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Experiences of abortion care in Australia: a qualitative study examining multiple dimensions of access

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Abstract

Background The United Nations' Sustainable Development Goals identify universal access to sexual and reproductive health services as a global priority. Yet barriers to abortion access remain, including legal restrictions, cost, stigma, and limited services and information. The aim was to identify barriers to and facilitators of abortion care access experienced in Australia.

Methods This qualitative phenomenological study examined abortion access in Australia, where abortion is decriminalised, from March 2020 to December 2022. We used social media and flyers in clinics to recruit adults who had sought abortion care, then interviewed them in-depth. We mapped participant experiences to five dimensions of access identified by Levesque et al.'s patient-centred access to healthcare framework: approachability, acceptability, availability and accommodation, affordability, and appropriateness.

Results The 24 participants lived across Australia and sought abortion during the COVID-19 pandemic. *Approachability*: Before seeking abortion, most did not know where to access information about the service and where to obtain it. *Acceptability*: Many were uncomfortable disclosing their abortion to family or friends; they reported that healthcare providers demonstrated varying levels of support. *Availability and accommodation*: Regional participants travelled far and faced long wait-times, exacerbated by pandemic restrictions. *Affordability*: Participants described financial stress paying for the service, travel, and related expenses. *Appropriateness*: Most participants expected judgemental care. Experiences varied widely: many participants experienced unempathetic, rushed, or judgemental interactions with healthcare staff, and many also reported at least one non-judgmental and supportive interaction on the same pathway to care.

Discussion Abortion seekers experienced varying obstacles when seeking care. The findings illustrate the need for population- and system-level initiatives such as: providing accurate information about and normalising abortion; implementing system-level strategies to reduce wait times, travel, and costs, especially for rural populations; and developing regulatory and quality improvement initiatives to increase the workforce and its readiness to provide high-quality, non-judgemental abortion care. Challenges seeking care during pandemic restrictions illustrate the importance of social support during care and choice between abortion modalities and service types. Consumer

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voices can help understand the diverse pathways to abortion care and inform solutions to overcome the multidimensional barriers to access.

Keywords Abortion, Healthcare access, Australia, COVID-19, Qualitative research

Introduction

To achieve the United Nations' Sustainable Development Goal 3 target of universal access to sexual and reproductive health services [1], the obstacles to abortion information and services must be understood and overcome. The World Health Organization (WHO) defines access as the "continual and organised" delivery of healthcare services in a "geographically, financially, culturally and functionally" [2] appropriate way. The WHO's conceptual framework for abortion care (2022) describes an enabling environment for access to high-quality care as comprising respect for human rights, legal and policy frameworks that support abortion, available and accessible information about abortion, and supportive and appropriately-resourced health systems [1]. When these components are absent, access to safe abortion care can be hindered by barriers such as legal restrictions to abortion provision, high costs, abortion stigma, and the limited availability of abortion methods, services and related information [1].

Various frameworks have been developed to illustrate the multidimensional factors influencing access to healthcare. The 2013 Conceptual Framework of Access to Healthcare by Levesque et al. draws comprehensively on previous definitions and frameworks for individual and community health to identify five common and crucial dimensions of access: approachability, acceptability, availability and accommodation, affordability, and appropriateness of service delivery [3]. Two qualitative studies have used this framework to explore access to telemedicine abortion care in rural Australia and in the United States, demonstrating applicability to a stigmatised service [4, 5]. Abortion stigma, an attribute that discredits a person due to their choice to obtain or provide abortions [6], contributes to secrecy among abortion seekers and providers [7] and exacerbates the lack of information [8] or misinformation about abortion [6]. Stigma is a common barrier to accessing high-quality sexual and reproductive health services across contexts, [9] yet is not explicitly mentioned in Levesque's framework.

Delays to care are disproportionately burdensome for abortion, which is a time-sensitive health service with growing complexity and costs and reduced service options as gestational age increases [10]. In Australia, abortion clinics (public and private) and general practitioners (GPs) can offer telehealth services for medication abortion [11]. Telehealth abortion is safe, acceptable, and effective for bolstering timely access to abortion [11–13] and can counteract health system limitations, [14] with particular benefits for rural populations [4]. Further strategies to ensure equitable and timely access to abortion care should be informed by lived experiences on pathways to abortion care. Accordingly, the aim of this study was to elucidate barriers to and facilitators of abortion care in Australia from the perspective of abortion seekers.

Setting

Abortion has been gradually decriminalised across Australian states and territories between 1998 and 2023 [15]. Australian surgical abortion regulations differ by state and territory, [16] with gestational age limits at the time of this study ranging from 14 to 24 weeks [17, 18]. Prescribed medication abortion until 63 days of gestation has been available nationwide since 2012 [19]. General practitioners can refer for care or prescribe medication abortion [20]. As of 2021, however, only around 7% of Australian GPs were registered to prescribe medication abortion [21]. Health professionals, including medical practitioners and pharmacists, have a right to conscientious objection from providing abortion care on religious, moral or personal grounds, [22, 23] with an estimated 14% of obstetricians and gynaecologists completely opposed to abortion [24].

Abortion care in public hospitals is mainly limited to foetal conditions [16, 25]. Most abortions are provided by GPs (medication abortion only), in specialised abortion clinics, or in private hospitals [20, 26, 27]. The costs of abortion care are partially subsidised by the federal Medicare Benefits Schedule for citizens, permanent residents, and some visa holders, or by private health insurance for those who have it [28]. Nonetheless, out-of-pocket costs for abortion seekers are common, [27] varying by abortion type, jurisdiction, gestational age, insurance scheme, [29] and between private and public facilities [25, 27].

Globally, the COVID-19 pandemic exacerbated health and social inequities and other pre-existing factors that limit access to sexual and reproductive health services [14, 30, 31]. As such, examining pathways to abortion care in this period can illuminate a range of structural factors that predated the pandemic and have continued to influence access, as well as the direct impacts of the pandemic on access pathways. In Australia, the extent of public health restrictions varied over time and between states and territories [30], and ranged from severe (no travel beyond 5 km from home and no one can accompany you for care) to negligible (screening questions for COVID symptoms before the service). In efforts to

facilitate access in the context of pandemic-related public health restrictions, Australia classified abortion as an essential service during the COVID-19 pandemic [30]. The Federal Government expanded Medicare-covered telehealth to include abortion services during the pandemic [32].

Methods

Study design

This qualitative phenomenological study examined experiences of abortion care in Australia from the start of the COVID-19 pandemic (March 2020) until October 2022. This study seeks to examine the multiple dimensions of abortion access in Australia, of which the pandemic is just one facet.

Participants and recruitment

Any person who attempted to access abortion services in Australia since March 2020, was at least 18 years of age, and was able to communicate in English for an interview was eligible to participate. Recruitment from November 2021 until October 2022 took place through Twitter, Instagram, and Facebook posts with messages including "Did you have an abortion in Australia during the COVID-19 pandemic?", "Did you seek abortion services since March 2020? Do you live in rural/remote Australia?", "Do you want to share your story for research", and "We'd like to hear about your experience to improve abortion services." After April 2022, once COVID-19 restrictions had lifted, recruitment flyers were distributed by sexual health clinics that provide abortions among their range of services. Eligible participants were directed through a QR code or URL to submit an expression of interest through Qualtrics (Qualtrics, Provo, UT), answering brief questions about their location, age, pandemic-related restrictions in place at the time of their abortion, whether they had obtained an abortion and if so, when and what type. We reviewed each expression of interest and selected participants to ensure a diversity of characteristics and experiences in terms of state or territory, type of abortion (medication vs. surgical), gestational age, regional/metropolitan residence, and age. After initial recruitment yielded a predominantly urban Victorian sample with mostly participants of European or non-Aboriginal Australian descent, we expanded attempts to recruit underrepresented groups of abortion seekers with flyers posted on rural and remote social media community noticeboards, online university cultural groups, and through regional sexual health clinics across Australia.

Data collection

We adapted a semi-structured interview guide from instruments used in similar studies in other countries, [8, 33] and added questions relevant to the Australian context and to pandemic conditions. Questions explored participants' experiences, from finding out they were pregnant, through seeking and obtaining care (or not), and any influence of location, delays to care, insurance status, and the COVID-19 pandemic on their experience. The semi-structured interview approach allowed for elaboration, probing, and modification of questions based on participant responses [34]. All interviews were audio-recorded and documented with field notes.

Each invited participant was emailed to schedule an interview, with information about the study attached. Interviews were conducted over Zoom by an experienced abortion researcher (SM) and lasted 30 to 105 min. After reviewing the Explanatory Statement and answering any questions, the interviewer audio-recorded verbal consent. Each participant chose between video and audio calls to maximise their comfort. We provided each participant with a AUD40 gift card in respectful recognition of their time. The study was approved by the Monash University Human Research Ethics Committee (Project 30926).

Data management and analysis

Automatic transcription was generated by Zoom software, and then quality checked and edited. Edited transcripts were imported into NVIVO 12 [35] for analysis. De-identified audio recordings, field notes, and sociodemographic information were stored electronically on a password protected Monash University server.

We used the 2013 patient-centred access to healthcare framework (hereafter referred to as 'Levesque's framework') [3] as a theoretical framework to inform data analysis and interpretation. It is a general healthcare framework with a patient-centred lens, and is well-suited to "comprehensively assess the complex and dynamic process" [36] that is common in abortion seeking. Levesque's framework evaluates the ways people seek information and care, their experiences with the multiple steps of care-seeking, and the interconnectedness of the dimensions of access [3]. Drawing on global literature about abortion access, we have adapted each dimension from Levesque's framework to abortion (detailed in Supplementary Table 1 and summarised in Tables 2 to 6) as the basis for our analysis.

Two researchers (SM and SW) familiarised themselves with the data by reading transcripts, listening to audio recordings, and writing reflective memos about each interview. We conducted thematic analysis based on a codebook, [37] using the five dimensions of access in Levesque's framework as the main codes, and developing sub-codes reflecting barriers and facilitators of access. We coded two transcripts, compared coding, and made minor adjustments to the codebook to ensure definitions

Table 1 Participant characteristics

Participant characteristic (n = 24)	
Age (mean: 29.6)	**n (%)**
20–24	5 (21%)
25–29	6 (25%)
30–34	9 (38%)
35+	4 (17%)
Identifies as	**n**
European or non-Aboriginal Australian descent	20 (83%)
Aboriginal	1 (4%)
Asian	1 (4%)
Hispanic	1 (4%)
Multiracial	1 (4%)
Location	**n**
Victoria	10 (42%)
Queensland	6 (25%)
New South Wales	3 (13%)
South Australia	2 (8%)
Australian Capital Territory	1 (4%)
Western Australia	1 (4%)
Northern Territory	1 (4%)
Tasmania	0
Rurality[1]	**n**
Urban	14 (58%)
Regional	10 (42%)
Abortion characteristics (n = 25)[2]	
Abortion type	**n**
Medication abortion	14 (56%)
Surgical abortion	9 (36%)
Hospital-based medical induction	2 (8%)
Modality	**n**
In-person only	19 (76%)
Combination telehealth and in-person	6 (24%)

[1] Per AIHW rural and remote classification system

[2]Twenty-one participants had one abortion during the study period, two participants had two abortions, and one had a miscarriage and did not ultimately obtain an abortion

were clear based on minimal discrepancies between the coders. All remaining transcripts were then coded by SW with weekly analysis meetings with SM to discuss and review coding decisions. The team documented their process through field notes and memo writing to practice reflexivity [38].

Results

Participant characteristics

A total of 24 participants (Table 1) were interviewed from 55 total expressions of interest, of which 14 were lost to follow-up and 17 excluded due to ineligibility (did not access abortion care during pandemic or not based in Australia) or in efforts to balance the sample across states and territories and between rural and urban participants. All participants identified as cis women and sought abortion services between April 2020 and November 2022. They ranged from 20 to 40 years old (mean: 29.6 years old) and lived in seven of the eight Australian states and territories. Ten (42%) lived in rural areas and 14 (58%) in urban ones, according to the Australian Institute of Health and Welfare rural and remote classification system [39], and 83% identified as having European or non-Aboriginal Australian descent. This sample represents the targeted diversity sampling and similar demographics to the Australian adult female population with some overrepresentation of non-metropolitan participants to account for the amplified challenges of rural abortion access [40].

Twenty-one participants had one abortion during the study period, two participants had two abortions each, and one had a miscarriage and did not obtain an abortion, with a total of 24 people and 25 abortion services included in the analysis. Of these, 14 were medication abortions within the 63-day gestational age limit, nine were surgical abortions, and two were hospital-based medical inductions beyond 20 weeks. Six participants used both telehealth and in-person consultations, while the remainder only had in-person consultations.

Experiences of abortion seekers for each dimension of Levesque's framework

For each dimension of access identified in Levesque's framework, we present an adapted definition specific to abortion, describe key aspects of how the sample experienced that dimension, and present illustrative quotes (Tables 2, 3, 4, 5 and 6).

Approachability

We found that before seeking abortion care, participants had limited prior understanding of, and information about, the availability, legality, and provision of abortion care. A few connected this to lack of education about abortion at a younger age, for example due to insufficient sexuality education in school or reflecting the religious beliefs of their family. Nearly all participants sought information outside of the healthcare system – primarily online and from family and friends. The main findings and quotes to illustrate these experiences are shown in Table 2.

Acceptability

Participants expressed different levels of (dis)comfort speaking to friends and family about their abortion and described how avoiding disclosure in their social and family networks created obstacles to access, such as challenges finding childcare. The majority did not feel comfortable speaking to their colleagues about having an abortion, though some told their supervisors to explain an absence from work. A quarter of participants said

Table 2 Abortion seekers' experiences of abortion care relative to the approachability dimension of Levesque's framework

A. Approachable abortion care includes availability of accurate abortion information to all people about abortion options, legalities, gestational limits, and where to access abortion.	
Participants had some prior understanding of the availability of abortion care, though the information they had was not comprehensive. They described having limited knowledge and uncertainty about:	
The types of abortions available	• *"I knew what options were available like […] medication, or like a surgical. […] I didn't know, like the specifics, but I knew enough." (ID020, Miscarriage, QLD, Regional)*
The legalities and gestational limits of abortions	• *"I didn't even know […] if it was illegal or legal." (ID013, Surgical, WA, Urban)* • *"I knew that there were time limits on when I could make a decision by […] and […] [that there were] different limits with both procedures." (ID012, Medication (x2), VIC, Urban)*
Who provided abortion and where to go	• *"I didn't know which places offered abortion." (ID006, Surgical, VIC, Urban)* • *"I just had no idea where to go, I didn't necessarily know that […] my GP could do it." (ID008, Medication, VIC, Urban)*
Many participants chose to seek information on abortion care independently of the healthcare system. The main methods of information-seeking included:	
Searching online	• *"I was completely isolated from my usual mechanisms of reaching information and […] at the mercy of Google, which ranks its first couple of pages based on how much you pay." (ID016, Medication, VIC, Urban)*
Family and friends	• *"I didn't know what I was in for and so finding out from other people [...] and listening to what they had to say about it […] was helpful." (ID003, Medication, SA, Urban)*
B. Approachable abortion care includes ensuring that tailored information is available to all people of reproductive ages.	
Some participants said they were not taught about abortion at a young age through credible sources, making the process of sourcing information independently difficult.	
• *"I didn't really have much of a sexual health education. I grew up in a religious family, quite conservative, […] so I didn't know anyone who'd had an abortion before." (ID008, Medication, VIC, Urban)*	

Table 3 Abortion seekers' experiences of abortion care relative to the acceptability dimension of Levesque's framework

A. Acceptable care includes accounting for social and cultural factors that can impact a person's decision and ability to access an abortion.
There was varying comfortability amongst participants about speaking to friends and family about their abortion.
• *It's not a tiny town, but everybody knows everybody. […] I haven't shared this information with anybody except for my partner and one close girlfriend so I just I wanted to keep it as private as confidential. […] I was definitely thinking that people are going to find out they're going to judge me. […] There's a lot of churches in this town and I think it's a very old-fashioned town, so [abortion is] something that's not talked about and not accepted." (ID022, Surgical, NSW, Regional)*
• *"We didn't want anyone to watch our kids because we didn't want anyone to know what we were doing." (ID013, Surgical, WA, Urban)*
Most participants did not feel comfortable speaking to their colleagues about having an abortion, though some did tell their direct supervisor.
• *"I was in like a really sort of pressurised work situation, and so I actually never got any time [off]. […] I think that speaks to a whole range of issues, particularly about gender relations in the workplace, and what is taboo, and what is acceptable personal leave." (ID008, Medication, VIC, 27, 2021, Urban)*
• *"I'm full time ongoing. […] It's [a] really small organisation and they're incredibly supportive so I never had to justify anything. […] It's just honestly so rare to not be questioned on needing time or needing space. And [it was made easier] because of the support of my boss as well." (ID001, Medication, VIC, Urban)*
B. Acceptable care includes abortion providers supporting abortion seekers in the decision making process.
Many participants valued being reminded by a medical practitioner that the choice to obtain an abortion was theirs and that this decision was not in question. However, some healthcare staff and providers were not supportive of the participant's decision to have an abortion.
Supportive staff
• *"[The abortion provider] just said, 'this is your choice. […] You know what you need, you know your life, you know what you're capable of, and what you're doing isn't wrong. You're just making a decision.'" (ID013, Surgical, WA, Urban)*
Unsupportive staff
• *"When I said I want to know what my options are to get an abortion […] [the GP] said, 'I don't recommend it because […] you'll regret it if you're 30.'"(ID002, Surgical, VIC, Regional)*
• *"The receptionist on the phone, just said 'no, we don't do that.' But she was very short and very abrupt, and […] that was really the end of the conversation." (ID019, Medication, QLD, Urban)*

their medical provider emphasised their free choice to obtain an abortion. However, others felt their provider did not support their decision, or even tried to dissuade them from having an abortion. The main findings and related quotes are shown in Table 3.

Availability and accommodation

All ten participants living in non-metropolitan areas described barriers when accessing abortion care. Of these, more than half travelled significant distances (ranging from two to 10 h by road or flying to more liberalised states) to access care and faced long wait times (between

Table 4 Abortion seekers' experiences of abortion care relative to the availability dimension of Levesque's framework

A. Available and accommodating care includes having both medication and surgical abortion options in all regions of the country through public and private services.	
Many participants in regional areas experienced barriers accessing local abortion care.	
• *"The [only provider in my local area] was only [providing] medical, they didn't do surgery […]. You could do like a rural medical one, where […] everything's like via post or something. But that was going to be too time consuming. Because I was rural at the time, […] I can't even really […] access a post office and a doctor to go get all these tests and everything done." (ID015, Medication, QLD, Regional*	
B. Available and accommodating care includes a reasonable distance to abortion care and sufficient availability in all areas in proportion to demand.	
Some participants, especially those from regional areas, had to travel significant distances to access abortion.	
• *"The GP is in town, which is about 45 minutes from my place. And the ultrasound clinic was an hour and a half from our house at the next major city. And then I did have to travel two-and-a-half hours to the abortion clinic." (ID025, Medication, NSW, Regional)*	
• *"Distance is a barrier, but [in the Northern Territory, where abortion is free], you know you can access it if you can get there." (ID021, Medication + Surgical, NT, Regional)*	
C. Available and accommodating care includes the presence of sufficient abortion providers throughout the country.	
Some participants faced long wait times due to a lack of abortion providers in their area.	
• *"I had to be flown down to Brisbane in order to have [the abortion]. But due to the high demand of abortions now, it was a month wait for me. […] Mentally, I wasn't able to tolerate or handle a month." (ID024, Hospital-based induction, QLD, Regional)*	
• *"I had to wait a while [and] […] [it was hard] finding out the date [of the abortion service] was a couple of weeks away. […] I still had to deal with knowing that it was coming up […] and then knowing I had to go and do it all alone." (ID003, Medication, SA, Urban)*	
D. Available and accommodating care includes the ability of abortion services to meet increases in service demand.	
The pandemic influenced the ability of abortion services to meet service demand, with many participants experiencing delays. Experiences of access were impacted by pandemic restrictions, including rules about how far they could travel for care and restrictions on being accompanied to the service. Some participants were offered telehealth services when they would have preferred in person care.	
Reductions in service availability	• *"[At the abortion clinic] they were understaffed. [...] I definitely think it was pandemic related as to why it was so busy, and people weren't getting seen quick enough." (ID012, Medication (x2), VIC, Urban)*
Prioritisation of telehealth services	• *"They were very strongly pushing for phone appointments because of wanting to have less people in the clinic. And I was already quite emotional about the decision that we were making [to have an abortion]. [...] So I was very reluctant to have a conversation over the phone with a stranger." (ID011, Medication, VIC, Urban)*
	• *"It [telehealth] was definitely impersonal. Because you want to meet the people that you're seeing, and you know, be able to talk to them face-to-face. […] You think that these medical professionals are there for you, but I suppose doing it via telehealth it doesn't feel that way." (ID007, Hospital-based induction, VIC, Regional)*
Travel restrictions	• *"I don't know what the exact rules [for travel over 5km] were, [or] whether you could [legally] access healthcare [at the time]." (ID009, Surgical, VIC, Urban)*
No accompanying person allowed	• *"[Pandemic] restrictions […] still made it quite difficult, because my partner was never allowed to come with me to any of the appointments. […] Not having that support was quite difficult." (ID018, Medication, QLD, Urban)*

one and six weeks to access the desired appointment, and often several hours in clinic waiting rooms) before securing an appointment due to a lack of abortion providers in their area. Barriers to abortion care were exacerbated by the COVID-19 pandemic, and participants described reduced service availability, prioritisation of telehealth over in-person care which was impersonal at times, and pandemic-related travel restrictions. Most participants who obtained care in 2020 and 2021 were not permitted to bring an accompanying person to their service due to public health measures. Abortion seekers expressed the influence of the pandemic as a barrier - but not the most significant one - experienced when seeking care. Key findings and related quotes to illustrate these experiences are shown in Table 4.

Affordability

Nearly all the participants had some out-of-pocket expenses for their abortion, and some experienced significant financial stress as a result. A few participants explicitly mentioned that the Medicare rebate was insufficient, and the two participants ineligible for reimbursement from health insurance mentioned high out-of-pocket costs. In contrast, a small number of participants received no-fee services because their state or territory of residence guaranteed free or low-cost abortion care. Additional expenses reported by participants included healthcare appointments (e.g. for referral, laboratory testing, or ultrasound), prescription medication, contraception, sanitary items, child-minding, travel, accommodation, and counselling services. About one quarter of abortion seekers and/or their partners lost income or had to take leave from work when accessing abortion care, especially those casually employed or needing to travel for care. Quotes to illustrate these experiences are shown in Table 5.

Appropriateness

Around two thirds of participants reported apprehension about judgement from healthcare providers or

Table 5 Abortion seekers' experiences of abortion care relative to the affordability dimension of Levesque's framework

A. Affordable care includes the ability to pay for abortion services regardless of procedure types, jurisdictions, and private and public service provision.

While most participants paid for their abortion, some struggled to do so. A small number received free services.

• *"The doctor asked, 'Do you want to travel to the sexual clinic for a low-cost service or do you want to be seen locally in a private practice?' So, I went with the sexual health clinic." (ID023, Medication, QLD, Regional)*

• *"We're very lucky here in South Australia in that the services actually don't charge [for abortion care]. The only thing that I had to pay for was the medication." (ID014, Medication, SA, Urban)*

• *"[The clinic] told me [the price] over the phone and I had a heart attack, because it was, it was $500. And with a health care card too, which is just, it's so much money. [...] I had to pay for that, on my own." (ID005, Surgical, VIC, Urban)*

B. Affordable care includes eliminating the additional financial burden for those without Medicare to pay for abortion.

Additional costs incurred when accessing abortion care included:

Out-of-pocked appointment costs GP appointments	• *"It was just so expensive. […] [I went to a private clinic] because I just wanted to get in and out pretty quickly." (ID004, Surgical, QLD, Urban)*
Prescribed medication, birth control, or sanitary items.	• *"We went to the chemist, and yeah, I think I spent about $150 just on medication. And then I also bought some Nurofen and Panadol and some pads as well." (ID017, Surgical, NSW, Regional)*
Child-minding	• *"I can't like, drive myself. [...] I need to bring my husband and then […] I can't bring four kids with me. So, I was like, someone's got to look after them at home." (ID020, Miscarriage, QLD, Regional)*
Travel and accommodation	• *"Petrol to get there was quite expensive. […] Parking, I think that was about $40 for the day." (ID017, Surgical, NSW, Regional)*
Loss of income	• *"I actually ended up paying it all, and [my partner] paid me back. [...] He had a really hard time paying that, [...] because he just had to take so much work off [unpaid to come to the appointments with me]." (ID004, Surgical, QLD, Urban)*
Counselling services	• *"I am really keen to actually, probably do an appointment with the counsellor soon [to process my abortion experience]. […] I can't afford it at the moment." (ID012, Medication (x2), VIC, Urban)*

C. Affordable care includes removing the additional financial burden of all facets of seeking abortion care for those without Medicare and others struggling to pay for abortion.

Participants without access to Medicare often had high out-of-pocket costs to access abortion care.

• *"[In addition to the cost of the abortion medication and transport costs], I had to pay […] the first GP I saw [around] 60 or 80 [dollars]. […] I didn't have any [Medicare] at that point." (ID023, Medication, QLD, Regional)*

Some participants mentioned the that the Medicare rebate was insufficient.

• *"I think they did [give a rebate] but I can't remember what that was in the end. [...] I can't remember it [the rebate] making much difference." (ID004, Surgical, QLD, Urban)*

anticipated needing to justify their decision to their provider. Many said that providers along the care pathway, including laboratory staff, ultrasonographers, and their general practitioner, assumed they wanted to remain pregnant. Those who did experience non-judgmental and supportive care valued this experience. More than a quarter of participants said they experienced a lack of empathy from at least one health care worker on their pathway to care. Those who received empathetic care during a healthcare interaction appreciated that the provider was patient and attentive to their emotions. The substantial minority of participants who felt their appointments were rushed described this as a key factor detracting from their care experience; in contrast, those who had sufficient time with providers said they valued this interaction. Referral experiences also varied, with a few participants reporting that their healthcare provider proactively facilitated access by referring to additional abortion services or helping them find a timely appointment, whereas others said they would have liked to receive more appropriate referrals. Similarly, experiences diverged in terms of dialectical engagement with providers. A few participants told us their providers listened to their preferences and engaged in a joint decision-making process to best meet their needs, while others said their providers spent inadequate time with them, leaving them feeling unsupported in choosing the service that best met their needs. The main findings and quotes to illustrate them are shown in Table 6.

Discussion

This analysis adapted Levesque et al's influential framework of patient-centred access to healthcare [3] to abortion access. We found that the framework facilitated a nuanced examination of the multifaceted and intersecting factors that influence access to abortion – a historically criminalised and still stigmatised service [41]. This adaption of Levesque's framework can be applied in different contexts to understand experiences of access to stigmatised health services and examine healthcare access in pandemic or other disaster conditions.

The findings identify important facets of abortion access from the client perspective, with implications for how to enhance access in all its dimensions.

Table 6 Abortion seekers' experiences of abortion care relative to the appropriateness dimension of Levesque's framework

A. Appropriate care includes the provision of non-judgmental abortion care.	
Nearly all participants mentioned experiences of judgement or apprehension of judgement from care providers. Examples include:	
Expecting to have to justify their decision to their provider	• *"I felt like I would possibly need to justify my decision [to the provider], which I was worried would be my undoing." (ID011, Medication, VIC, Urban)*
Different types of providers along the care pathway assumed the client wanted to remain pregnant	• *"[The GP] was talking to me as though I was gonna continue with the pregnancy. […] I knew in myself, that this [having a baby] wasn't something that I could cope with." (ID009, Surgical, VIC, Urban)* • *"I went in for a blood test and the nurse knew that I was getting tested for pregnancy. […] She also said to me like* • *'Oh, is it your first one? Congratulations.' And I was […] like, 'Oh thanks, but I'm not keeping it.'" (ID002, Surgical, VIC, Regional)* • *"I said [to the receptionist], 'I think I'm about five weeks', and she said, […] 'There's no point doing an ultrasound because you won't be able to see [the embryo], you're better off coming back later.' […] Then I had to tell her in a very crowded room that I was terminating. […] [The receptionist was] not sensitive to the situation, and just assumed that I was, you know, an expectant mom." (ID022, Surgical, NSW, Regional)*
Participants said they valued any experience of non-judgmental, supportive care.	
• *"They [clinic staff] were fantastic. [I] spoke to somebody on the phone […] and you're thinking, oh God, they're judging me […]. But you know, [they were] […] just very non-judgmental, […] supportive and helpful." (ID009, Surgical, VIC, Urban)*	
B. Appropriate care includes the provision of empathetic abortion care.	
Participants who experienced empathetic care said their providers were patient and attentive to their emotions.	
• *"[On the phone I said,] 'I don't understand how this all works. […] I've never done this before. I don't want to be pregnant.' […] [The abortion clinic staff] were just really calm, and […] [said] 'It's okay, just take a deep breath, […] Should I give you a call back in 10 minutes? Are you feeling safe? Do you want to lie down? Like, do you want to put me on speakerphone whilst you make yourself a cup of tea?'" (ID004, Surgical, QLD, Urban)*	
• *"[I experienced] just this extraordinary level of care checking [from my GP] [...]. I felt like [it] was the first time somebody [...] actually understood […] what was going on." (ID016, Medication, VIC, Urban)*	
• *"I really didn't want [to] get an ultrasound […] by myself. […] They were like, 'someone will come in with you, you don't have to, like, look at anything.' […] They were […] good at calming all the things that I was bringing up." (ID008, Medication, VIC, Urban)*	
However, several participants said they experienced a lack of empathy and patience during the appointment.	
• *"When she [the nurse] was going through the forms, she was just sort of like glossing over parts of it. You know, and I just remember thinking like, this is really important to me, […] [but] I wasn't really in the position to be like, 'Oh, sorry, you know, go back through that' […]. I know that that's something that they do routine all the time, so I don't know whether they're a little bit desensitized to us." (ID021, Medication + Surgical, NT, Regional)*	
• *"It was the only clinic that I could get into on a public holiday, everywhere else was closed. […] I went to see a random male doctor who referred me to get my bloods done. […] He also referred me to a women's health clinic. He wasn't very nice to me […] no sympathy, nothing. […] I was in there for about two minutes. […] There was just no conversation at all." (ID005, Surgical, VIC, Urban)*	
C. Appropriate care includes providers allocating adequate time during abortion provision.	
Participants valued when their provider took time during their appointments	
"[The] emotional support in terms of my GP [was great]. I hope everyone gets access to a GP […] who will take the time to sit with you and go through all the options. Like, we were certainly extending beyond standard appointments. In my time with her, we were really going through things and understanding what was going to happen." (ID001, Medication, VIC, Urban)	
Several participants felt that their appointments were rushed.	
• *"The anaesthetist came in and spoke to me just about the drugs that they would use and then, […] I just went straight in [to surgery]. […] I didn't really have a lot of contact with anyone there. […] It was very rushed, and […] I felt very vulnerable at the time." (ID017, Surgical, NSW, Regional)*	
• *"Everyone was just rushing around like they were overbooked, but the whole vibe wasn't… great. (ID005, Surgical, VIC, Urban)*	
• *"[The doctor] was just very dismissive about the whole thing. […] I was literally on the phone with him, for I think three minutes in total. […] I left more confused I think than anything. […] [It felt like] he was like, well you know, this is the too hard basket. I don't want to deal with this." (ID018, Medication, QLD, Urban)*	
D. Appropriate care includes abortion providers giving appropriate referrals to additional abortion services.	
Many participants appreciated their healthcare provider proactively facilitating access by referring to additional abortion services.	
• *"[The sonographer] made a call to my GP's office, […] and they got [me] booked in […]. That was like, really efficient and a relief. It meant that I came away from the appointment with a clear plan […], the sense of agency, and some sort of picture of what was about to happen." (ID008, Medication, VIC, Urban)*	
A few participants felt that they were referred to a place that was not vetted by their providers and therefore was not appropriate.	
• *"There's no [alternative] services, there's nothing. So, you know, anything would be better than nothing. […] I don't know if [my GP is] aware [how bad this clinic was], or if she has a relationship with this clinic, or if she knows these people. But no, I wouldn't send anybody there. It was appalling." (ID022, Surgical, NSW, Regional)*	

Table 6 (continued)

E. Appropriate care includes the provision of tailored and continuous care that is centred around the patient's needs whilst fully informing them of their options.
Some abortion providers listened to abortion seekers concerns and preferences and engaged in a joint decision-making process to best meet the client's needs.
• *"[The GP] gave me the options. We weighed them up together and then made the decision together. I sort of already knew what I wanted to go towards, but he was really good in giving me, like, in talking to me about both [types of abortion]." (ID025, Medication, NSW, Regional)*
• *"I spoke to both a nurse, the doctor who did the scan, and the anaesthetist. [...] I went in and spoke to each of them separately, which […] gave a lot of opportunity for asking questions." (ID019, Medication, QLD, Urban)*
• *"[The doctor] asked me just, like, if I was thinking of keeping it or not." (ID004, Surgical, QLD, Urban)*
In contrast, some providers did not spend adequate time, leaving the client feeling unsupported in making a decision that best meet their needs.
• *"I probably would have definitely liked to have a longer appointment with the psychologist at the start and […] to have a bit more time with the doctor […]. I just feel like that would have comforted me a little bit more, to have a proper conversation with the doctor or the person performing the procedure about what was going to happen and what they were going to do." (ID017, Surgical, NSW, Regional)*
• *"I had told the doctor that I didn't [want to see the ultrasound screen] […] and he left the ultrasound, like, face up [and visible to me], instead of down, which I didn't like." (ID004, Surgical, QLD, Urban)*

Approachability

We found that abortion seekers had relatively poor experiences in the dimension of approachability, with most having insufficient prior information about how to obtain abortions. These findings align with other studies in Australia [4, 42–45] and globally, [8, 46–48] highlighting that abortion seekers are often unsure where to seek care, unaware of the laws governing abortion and gestational age limits, and commonly use sources outside of the health system to learn about abortion – with potential risks in terms of accuracy of information. This is important in light of WHO guidelines identifying available and accessible information as a key component of an enabling environment for abortion [1].

To improve approachability, our findings suggest the need for community-wide dissemination of abortion information [46], for example through smartphone applications [49] or telephone services such as the 1800MyOptions hotline in Victoria [40, 50]. Further, lack of public discourse, which in part relates to stigma, can contribute to an environment in which abortion seekers do not know where to seek, and have limited options for obtaining, information and care – even where abortion is decriminalised. Our findings align with other studies showing that families and friends are a key support and information source for abortion seekers, highlighting the need for formal sources of trusted information [42].

Acceptability

Abortion seekers described mixed experiences in the dimension of acceptability, expressing different levels of (dis)comfort talking about their abortion/s. For some, this reflected their religious upbringing or living in a small community. Secrecy is a common form of abortion stigma management, with implications including social isolation and distress, which in turn can have negative mental health consequences [7]. In contrast some participants in this study described the process of disclosing their abortion to non-judgmental and empathetic providers and friends and family as positive and normalising.

Strategies to reduce community-level abortion stigma can increase the acceptability of abortion. Research in other settings examines strategies to reduce the secrecy around abortion as a pathway to de-stigmatisation [51–53]. Comprehensive sexuality education can normalise open discourse about sexual and reproductive health [54], including abortion, while also equipping young people with information about accessing healthcare services. This approach would address the knowledge gaps identified in this and other studies [55], but can be difficult to introduce in schools due to the intersecting stigmas associated with abortion and with sexual activity among adolescents [8].

Availability and accommodation

Experiences in the dimension of availability and accommodation varied by place of residence, with those living outside metropolitan areas disproportionately describing challenges including long wait times and large distances to obtain care. This is consistent with the notion of "abortion deserts" coined in the United states, in reference to places with no abortion care available nearby [56]. As elsewhere, [57] abortion providers in Australia are limited [58], particularly in rural areas [20, 40]. Provider shortages can limit the choices of abortion seekers between abortion types and between private and public care, and may result in delays as well as significant travel to obtain abortion care or the necessary medications [20, 59]. Attempting to integrate abortion care into existing sexual health provision in rural areas may enable more equitable access in these areas [60].

To enhance timely access to abortion, regulatory changes such as task-sharing, recommended by the WHO, [61] can increase the availability of abortion providers relative to demand. In Australia, the Therapeutic Goods Administration (the national regulation body

for therapeutic goods such as the abortion medication licensed as MS-2Step) made changes in 2023 to reduce exceptional regulation of abortion; it now permits nurse practitioners to prescribe MS-2Step when certified, and unnecessarily stringent requirements for retraining and registration for GPs and pharmacists providing medication abortion have been removed [19, 40, 62]. In addition, medication abortion is safe and effective up to 70 days gestation, [63] suggesting that current limits in many jurisdictions around the world, including Australia, could be safely extended. Doing so would provide abortion seekers more time to make informed decisions about abortion care and type [11].

Additionally, our findings align with evidence that the COVID-19 pandemic limited the capacity of providers and the health system to make timely services available and to accommodate the needs of abortion seekers, particularly in rural areas [14, 30]. Telehealth abortion was increased in Australia and globally during the pandemic to reduce the need to travel for care, enhancing availability in the context of health system pressure and travel restrictions [11–13]. However, telehealth may not accommodate all abortion seekers [30, 64]. For example, some individuals from migrant or refugee-like backgrounds or those experiencing family violence may have difficulty accessing telehealth services, as their personal safety may be compromised by an unsafe home environment or being around people who do not support their abortion decision [30].

Further, our findings show that the pandemic limited interpersonal contact and social support, which are important facets of accommodating abortion care. For example, telehealth evoked negative feelings for some participants due to the impersonal nature of an online interaction. Additionally, participants described the temporary restriction on bringing an accompanying person to their service during the pandemic as one of the most challenging aspects of their abortion experience. The benefits of accompaniment and social support may be overlooked in abortion care, yet integrating it can enhance patient-centred care [65].

Affordability

The results highlight inequities in the affordability of abortion care based on location, income, employment type, and insurance status, and showcase the financial burden of abortion travel. The affordability of abortion remains a problem in Australia, where a 2017 study found that 20% of more than 2,300 abortion clients were concerned about their ability to pay for abortion care [27]. Addressing the financial barriers to abortion would contribute to an enabling environment for the service [1].

The dimension of affordability can be improved through publicly-funded initiatives to reduce out-of-pocket expenses for abortion seekers [29]. For example, the Netherlands offers free abortions to those living or working in the country under their Long Term Care Act, [47] and universal access to free abortion has been introduced in the Australian Capital Territory in Australia [66]. Financial barriers can be further reduced by initiatives to fund travel for abortion care. In some places, including the United States and Europe, support for those who can't afford to travel is provided by civil society organisations [67]. A model of publicly-funded abortion travel is found in Australia through the Northern Territory's Patient Assistance Travel Scheme funded by the Department of Health [68]. Such policies can help address the inequities of the 'post-code lottery' – that where someone lives dictates the accessibility and affordability of public abortion care [40, 69, 70].

Appropriateness

Our findings demonstrate a diversity of experiences in the dimension of appropriateness. Some participants described very positive treatment, some very negative treatment, and some experienced both at different points in their service. Inappropriate interactions with healthcare staff and providers were reported by abortion seekers across states and territories, in urban and rural areas, and in different settings including GP clinics, at ultrasound, during bloodwork, and in dedicated abortion clinics. Overall, abortion seekers in the study expressed a desire for adequate time to ask questions and have their concerns addressed in a supportive, non-judgemental environment. Yet this can be challenging in the limited time allocated to reimbursable healthcare appointments, [40] which may be insufficient to support dialectical decision-making between abortion seekers and providers.

To ensure appropriate services, different models of care can be explored to create more productive consultation time with providers. For example, a Scottish study found that disseminating an informational video about abortion care before seeing the provider gave clients more time to ask focused questions during the appointment [48]. Additionally, equipping practising and prospective healthcare providers with the skills to deliver sensitive, tailored, judgement-free, and empathetic abortion care can facilitate appropriateness as defined by abortion seekers in this study and elsewhere [33].

Strengths and limitations

This study contributes to gaps in the literature by centring the lived experiences of abortion seekers. The findings have particular relevance in Australia, where despite a National Women's Health Strategy [71] supporting universal abortion access, a 2023 Senate inquiry identified numerous barriers to equitable access, particularly in rural areas [40]. This analysis complements

prior Australian studies that primarily drew on provider perspectives, [43, 72, 73] or focused on one state or territory, and took place before broad decriminalisation [42, 59]. Further, this study elucidates a range of factors influencing abortion access during the pandemic, rather than focusing only on telehealth provision. This study illustrates that examining abortion seekers' experiences to identify barriers and facilitators of access is important, even in relatively favourable policy environments.

The study also has limitations. Social media was our primary recruitment method during the COVID-19 pandemic. Stigma may have limited the public sharing of recruitment materials. However social media is commonly used for recruitment in Australian studies, including about abortion. Research on social media recruitment during the pandemic suggests that platforms such as Facebook are appropriate for reaching diverse communities [64]. Additionally, a systematic review found that social media recruitment has benefits for stigmatised topics such as sexual health [74]. Once severe pandemic restrictions ended, we diversified our recruitment by distributing flyers through sexual health clinics, particularly those located in rural areas.

The study sample was diverse in terms of participant age and location, gestational age at time of the abortion, and type of abortion procedure. However, there is an overrepresentation of participants from Victoria, the second most populous state in the country and the research team's location. All participants were able to pay for care, so our data may exclude individuals who are unable to afford care; this is also represents an evidence gap, as existing data sources do not elucidate the extent to which financial barriers prevent people from obtaining abortion care.

Conclusion

This study examined lived experiences of five domains of abortion access: approachability, acceptability, availability and accommodation, affordability, and appropriateness. Even in a context with supportive legal and policy frameworks, abortion seekers in Australia experienced challenges when seeking services and information. Addressing obstacles to abortion care around the world is a priority under the Sustainable Development Goal 3 [1] focus on universal access to reproductive healthcare. Barriers to care, already worsened by the COVID-19 pandemic, are likely to be even more burdensome in more legally restrictive settings [1].

Initiatives to improve access could focus on creating an enabling environment for abortion, taking into account general health system limitations and the ongoing stigma around abortion in many parts of the world. Regardless of context, an enabling environment for universal abortion access requires effective mechanisms to educate the population about abortion and provide abortion seekers with *accurate and credible training and information*. An enabling environment is also premised on *supportive and appropriately-resourced health systems*. To achieve this, investments are needed to reduce wait times, costs, and travel, especially for rural populations. Regulatory and workforce strategies to increase the types and number of abortion providers, improve the patient-centredness of healthcare providers, and reduce stigma in healthcare settings can improve experiences of those who are accessing care. Consumer voices can help understand the diverse pathways to and through abortion care and play an important role in informing solutions to overcome the multidimensional barriers to access.

Supplementary Information

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Supplementary Material 1

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Author contributions
SM, AT and JF conceptualised the study. SM recruited participants and conducted interviews. SW developed the analysis strategy, codebook, and analysis with supervision from SM. SW drafted the paper with substantive redrafting and revisions by SM. All authors reviewed drafts, provided significant revisions and feedback, and approved the submitted version.

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Data availability
The datasets generated and/or analysed during the current study are not publicly available for privacy reasons but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethics approval for this study were obtained from the Monash University Human Research Ethics Committee (ID 30926), with all methodology completed in accordance with the Declaration of Helsinki. All methods were performed in accordance with the Declaration of Helsinki. All interviews with participants were audio-recorded following informed verbal consent, in compliance with the Monash University Human Research Ethics Committee.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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