanned pregnancy." or it could be because you're in a relationship where you can't control when and where you have sex or when and where you use the contraception or it could be because you have other issues in your life that are affecting yourself and sexuality. If someone comes to a GP with an unplanned pregnancy then there should be support services, mental health services, potentially domestic violence access to services, all these kind of issues that you may want to discuss… it's her choice, she could be dealing with that pregnancy having not told her partner, which is absolutely her right, she could be dealing with that pregnancy not having a partner which is absolutely her right." (40-49 age)

Sexuality and relationships

Queer women highlighted that they would like local services to be competent in providing a safe environment free of stigma allowing for disclosure of sexual orientation and sexual behaviour, and for women to attain appropriate advice about their sexual and reproductive health needs.

"I think also localised where you could access services if you need it, especially for teenagers who may not feel comfortable talking to their parents or teachers, knowing where they can access free confidential services." (30-39 age)

Participants also raised the importance of language in health communication to ensure all individuals with female reproductive system feel welcome and safe to visit a health service provider.

> *"…most feminist organisations or women organisations say they're open to people of intersex and transgender and stuff as well. But there might be a place that doesn't have that language about being open and if they've already changed their actual legal identity to male… Can they access that women's only service if they're actually legally recognised as a male now?... Instead of women's health centre just like, reproductive rights centre or something like that."* (19-29 age)

Location and opening hours

Younger respondents described the importance of the physical location of appropriate services. For both younger and older participants, their concern was convenient opening hours for timely appointments or walk-in availability.

The Canberra Sexual Health Centre was highly recommended by respondents under 40 years of age in discussion, however, women noted the limited opening hours meant having to make private booking or rearranging work and study schedule to fit in a visit to the clinic.

> *"The idea of there being a place like that's open seven days a week and for extended hours is very attractive. The Sexual Health Centre at Canberra Hospital, parking is a real pain and I always have to make the appointment during a work day, duck away and come back again... Sorry no I'll put on the work calendar that I have a doctor's appointment and then I'll go to the walk-in clinic and just take my chances with the queues"* (30-39 age)

> *"I know a lot of students, they already have to go out, for all the universities and CIT and everything probably about three days a week and on one of their days off they're meant to be studying the last thing they want to do is either drive or catch a bus out to that side of town again just for an hour to visit to come back again. They can't just afford the cost of it when it comes to fuel and parking and bus tickets and everything."* (19-29 age)

Young women described the ease of accessing the ECP over the counter at any pharmacy was beneficial to those with poor transportation, especially in the time of panic.

> *"I'll go to school and during my break I'll grab it and I'll just deal with it because it was a very – I remember being very anxious and very paranoid and everything so any price wasn't too much."* (19-29 age)

Accessing MTOP via a GP

All women in the forum discussions agreed that the option for women in the ACT to access MTOP with their regular GP or a healthcare professional who is certified to prescribe and dispense the abortion pills should be available. More than half of the women in the discussions were not only accepting of visiting their regular GP to access MTOP but also expressed they would prefer this option if legally available out of the other options of visiting a standing clinic or telemedicine due to:

- trust in regular GP for coordinated care,
- confidentiality and privacy in visiting a general practice instead of entering a clinic specifically for TOPs,
- time saved in accessing MTOP instead of organising a day off for a STOP,
- less invasive than STOP,
- and less medicalised and less stress involved compared to visiting an unfamiliar clinic.

- *"It's more private, you don't have to go out of the way to get help. You're talking hopefully to someone that you've talked to before and that you trust and knows your medical history. Yeah, it gives you much greater choice, cheaper than going to a - potentially, hopefully… The good thing about that as well is if one GP says "No, I'm not going to give it to you." you can just go to another one so there's a range of choice there."* (40-49 age)

These findings and as identified in previous research, reinforce the need to acknowledge the importance of subjective, social and legal factors that influence women's health care choices, as well as the practical and logical reasons.[130]

Many women pointed out that this would increase accessibility to TOP for adolescent and young women, or women experiencing domestic violence who would require a greater amount of privacy and can only afford to spend minimal time accessing necessary services. As a previous study has shown that women who are young and/or disadvantaged make contact with a health provider significantly later in their pregnancy than other women, improving options for accessing TOP in the ACT would increase equitable access to early TOP.[131]

> *"That would be much better. As long as it's easier, there's more options. Access benefits. If there's more people able to dispense then the time to wait will be less and the options are greater."* (40-49 age)

> *"I know that family domestic violence is a massive issue ... So that's also an issue is also having the time and especially if you have young children, how do you then have an appointment without your partner knowing and taking care of your young children and accessing those services without your partner knowing. Or even if your partner does know or you're a single parent how do you access it? How do you work out the actual logistics of that service? That's why maybe the medical termination could help where it's a lot more discreet, you can do it at home, you miscarry – thinking about family domestic violence, that's a big concern."* (19-29 age)

Participating healthcare providers were in support of women being able to access MTOP from certified GPs, however, caution was highlighted for vulnerable women who may have problems with medical compliance in remembering to take the second pill of the MTOP procedure.

> *"They are so vulnerable, and their lives are so transient. Especially if there are drugs* [MTOP] *involved. I'm not saying it's the best form, but sometimes if you look at it as a whole, it* [STOP] *can be the best option if there's other factors influencing the compliance of the medical."*

Women's views on expanding choice and options

Women identified some key areas where sexual and reproductive health services could be expanded to enable better choice and options, as well as improving access, for women.

<u>School youth health nurses</u>

In 2009, School Youth Health Nurse Pilot Program was commenced in eight ACT government high schools, in which the nurse team worked with the school to tailor the Program according to the school needs and had a private office space where students may drop-in or attend

[130] Newton, Danielle, Chris Bayly, Kathleen McNamee, et al. 'How do women seeking abortion choose between surgical and medical abortion? Perspectives from abortion service providers', *Australian and New Zealand Journal of Obstetrics and Gynaecology,* vol. 56/no.5, (2016), pp 523-529.

[131] HJ Rowe et al., 'Considering abortion: a 12-month audit of records of women contacting a Pregnancy Advisory Service', *Medical Journal of Australia,* vol. 190, no. 2, 2009, pp 69.

consultations at appointed times.[132] Each nurse covered two schools, spending two days per week in each school.

Young women highlighted the need for well-designed sex education in school that was not just a checklist off the high school Personal Development, Health and Physical Education curriculum. They highlighted that schools are often the one secure point in young people's lives, so schools should be designed to provide an array of support for students.

Women of all ages also discussed that it would be ideal to have knowledgeable, trusted and qualified staff working in all high schools as educators and as someone young people can approach for confidential enquiries. This role would improve young people's access to accurate and reliable information about sexual and reproductive health, including relationship matters and mental health concerns, and open pathways for young people to become informed decision-makers, and appropriately and effectively navigate relevant local services.

> *"So, it's about having opportunities in the school spaces for those conversations, whether it's school counsellors, school nurses, those type of things, people drop like mobile services that come in and provide those conversations."*

The perception of adolescent women needing someone to talk to was also directly observed by ACT healthcare providers in schools, women's health and youth health who revealed that many adolescents only receive advice from similarly aged peers if they do not have other trusted people in their lives.

> *"It's also not necessarily having the adult role models to discuss it with and or being afraid to talk to Mum and Dad and say, "This has happened and I need some guidance and I need some advice on what to do," and or it's occurred in a situation where there's been something like alcohol that Mum and Dad have got angry about the alcohol but don't know the rest of the story, so I can't go back to that event, because they're going to be angry at me. So, I can't talk with anyone about it. So, I talk with my friends, who are 15, 14, don't have a whole lot more emotional maturity than me, and don't necessarily get the best advice. So, it cycles on."*

Sexual health centre

The Canberra Sexual Health Centre was discussed as a service for sexual health information and STI testing. Although the centre has been opened since 1979 (as the Gilmore Clinic) at the Canberra Hospital, the number of women who were not aware of the service and thought that they could only access STI testing with a GP was surprising.

Whereas, women who had visited the centre all reported positively about their experiences there.

> *"…having free sexual health checks at Canberra Hospital, I've taken so many friends because they didn't realise that they could go without parents, they didn't realise that they could go and it was free, and that they could have a comprehensive check and you discuss all your risk factors so they're not going to do… check for things that they don't assess you as a high-risk for. And it's all they do, so they're good at it. They know the right questions to ask to assess your risk category. If that wasn't freely accessible to me then I probably wouldn't have been checked as regularly as I should. I still don't think that enough people access them as regularly as they should."* (19-29 age)

> *"I've accessed a lot of healthcare in my life for other health issues and I think some of the best healthcare I've received is at the sexual health clinic at TCH. I can't fault them in any*

[132] M Banfield, K McGorm and G Sargent, 'Health promotion in schools: A multi-method evaluation of an Australian school youth health nurse program', *BMC nursing*, vol. 14, no. 1, 2015, pp 21.

way. Really comforting, really reassuring. 10 out of 10. 5 stars because they were responsive to my needs" (19-29 age)

The main issue raised about the Canberra Sexual Health Centre by women of all ages was the physical accessibility of the centre, that the centre was not well publicised and difficult to get to, especially within the limited opening times.

"…a lot of people don't know about it or it's too hard to get to. If you're a student and you don't have a car then it's not necessarily that easy to get out to Woden." (19-29 age)

Women in focus groups, especially adolescent and young women, suggested that access STI testing could be made more accessible and available at Walk-in Clinics.

Walk-in Clinics (WiCs)

Young women in the study either explained their personal experiences or second-hand experiences of visits to WiCs of which all were positive. The women described the current locations of WiCs in Belconnen and Tuggeranong, and Gungahlin as convenient for young people residing and going to school in suburban areas whereas access to specific sexual health services in the city may be complicated by poor transportation and additional costs.

The long opening hours over seven days a week and no-reservations model were also highlighted as advantageous in improving access for young people to local and reliable source of information about sexual and reproductive health in a safe and confidential setting. The respondents also discussed the ease of conversing with the nurse practitioners who are knowledgeable, non-judgemental and professional.

"I feel like they would be like this is where you need to go, this is who you can talk to." (15-18 age)

"But they have a bunch of pamphlets on the wall, so you could probably find one." (15-18 age)

"It feels more like….more anonymous because you don't know them, and they don't really know you like they have your records, they know what's happening with you, you see them for that and then you're gone, and you don't really have to see them that much. Whereas with a doctor it's a bit more personal." (15-18 age)

"They are really great! I've used them before and they are fantastic! Nurse practitioners – amazing! Loveliest women!" (19-29 age)

"They're all located near colleges as well, so it would be great for kids, like students. Every single one of them are." (40-49 age)

"…The reason I'd bypass the GP is because the nurses are more understanding. I think as a rule most nurses have better patient care than what doctors do." (40-49 age)

"Certainly, rather than going to your doctor or going to the clinics, again trying to get parking." (50-59 age)

Young women who resided in the localities of WiCs were overwhelmingly positive about the idea of STI testing available at WiCs because they already had a positive first-hand experience visiting the nurse-led centre to deal with other one-off health issues and injuries. They also saw benefit in the fact there was greater anonymity than visiting their family GP, WiCs are free to visit, and more physically accessible than the Canberra Sexual Health Centre.

"God yeah! It's already close to me, I live in Tuggeranong so it's just like a 10-minute drive. If there was one at the walk-in centre at Tuggeranong oh my god I'd go and get it checked for fun!" (19-29 age)

"I feel like I could definitely go to the walk-in because like no one knows what you're there for. And then they're really nice there. As well so I feel like I'd be fine going there [for STI testing]. *We love the walk-in centre."* (15-18 age)

Unexplored issues for future work

Women in our study identified issues relating to sexual and reproductive health matters that were not covered by our questions including: menopause, endometriosis, polycystic ovarian syndrome, adenomyosis, fertility and assisted reproduction, and miscarriage support.

Menopause

Women in their late 30s and above in the study raised menopause and the impacts it will have or has on their daily lives. The women described that information about menopause is not consistent across the internet and not much better from healthcare providers they consulted. Women in their late 30s and early 40s were worried about what to expect and expressed being ill-informed about identifiable symptoms of the different stages of menopause. Whereas women experiencing menopause spoke about the poor and delayed advice and support t received in managing symptoms of menopausal transitions. The uncertainty of symptoms by women and their healthcare providers, and the uncertainty of having no diagnosis or explanation can lead women (especially women experiencing early menopause) to feel that their menopausal experiences are not legitimate and therefore not treatable or manageable.[133]

Gynaecological issues

Gynaecological issues including endometriosis, polycystic ovarian syndrome (PCOS), and adenomyosis, were mentioned by women of all ages in this study, and the commonality of delayed diagnosis and complexity in managing the symptoms.

The participants were either personally affected by these gynaecological issues or concerned about a family member or friend living with a gynaecological issue. Both groups of respondents emphasised the poor amount of appropriate information online as well as from local services and their experience and difficulty in navigating the health system. Women were concerned with the adverse effects on quality of life, fertility, and the ambivalence and inconsistency from multiple health professionals about managing the chronic and debilitating disease. Women identified the need for dedicated information sources, services and community peer support groups.

[133] M Boughton and L Halliday, 'A challenge to the menopause stereotype: young Australian women's reflections of 'being diagnosed' as menopausal: Young and menopausal: reflections on being diagnosed', *Health & Social Care in the Community*, vol. 16, no. 6, 2008, pp 565-572.

Conclusion

This report about the views and experiences of ACT women adds a local context to the national and international evidence about the factors that influence sexual and reproductive health, and the barriers that can limit use of and access to information and services. It also reinforces that many of the findings from previous research by WCHM are still relevant today.

This research showed that ACT women want to be able to make informed choices about their sexual and reproductive health, and to access relevant services and support. But women of all ages in the ACT told us they are still experiencing barriers to accessing information and services to help them maintain their sexual and reproductive health and to making informed choices. These barriers include availability, accessibility, affordability and appropriateness/acceptability of services and affect their ability to manage their sexual and reproductive health.

It is our view that women generally know when they need to access a healthcare service, and that the best outcome is usually achieved when women are able to make informed choices about their care with the support of a healthcare provider who understands and respects their wishes.

We hope that this report which shares the views and experiences of local women can assist in informing practical actions and solutions to improving the health and wellbeing outcomes for ACT women.

Reference List

Agu J, Lobo R, Crawford G, and Chigwada B, 'Migrant sexual health help-seeking and experiences of stigmatization and discrimination in Perth, Western Australia: Exploring barriers and enablers', *International Journal of Environmental Research and Public Health*, vol. 13, no. 5, 2016, pp. 485.

Alperstein G, Bernard D, Elliot A, Bennett DL, Kerr-Roubicek H, Usherwood T, Quine S, and Kang M, 'Towards better practice in primary health care settings for young people', *Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals*, vol. 17, no. 2, 2006, pp. 139-144.,

Aminisani N, Armstrong B, and Canfell K, 'Cervical cancer screening in Middle Eastern and Asian migrants to Australia: A record linkage study', *Cancer Epidemiology*, vol. 36, no. 6, 2012, pp. e394-e400.

Australian Government, 'National Women's Health Policy 2010', *Department of Health and Ageing*, Canberra, ACT, 2010, retrieved on 20 August 2018, https://www.health.gov.au/internet/main/publishing.nsf/Content/3BC776B3C331D5EECA257BF0001A8D46/$File/NWHP_access_final.pdf

Australian Bureau of Statistics, 'Overweight and obesity 2011-13', *Profiles of Health,* Australia, 2013*,* cat. no. 4338.0, 2013, retrieved on 7 November 2017, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4338.0~2011-13~Main%20Features~Overweight%20and%20obesity~10007

Australian Government Department of Health, *National Cervical Screening Program – program overview,* 2017, retrieved on 7 November 2017, http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/cervical-screening-1

Australian Government Productivity Commission, *Report on Government Services 2018*, (Canberra, ACT), retrieved on 5 September 2018, http://www.pc.gov.au/research/ongoing/report-on-government-services/2018/health/primary-and-community-health

Australian Institute of Health and Welfare, 'Australia's mothers and babies – 2016 in brief', *Perinatal Statistics Series*, no. 34 Cat. No. PER 97., Canberra, ACT, 2018, retrieved on 28 September 2018. https://www.aihw.gov.au/getmedia/7a8ad47e-8817-46d3-9757-44fe975969c4/aihw-per-97.pdf.aspx?inline=true

Australian Medical Association, *Sexual and Reproductive Health,* 2014, retrieved on 25 October 2017, https://ama.com.au/position-statement/sexual-and-reproductive-health-2014

Baird B, 'Decriminalization and women's access to abortion in Australia', *Health and Human Rights*, vol. 19, no. 1, 2017, pp 197-208.

Baker K, and Beagan B, 'Making assumptions, making space: An anthropological critique of cultural competency and its relevance to queer patients', *Medical Anthropology Quarterly*, vol. 28, no. 4, 2014, pp 578-598.

Banfield M, McGorm K, and Sargent G, 'Health promotion in schools: A multi-method evaluation of an Australian school youth health nurse program', *BMC nursing*, vol. 14, no. 1, 2015, pp 21.

Baptiste-Roberts K, Oranuba E, Werts N, and Edwards L, 'Addressing health care disparities among sexual minorities', *Obstetrics and Gynecology Clinics*, vol. 44, no. 1, 2016, pp 71-80.

Bateson D, 'Gaps in good birth control', *Medical Observer,* 2014, retrieved on 20 August 2018, https://www.medicalobserver.com.au/news/gaps-good-birth-control

Booth ML, Bernard D, Quine S, Kang MS, Usherwood T, Alperstein G, and Bennet DL, 'Access to health care among Australian adolescents young people's perspectives and their sociodemographic distribution', *Journal of Adolescent Health*, vol. 34, no. 1, 2004, pp. 97-103.

Boughton M, and Halliday L, 'A challenge to the menopause stereotype: young Australian women's reflections of 'being diagnosed' as menopausal: Young and menopausal: reflections on being diagnosed', *Health & Social Care in the Community*, vol. 16, no. 6, 2008, pp 565-572.

Breast Cancer Network Australia, 'BreastScreen Australia', retrieved on 21 June 2018, https://www.bcna.org.au/about-us/advocacy/position-statements/breastscreen-australia/

Brown RP, McNair RP, Szalacha LP, Livingston PMP, and Hughes TP, 'Cancer risk factors, diagnosis and sexual identity in the Australian longitudinal study of women's health', *Women's Health Issues*, vol. 25, no. 5, 2015, pp 509-516.

Chan A and Sage LC, 'Estimating Australia's abortion rates 1985-2003', *Medical Journal of Australia*, vol. 182, no. 9, 2005, pp 447-452.

Children by Choice, 'Abortion and Medicare', *Children by Choice* [website], 2016, retrieved on 20 August 2018, https://www.childrenbychoice.org.au/factsandfigures/abortionandmedicare

Committee on Health Care for Underserved, 'Access to contraception', T*he American College of Obstetrics and Gynaecology,* Committee Opinion no. 615, 2015, pp. 1-6.

Conley TD, Moors AC, Matsick JL, and Ziegler A, 'The fewer the merrier?: Assessing stigma surrounding consensually mon-monogamous romantic relationships', *Analyses of Social Issues and Public Policy*, vol. 13, no. 1, 2013, pp 1-30.

Conley TD, Ziegler A, Moors AC, Matsick JL, and Valentine B, 'A critical examination of popular assumptions about the benefits and outcomes of monogamous relationships', *Personality and Social Psychology Review*, vol. 17, no. 2, 2013, pp 124-141.

Cooper Robbins SC, Bernard D, McCaffery K, Brotherton J, Garland S, and Skinner SR, '"Is cancer contagious?": Australian adolescent girls and their parents: making the most of limited information about HPV and HPV vaccination', *Vaccine*, vol. 28, no. 19, 2010, pp 3398.

Crimes (Abolition of Offence of Abortion) Act 2002 (ACT).

Cummings M, and Kang M, 'Youth health services: Improving access to primary care', *Australian Family Physician*, vol. 41, no. 5, 2012, pp. 339-341.

Davidson E, 'Let's talk about sex', *RiotACT*, retrieved on 21 June 2018, https://the-riotact.com/lets-talk-about-sex/220928

Dehlendorf C, Fox E, Sobel L, and Borrero S, 'Patient-centered contraceptive counseling: Evidence to inform practice', *Current Obstetrics and Gynecology Reports*, vol. 5, no. 1, 2016, pp 55-63.

Dehlendorf C, Levy K, Ruskin R, and Steinauer J, 'Health care providers' knowledge about contraceptive evidence: a barrier to quality family planning care?', *Contraception*, vol. 81, no. 4, 2010, pp 292-298.

Department of Health, *Annual Medicare Statistics*, (Canberra, ACT: Australian Government, 2018), retrieved on 5 September 2018, http://health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics

Department of Human Services, *Medicare Item Reports*, (Canberra, ACT: Australian Government), retrieved on 20 August 2018, http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

Dixon SC, Herbert DL, Loxton D, and Lucke JC, ''As many options as there are, there are just not enough for me': Contraceptive use and barriers to access among Australian women', *The European Journal of Contraception and Reproductive Health Care*, vol. 19, no. 5, 2014, pp 340-351.

Duley P, Botfield JR, Ritter T, Wicks J, and Brassil A, 'The strong family program: An innovative model to engage Aboriginal and Torres Strait Islander youth and elders with reproductive and sexual health community education', *Health Promotion Journal of Australia: Official* Journal of Australian Association of Health Promotion Professionals, vol. 28, no. 2, 2017, pp.132-138.

Finer LB, Frohwirth LF, Dauphinee LA, Singh S, and Moore AM, 'Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives', *Perspectives on Sexual and Reproductive Health*, vol. 37, no. 3, 2005, pp 110-118.

Friedman AM, Hemler JR, Rossetti E, Clemow LP, and Ferrante JM, 'Obese women's barriers to mammography and pap smear: the possible role of personality', *Obesity*, vol. 20, no. 8, 2012, pp 1611-1617.

Fuldeore MJ and Soliman AM, 'Prevalence and symptomatic burden of diagnosed endometriosis in the United Stations: National estimates from a cross-sectional survey of 59,411 women', *Gynecologic and Obstetric Investigation*, 2017, vol. 82, no. 5, pp 453-461.

Gemzell-Danielsson K, Cho S, Inki P, Mansour D, Reid R, and Bahamondes L, 'Use of contraceptive methods and contraceptive recommendations among health care providers actively involved in contraceptive counseling — results of an international survey in 10 countries', *Contraception*, vol. 86, no. 6, 2012, pp 631-638.

Ghane A, Sweeny K, and Dunlop WL, 'A multimethod approach to women's experiences of reproductive health screening', *Women's Reproductive Health*, vol. 2, no. 1, 2015, pp 37-55.

Goldhammer DL, Fraser C, Wigginton B, Harris ML, Bateson D, Loxton D, Stewart M, Coombe J, and Lucke JC, 'What do young Australian women want (when talking to doctors about contraception)?', *BMC family practice*, vol. 18, no. 1, 2017, pp 35.

Goldstone P and Thompson M, 'The tyranny of distance for Australian women seeking abortion', *O&G Magazine*, vol. 20, no. 2, 2018, pp 45-47.

Greenwood W, and Wilkinson J, 'Sexual and reproductive health care for women with intellectual disabilities: A primary care perspective', *International Journal of Family Medicine*, vol. 2013, 2013, pp. 8.

Hall MT, Simms KT, Lew JB, Smith MA, Saville M and Canfell K, 'Projected future impact of HPV vaccination and primary HPV screening on cervical cancer rates from 2017-2035: Example from Australia', *Plos One*, vol. 13, no. 2, 2018, pp e0185332.

Health Act 1993 (ACT), http://www.austlii.edu.au/au/legis/act/consol_act/ha199369/.

Hinchliff S, and Gott M, 'Seeking medical help for sexual concerns in mid and later life: A review of the literature', *Annual Review of Sex Research*, vol. 48, no. 2, 2011, pp. 106-117.

Hobbs MK, Taft AJ, Amir LH, Stewart K, Shelley JM, Smith AM, Chapman CB, and Hussainy SY, 'Pharmacy access to the emergency contraceptive pill: a national survey of a random sample of Australian women', *Contraception*, vol. 83, no. 2, 2011, pp 151-158.

Hubach RD, 'Disclosure matters: Enhancing patient-provider communication is necessary to improve the health of sexual minority adolescents', *Journal of Adolescent Health*, vol. 61, no. 5, 2017, pp 537-538.

Hussainy SY, Stewart K, Chapman CB, Taft AJ, Amir LH, Hobbs MK, Shelley JM, and Smith AM, 'Provision of the emergency contraceptive pill without prescription: Attitudes and practices of pharmacists in Australia', *Contraception*, vol. 83, no. 2, 2011, pp 159-166.

Ireland LD, Gatter M, and Chen AY, 'Medical compared with surgical abortion for effective pregnancy termination in the first trimester', *Obstetrics and gynecology*, vol. 126, no. 1, 2015, pp 22-28.

Jatlaoui TC, Shah J, Mandel MG, Krashin JW, Suchdev DB, Jamieson DJ, and Pazol K, 'Abortion surveillance - United States, 2014', *Morbidity and mortality weekly report. Surveillance summaries (Washington, D.C. : 2002)*, vol. 66, no. 24, 2017, pp 1-48.

Jean Hailes, 'Women's health survey 2018: Understanding health information needs and health behaviour of women in Australia', Melbourne, VIC, 2018, retrieved on 5 September 2018, https://jeanhailes.org.au/contents/documents/News/Womens-Health-Survey-Report-web.pdf

Johnson MJ and Nemeth LS, 'Addressing health disparities of lesbian and bisexual women: A grounded theory study', *Women's Health Issues,* vol. 24, no. 6, 2014, pp 635-640.

Kelly J, and Luxford Y, 'Yaitya tirka madlanna warratinna: Exploring what sexual health nurses need to know and do in order to meet the sexual health needs of young Aboriginal women in Adelaide.' *Collegian*, vol. 14, no. 3, 2007, pp. 15-20.

Kilander H, Salomonsson B, Thor J, Brynhildsen J, Alehagen S, Medicinska F, 'Contraceptive counselling of women seeking abortion: A qualitative interview study of health professionals experiences', *European Journal of Contraception & Reproductive Health Care*, 2017, vol. 22, no. 1, pp 3-10.

Kim K, and Han HR, 'Potential links between health literacy and cervical cancer screening behaviors: A systematic review', *Psycho-Oncology*, vol. 25, no. 2, 2016, pp 122-130.

Koch PB, and Mansfield PK, 'Facing the unknown: Social support during the menopausal transition', *Women & Therapy*, vol. 27, no. 3-4, 2004, pp 179-194.

Larkins SL, and Page P, 'Access to contraception for remote Aboriginal and Torres Strait Islander women: Necessary but not sufficient', *The Medical journal of Australia*, vol. 205, no. 1, 2016, pp 18-19.

Lodge G, Sanci L, and Temple-Smith MJ, 'GPs perspectives on prescribing intrauterine contraceptive devices', *Australian family physician*, vol. 46, no. 5, 2017, pp 328.

March WA, Moore VM, Willson KJ, Phillips DIW, Norman RJ, and Davies MJ, 'The prevalence of polycystic ovary syndrome in a community sample assessed under contrasting diagnostic criteria', *Human Reproduction*, vol. 25, no. 2, 2010, pp 544-551.

Marie Stopes Australia, 'Abortion', *Marie Stopes Australia* [website], retrieved on 20 August 2018, https://www.mariestopes.org.au/abortion/

Marie Stopes Australia, *Emergency contraception awareness high but access low among Australian Women,* 2017, retrieved on 20 October 2017, https://www.mariestopes.org.au/your-choices/emergency-contraception-low-uptake-australia/

Mather T, McCaffery K, and Juraskova I, 'Does HPV vaccination affect women's attitudes to cervical cancer screening and safe sexual behaviour?', *Vaccine*, vol. 30, no. 21, 2012, pp 3196-3201.

McNair R, Szalacha LA, and Hughes TL, 'Health status, Health service use, and satisfaction according to sexual identity of young Australian women', *Women's Health Issues*, vol. 21, no. 1, 2011, pp 40-47.

ME Bank, *ME's 14th Household Financial Comfort Report* [Report] (Melbourne, VIC: 2018), https://www.mebank.com.au/getmedia/2046702b-39c0-457b-8950-80d75e716bcd/ME-s-14th-Household-Financial-Comfort-Report_August-2018.pdf, 52.

Mengesha ZB, Dune T, and Perz J, 'Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: A systematic review', *Sexual* Health, vol. 13, no. 4, 2016, pp. 299-310.

Mengesha ZB, Perz J, Dune T, and Ussher J, 'Preparedness of health care professionals for delivering sexual and reproductive health care to refugee and migrant women: A mixed methods study', *International Journal of Environmental Research and Public Health*, vol. 15, no. 1, 2018, pp. 307-316.

Moreira ED, Jr., Brock G, Glasser DB, Nicolosi A, Laumann EO, Paik A, Wang T, and Gingell C, 'Help-seeking behaviour for sexual problems: the global study of sexual attitudes and behaviors', *Internationa Journal of Clinical Practice*, vol. 59, no. 1, 2005, pp 6-16.

Munson S, and Cook C, 'Lesbian and bisexual women's sexual healthcare experiences', *Journal of Clinical Nursing*, vol. 25, no. 23-24, 2016, pp 3497-3510.

Newson L and Panay N, 'Managing common problems in the menopause'. *InnovAiT,* 2018, vol. 11, no. 7, pp. 378-386.

Newton D, Bayly C, McNamee K, Hardiman A, Bismark M, Webster A, and Keogh L, 'How do women seeking abortion choose between surgical and medical abortion? Perspectives from abortion service providers', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol. 56, no. 5, 2016, pp 523-529.

O'Mallon F, 'ACT Health Minister Meegan Fitzharris says review into abortion access ready next year', *The Canberra Times*, retrieved on 21 June 2018, https://www.canberratimes.com.au/national/act/act-health-minister-meegan-fitzharris-says-review-into-abortion-access-ready-next-year-20171117-gznwy6.html

Power J, McNair R, and Carr S, 'Absent sexual scripts: lesbian and bisexual women's knowledge, attitudes and action regarding safer sex and sexual health information', *Culture, Health & Sexuality*, vol. 11, no. 1, 2009, pp 67-81.

Rich JL, Chojenta C, and Loxton D, 'Quality, rigour and usefulness of free-text comments collected by a large population based longitudinal study - ALSWH', *PLoS ONE*, vol. 8, no. 7, 2013, pp e68832.

Richters J, Fitzadam S, Yeung A, Caruana T, Rissel C, Simpson JM, and de Visser RO, 'Contraceptive practices among women: The second Australian study of health and relationships', *Contraception*, vol. 94, no. 5, 2016, pp 548-555.

Ride G, and Newton DC, 'Exploring professionals' perceptions of the barriers and enablers to young people with physical disabilities accessing sexual and reproductive health services in Australia', *Sexual Health*, vol. 15, no. 4, 2018, pp. 312-317.

Rissel CE, Richters J, Grulich AE, de Visser RO, and Smith AMA, 'Sex in Australia: Attitudes towards sex in a representative sample of adults', *Australian and New Zealand Journal of Public Health*, vol. 27, no. 2, 2003, pp 118.

Ritter T, Dore A, and McGeechan K, 'Contraceptive knowledge and attitudes among 14-24-year-olds in New South Wales, Australia', *Australian & New Zealand Journal of Public Health*, vol. 39, no. 3, 2015, pp. 267-269.

Rowe H, Holton S, Kirkman M, Bayly C, Jordan L, McNamee K, McBain J, Sinnott V, and Fisher J, 'Prevalence and distribution of unintended pregnancy: The understanding of fertility management in Australia national survey', *Australian and New Zealand Journal of Public Health*, vol. 40, no. 2, 2016, pp 104-109.

Rowe HJ, Kirkman M, Hardiman EA, Mallett S, and Rosenthal DA, 'Considering abortion: a 12-month audit of records of women contacting a Pregnancy Advisory Service', *Medical Journal of Australia*, vol. 190, no. 2, 2009, pp 69.

Rowlands IJ, Loxton D, Dobson A, and Mishra GD, 'Seeking health information online: Association with young Australian women's physical, mental, and reproductive health', *J Med Internet Res*, vol. 17, no. 5, 2015, pp e120, in PMC [online database].

Sexual Health and Family Planning ACT, 'Pregnancy options', 2015, retrieved on 20 August 2018 http://www.shfpact.org.au/images/Documents/PregnancyOptions2015.pdf

Shankar M, Black KI, Goldstone P, Hussainy S, Mazza D, Petersen K, Lucke J, and Taft A, 'Access, equity and costs of induced abortion services in Australia: A cross-sectional study', *Australian and New Zealand Journal of Public Health*, vol. 41, no. 3, 2017, pp 309-314.

Sifris R and Belton S, 'Australia: Abortion and human rights', *Health and Human Rights Journal*, vol. 19, no. 1, 2017, pp 209-220.

Tabbot Foundation, 'Abortion Canberra, ACT', *Tabbot Foundation* [website], retrieved on 20 August 2018, https://www.tabbot.com.au/medical-abortion/abortion-canberra.html

Tetley J, Lee DM, Nazroo J, and Hinchliff S, 'Let's talk about sex – what do older men and women say about their sexual relations and sexual activities? A qualitative analysis of ELSA Wave 6 data', *Ageing and Society*, vol. 38, no. 3, 2018, pp. 497-521.

United Nations Department of Economic and Social Affairs, 'World contraceptive use 2017', *Population Division*, 2017, retrieved on 20 August 2018, http://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2017.shtml

United Nations Population Fund, *Sexual & reproductive health,* 2016, retrieved on 20 October 2017, http://www.unfpa.org/sexual-reproductive-health

World Health Organization, 'Safe abortion: Technical and policy guidance for health systems', *World Health Organization*, 2nd ed. Geneva, retrieved on 20 August 2018, http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

Ward J, Bryant J, Wand H, Pitts W, Smith A, Delaney-Thiele D, Worth H, and Kaldor J, 'Sexual health and relationships in young Aboriginal and Torres Strait Islander people: Results from the first national study assessing knowledge, risk practices and health service use in relation to sexually transmitted infections and blood borne viruses,' *Baker IDI Heart & Diabetes Institute*, Alice Springs, NT, 2014, retrieved on 28 September 2018, https://www.baker.edu.au/Assets/Files/Final%20Goanna%20Report%20July%202014.pdf

Ward K, Quinn H, Menzies R, and McIntyre P, 'A history of adolescent school based vaccination in Australia', *Communicable diseases intelligence quarterly report*, vol. 37, no. 2, 2013, pp E168.

Wigginton B, Harris ML, Loxton D, and Lucke JC, 'A qualitative analysis of women's explanations for changing contraception: the importance of non-contraceptive effects', *The journal of family planning and reproductive health care*, vol. 42, no. 4, 2016, pp 256-262.

Winner B, Peipert JF, Zhao Q, Buckel C, Madden T, Allsworth JE, and Secura GM, 'Effectiveness of long-acting reversible contraception', *The New England journal of medicine*, vol. 366, no. 21, 2012, pp 1998-2007.

World Health Organization. Department of Maternal NC, and Adolescent H, *Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services* Book, Whole (Geneva: World Health Organization, 2012).

World Health Organization, *Safe abortion: Technical and policy guidance for health systems*, Geneva, 2003, p 12.

Yeniel O, Cirpan T, Ulukus M, Ozbal A, Gundem G, Ozsener S, Zekioglu O, and Yilmaz H, 'Adenomyosis: Prevalence, risk factors, symptoms and clinical findings', *Clinical and experimental obstetrics & gynecology*, vol. 34, no. 3, 2007, pp 163.

Zhou N, 'Australia could become first country to eradicate cervical cancer', *The Guardian*, appeared on 4 March 2018, retrieved on 5 September 2018, https://www.theguardian.com/society/2018/mar/04/australia-could-become-first-country-to-eradicate-cervical-cancer