Evaluation Report

The Compassionate Reproductive Health Care for Vulnerable People in Tasmania project

January 2023

CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

Women's Health Tasmania

ACKNOWLEDGEMENT OF COUNTRY

Children by Choice acknowledge and honour the traditional owners of the land on which we do our work, and their continued connection to land and community.

We recognise the three separate cultures of Aboriginal, Torres Strait Islander and South Sea Islander people.

Children by Choice recognise that we are working on Turrbal and Yuggera people's land. We also recognise the Palawa Pakana people, the traditional owners of Tasmania whose lands on which this project was undertaken.

We would like to pay our respects to elders past and present and acknowledge that so-called Australia always was and always will be Aboriginal land.



Children by Choice 2023
Brisbane, Queensland

This report was prepared by Kari Vallury
on behalf of Children by Choice, in collaboration with Women's Health Tasmania.

We wish to thank our funders, and Women's Health Tasmania, as well as all of the incredible professionals who supported us in undertaking this evaluation by sharing their time, expertise and experiences.

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Executive Summary

The Compassionate Reproductive Health Care for Vulnerable People in Tasmania project was a pilot train-the-trainer project delivered over 12 months from January to December 2022. The project aimed to build the capacity of Women's Health Tasmania (WHT) - through a partnership with and mentoring by Children by Choice (CbyC) – to adapt and deliver elements of CbyC's reproductive autonomy training in 3 regions of Tasmania. The project's secondary aim was to build the knowledge and skills of Tasmanian health and community professionals to provide best practice pregnancy options, abortion and Reproductive Coercion and Abuse-related care.

A mixed methods evaluation was embedded in the project from its commencement and was conducted by the Senior Research Officer at Children by Choice. The evaluation aimed to ascertain the effectiveness, barriers and enablers of and associated with the project its impacts (individual, organisational and systemic), and recommendations for expansion/continuation of the project.

The evaluation involved pre- and (6-8 weeks) post-training questionnaires. These were sent to all participants, of which all completed the pre- and 37 the post-training surveys. In-depth, semi-structured interviews were also conducted with 7 training participants and 3 project staff members.

The project was found to be incredibly well-received by participants, with 9/10 reporting they'd recommend the training to colleagues, high levels of participant satisfaction, an increase in confidence in providing best-practice care in a range of areas, a reduction in anticipated abortion stigma, and stronger professional networks. These outcomes were enabled by the skills and diversity of the project team across sites, the training content, the effectiveness of facilitators, and local knowledge and relationships held by WHT.

Recommendations

General

1. The program was described as of great value by staff and participants, and all saw immense value in continuing the program to enable the project to expand its reach.
2. Poverty, low levels of Sexual and Reproductive Health (SRH) literacy among marginalised communities, and professional isolation and siloes emerged as key systemic barriers to SRH equity and wellbeing in Tasmania.
3. Any additional programs should embed an equity focus and explicitly work to ensure members of Tasmania's most marginalised sub-populations, and the professionals who work within and with them, are addressed.
4. Staff should explore the feasibility of direct-to-consumer trainings, such as delivery in schools, to young mothers, or to clients of violence services. Direct-to-consumer programs would be most accessible if there was no financial cost to participants, and they were provided locally.
5. Any additional programs or projects should consider the income and cultural contexts of their target populations, recognising regional and cultural variations within the state.
6. WHT's relationships with key organisations were both strengthened because of the pilot program, and were vital to gaining access to training participants, organisations and communities. These relationships will remain crucial to the success of future projects.
7. Some confusion around intellectual property ownership of the training material warrants discussion and a written agreement.
8. A Sharepoint accessible to staff in collaborating organisations should be established.

Training content and delivery

9. Future trainings should remain as a half-day format, though may benefit from an additional hour of content and workshopping. The training package could be expanded and offered as half-day and full-day options: there appears to be demand for both.
10. It is recommended that promotion for future trainings explicitly target the recruitment of Obstetrician-Gynaecologists, pharmacists, imaging professionals, GPs, administration staff, receptionists, and school nurses.
11. To foster staff wellbeing and the feasibility of delivery, a less intense training schedule is recommended. It is suggested training could be delivered twice in a single region in a single week to maximise accessibility, with this schedule then repeated after some time in the other two/three regions.
12. It is recommended that a fourth region is added to expand the reach to participants in Compassionate Reproductive Health Care for Vulnerable People in Tasmania, although a local needs analysis should be conducted to explore demand before this action is taken.
13. Participants saw value in having a formal printable resource on RCA they could distribute, as well as resources/links to resources in diverse languages and Easy English.
14. More content and discussion on how to sensitively enquire about and respond to RCA was requested by multiple participants.

Additional projects

15. A professional support/debriefing service, such as what Children by Choice offer, may be particularly valuable to Tasmanian practitioners. There appears to be limited support available to professionals involved in abortion provision and in supporting abortion seekers.
16. Post-abortion support groups may be very valuable in the Tasmanian context. Participants described limited (timely) access to psychologists and social workers for abortion seekers.

Background

This evaluation report describes the progress, effectiveness, implementation and impacts of the Compassionate Reproductive Health Care for Vulnerable People in Tasmania project.

The evaluation was designed to support both the implementing organisations and funders to understand the progress and impact of the first year of this collaborative pilot project. As such, it measured aspects of the process of training development, collaboration and implementation, including learnings for future improvement, as well as the impact of the project on its participants and their communities, as much as is possible within the project and evaluation scope. The evaluation also explored barriers and facilitators of project implementation and impact, both project-related and external, including culture, knowledge, appetite, setting, and socio-political context.

The Compassionate Reproductive Health Care for Vulnerable People in Tasmania project aimed to build the capacity of Women's Health Tasmania (WHT) - through a partnership with and mentoring by Children by Choice (CbyC) – to adapt and deliver elements of CbyC's reproductive autonomy training materials to/in the Tasmanian context. It involved the adaptation of content to the Tasmanian context to create a single, half-day training covering core aspects of CbyC's training suite deemed most relevant. This was supported by the development of an e-learning module and facilitator guides, and included travel of both teams to Queensland and Tasmania respectively for project planning and delivery.

Methods

The evaluation was carried out by Children by Choice's Senior Research Officer (SRO). The SRO was not involved in the project other than to establish the monitoring and evaluation processes, and undertake evaluation activities.

The mixed-methods evaluation involved a combination of pre-and post-training surveys and a series of one-on-one, semi-structured interviews. A pre- and post-training survey was completed by training participants 1) in the month prior to the training date and 2) approximately 6-8 weeks after they had attended training. The survey was shared via Qualtrics online and included questions about participants' roles and organisations, and a suite of items that assessed knowledge, attitudes, and the impacts of the training on confidence and capacity of participants to provide and have inclusive, accurate, up-to-date care and referrals. Furthermore, items assessed participant satisfaction with various aspects of the trainings they attended and provided space for open-text recommendations and feedback.

Interviews were then undertaken to garner feedback on priority areas, identified jointly by the project teams in Tasmania and Queensland. Each interview lasted for an hour. Feedback was sought regarding:

1. training content and delivery,
2. short term impacts on practice, and
3. future training needs, and the sexual and reproductive health needs and priorities of interviewees' organisations, programs or geographical communities.

The results presented below include integrated findings from the surveys and interviews.

Participants

Survey participants

All 55 attendees at the training sessions held in Tasmania in September 2022 completed the first survey in the month leading up to their training session (along with several people who were later unable to attend a training session).

37 participants also completed the post-evaluation survey 6-8 weeks post-training. Among post-training survey respondents, 24% reported having attended the training in Burnie, 56% in Hobart and 20% from Launceston.

Table 1 shows the professional characteristics of the survey respondents at each timepoint. Psychologists, social workers and counsellors (n=18) comprised the largest single professional group of respondents, followed by Nurses and midwives (n=13). Among the other 21 participants were a diverse mix of community, health and legal staff, and students.

Of note, no Obstetrician-Gynaecologists, pharmacists, sonographers or administration workers completed the pre- or post-training surveys, and GPs were poorly represented. It is presumed that these groups were also thus under- or not represented among the training participants, despite playing a primary role in the provision of and referral to abortion care in Tasmania.

Participants

Professional characteristics of survey respondents

Table 1: Respondent characteristics - profession/role

Profession	Number of respondents	
	Pre-training	Post-training
Psychologists, social workers, counsellors	18	11
Nurses and midwives	13	7
GPs	1	1
Allied health workers	2	3
Public or community health workers	1	5
Other (students, support workers, community workers, youth workers, lawyers and solicitors, doulas, CEOs, forensic nurse examiners)	17	5
Total	**52 (of 58 respondents)**	**32 (of 37 respondents)**

Participants

Organisational settings represented

among pre-training survey respondents

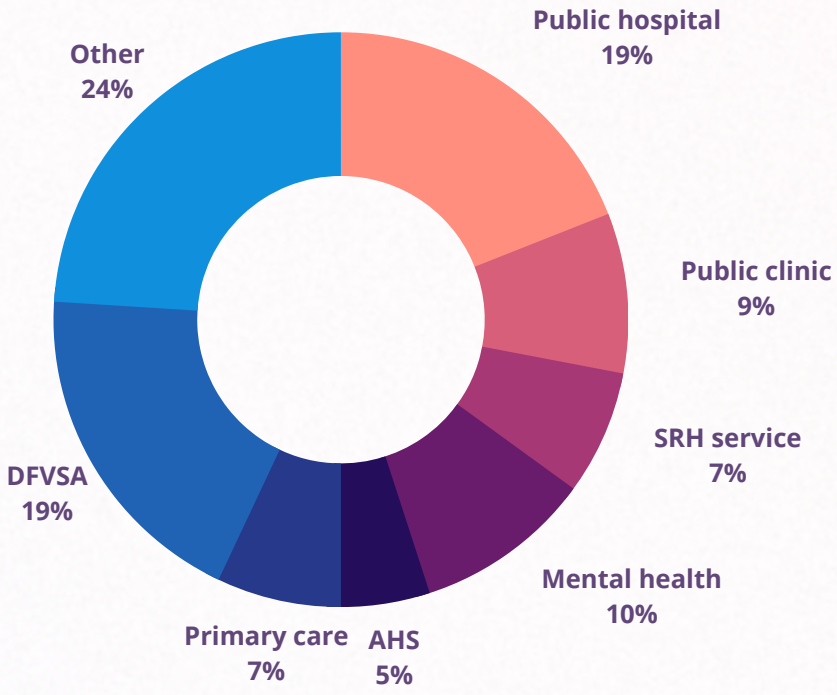


Figure 1: Organisational representation by type (pre-training respondents)
AHS = Aborigial health service

Public hospitals were the most well represented organisations, along with mental health, domestic and family violence and sexual assault (DFVSA) services and Sexual and Reproductive Health (SRH) services.

The “other” category included participants working in community services, NGOs, educational institutions, government, a community-based drug and alcohol service and a community legal centre.

None of our participants worked in private hospitals or clinics, or in schools, and primary care settings were under-represented.

Participants

15 (31%) of the pre- and 10 (34%) of the post-training respondents were involved in the provision of abortion (related) care, from hospital and clinic based surgical and medication abortion provision to pregnancy options, pathways and post-abortion support.

Almost half of the participants (43%) were involved in the provision of contraception, directly or via information, counselling and support.

Interviewees

3 members of the project team (staff involved in delivery of the project from both CbyC and WHT) and 7 training participants participated in individual interviews.

The interviewees were purposively recruited to represent the three geographical regions in which the trainings were conducted, and all interviewees represented different organisations, roles and educational backgrounds. All but one were women, and most worked with marginalised sub-populations of women.

Findings

Training content & delivery

To ensure the content and delivery of the training package in Tasmania was aligned with local needs and priorities, staff at WHT conducted a needs analysis prior to the delivery of the trainings, consulting with key stakeholders around the state to identify their preferred training length, mode of delivery and training needs. The stakeholders consulted by WHT staff expressed a preference for a half day training, and a desire to learn more about abortion pathways in Tasmania.

An adapted, locally relevant training package was thus developed by WHT staff with support from CbyC's project officer. CbyC's training packages– Pregnancy Options, Reproductive Coercion and Abuse, and Practice Skills, each with over 4 hours of content – were amalgamated into a single 4-hour workshop format. It focused on 1) pregnancy options, with a focus on abortion care pathways in Tasmania and 2) identifying and responding to Reproductive Coercion and Abuse. The training package also briefly touched on contraceptive options and practice skills. All project staff felt the training package developed was appropriately pitched in terms of literacy and priorities, and participants agreed.

Project staff spoke about the adapted package as flexible, accessible, and focused on inviting engagement and knowledge sharing between participants. Content was reportedly adapted for the needs and priorities of each region and as trainings progressed as needed to suit varied participant groups and local priorities. Many participants interviewed spoke about this flexibility, and the inclusive, interactional nature of the trainings, as one of the most enjoyable and valuable aspects of the training.

Findings

As WHT's needs analysis also identified, interviewees spoke about the burden of incredibly high workloads, particularly in primary care, as a barrier to attendance at professional development activities in Tasmania. Nevertheless, there were multiple survey participants and interviewees who explicitly mentioned that they felt the training would be strengthened with an additional 30 minutes to one hour to allow deeper exploration of a) sensitive enquiry and responses to RCA, and b) further time for conversation/ knowledge-sharing. Two participants reported they'd love a full day and one said they'd like to attend the same training again.

Reach

This training package was delivered via 4 sessions in 3 key locations across Tasmania: Bernie, Launceston and Hobart. Almost all interviewees spoke about a preference among many people in Tasmania to travel only short distances for care and activities. Therefore, providing training as close to as many potential participants as possible was seen as vital for the success of the projects. Project staff spoke to the potential need to add a fourth region to future training schedules for this reason.

Project staff anticipated difficulty recruiting training participants, based on prior experiences and knowledge of how over-burdened many services and professionals in Tasmania are. They were instead shocked by the positive response, with all of the trainings filled to capacity.

Participant interviewees reported knowing of staff who would have loved to attend if spaces had been available, and others reported having shared news of the training with staff in other regions within statewide services, indicating demand for future delivery of the same training remains.

Some interviewees reported there was some confusion around whether one of the training sessions was full or not – it seems this confusion was due to a date change required due to an unplanned public holiday for the Queen's passing, and thus confusion was unavoidable.

Interviewees expressed feeling GPs and receptionists should be the focus of recruitment around future trainings, as these groups of professionals are often in the position of 'gatekeeper' and hold power over referral and other processes that can facilitate or delay access to abortion-related care. One interviewee expressed numerous interactions with GPs around the state who express being unsure about how to refer, and which tests and information are needed to accompany referrals, to abortion services. Others suggested it would be valuable to deliver a version of the training directly to young mums, school students and staff to address misinformation and build health literacy.

Motivations and priorities

> "This is information every social worker should know".
>
> Training participant

All evaluation participants were asked to describe their motivations for attending the training sessions. Most reported broadly wanting to expand their knowledge and skills to improve their practice and their organisations' systems and procedures, and be able to better assist their clients, broadly. A number of participants reported that they worked with vulnerable people, including those experiencing violence and young people, and wanted support to improve their confidence, knowledge and skills in supporting these groups with RCA and pregnancy options specifically. Several spoke to the opportunity to learn from experts and others took the opportunity up as routine PD.

Findings

Specifically, via the training, participants had hoped to gain a greater understanding of:

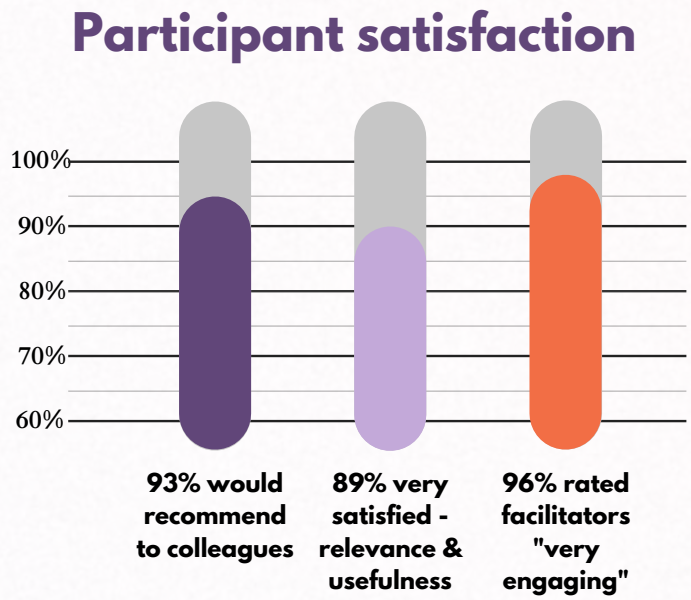
1. Tasmania-specific abortion care pathways and rights, including:
    - Sources of support available to clients in specific areas and to key populations
    - Locally-specific referral pathways, including who to refer pregnant people to in various circumstances
    - Current abortion options available in and across Tasmania
    - The abortion process, including the types of support abortion seekers need before, during and after having different types of abortions and abortions at different gestations
    - Pregnancy options
    - Private and community sector options (beyond the public system)
    - Women's/client's rights in relation to the law, contraception, abortion and RCA in Tasmania

2. Evidence-based, de-stigmatising and inclusive information about:
    - Abortion rights advocacy
    - How to recognise and respond to RCA, including systemic coercion
    - Advice for working with migrant, refugee and culturally and linguistically diverse communities
    - Tools and information for working more effectively with clients
    - De-stigmatising and inclusive language, and having difficult conversations
    - General expansion of knowledge

Findings

Participant satisfaction

9/10 participants reported being very satisfied with the relevance and usefulness of the information provided in the trainings and said they would recommend the training to colleagues.



Participants were particularly happy with the facilitators, describing them as engaging, sensitive, professional, knowledgeable, passionate, and inclusive. Many participants referred to the safe and confidential environment created by facilitators as enabling participation and creating a sense of wellbeing and safety to speak honestly and without judgment.

Participants spoke at length about how inclusive and hands on the training was. They valued the numerous opportunities for the sharing of knowledge and practice wisdom between attendees. Learning from a diversity of professionals and hearing feedback and experiences from multiple sectors led to a more holistic understanding of the issues and systems in Tasmania, and expanded participants' professional and referral networks.

Findings

"The training was extremely engaging and worthwhile, and felt easy and enjoyable, even when discussing difficult topics. I found the workshop style and discussion around the training led by fantastic facilitators allowed us to apply the training principles to both our professional and personal lives in an engaging and impactful way."
Training participant

The most valued elements of the training sessions were:

- Networking, conversations, and relationship building
- Learning about the red and yellow flags for RCA
- Local abortion care and referral pathway details
- The Map that was shared, and
- Language – to be able to normalise and 'find a voice' around abortion, for inclusivity, and for RCA enquiry

Participants who had previously done values clarification work, or who had expertise in pregnancy options, identified these as the least valuable elements.

One trainee noted that, "the request to list pronouns - this can be traumatising to anyone who remains unsure of their pronouns". Project staff were aware of this and reflected that 'inviting' rather than 'requesting' people to share pronouns was a change they would implement in future sessions.

"It was fantastic, and one of the most engaging training workshops I have participated in in a really long time!".

"This was a thorough package suitable to people within and outside the immediate sector."

Impacts

The evaluation identified a range of impacts that the training had on the organisations and staff involved in the project implementation, along with the training participants, their organisations, and clients.

The impacts described by evaluation participants went beyond what the project team had anticipated was possible (to measure) in a short time frame and indicated the value in this project lies not only in knowledge-sharing with and between professionals, but in network building, systemic change, and stigma reduction.

Confidence and quality of care

> "Fabulous day that has enabled me to find gaps in our service and really motivated me to do better for our women!"

We assessed participants' confidence in providing core, relevant elements of SRH care before and (6-8 weeks) after they attended the training. Table 3 indicates that the training led to meaningful improvements across all domains of confidence in provision of quality care.

Prior to the training, participants were, on average, somewhat confident providing the forms of care assessed. They were least confident identifying RCA with their clients. After training, participants were most confident providing advice around non-directive pregnancy options and identifying RCA.

Impacts

Table 2: Change in confidence pre and post training

Confidence in:	Pre-training average score (n=49)*	Post-training average score (n=24)*
Providing non-directive advice around pregnancy options	*2.41*	*1.66*
Providing compassionate SRH care	*2.41*	*1.96*
Identifying RCA	*2.28*	*1.76*
Providing trauma-informed SRH care	*2.59*	*1.85*

*With 1 representing the highest level of confidence and 4 the lowest.

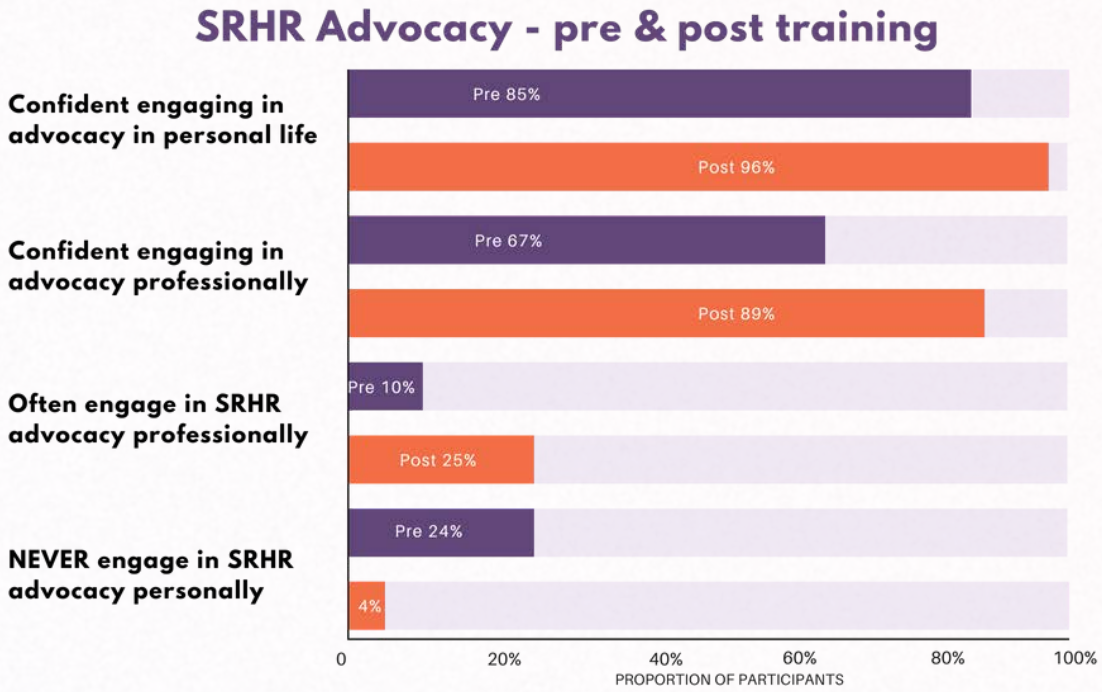
Multiple participants reported they have embedded RCA screening questions into their routine practice with clients.

Interviewees described increased confidence in having conversations about pregnancy options and asking difficult questions to identify RCA. Practicing these conversations was seen as particularly helpful in this regard, along with the 'red flags' component of the training. Some participants expressly asked for more time to have practice conversations in which they could learn to 'plant seeds' to help clients reflect and identify RCA in their own time.

Training also impacted interviewees' confidence in using inclusive language within their work and with their clients. One participant reported she has changed her use of gendered language in her practice to be more inclusive.

Impacts

Advocacy



Personal advocacy

Pre-training, most participants (85%) reported feeling somewhat or very confident advocating for reproductive rights and abortion access in their personal lives (with friends, family, on social media, etc). After training, this proportion had risen to 96%.

While the proportion of participants who reported engaging in Sexual and Reproductive Health and Rights (SRHR) advocacy in their personal lives remained constant at 18% pre and post training, the proportion who said they never engaged in SRH advocacy declined significantly from 24% to 4%, and those who reported doing personal SRHR-related advocacy sometimes increased (from 57% to 79%).

Impacts

Professional advocacy

The proportion of participants who reported feeling confident advocating for reproductive rights and abortion in a professional context rose significantly from 67% pre-training to 89% post-training.

Similarly, the proportion of participants who often engaged in SRHR advocacy in professional settings rose from 10% to 25% as a result of the training.

One interviewee described how misinformation related to abortion was a particular issue among marginalised young in their region, which was reducing access to abortion services. They described how the training had given them the confidence to advocate against misinformation and respond with the truth about abortion processes and systems.

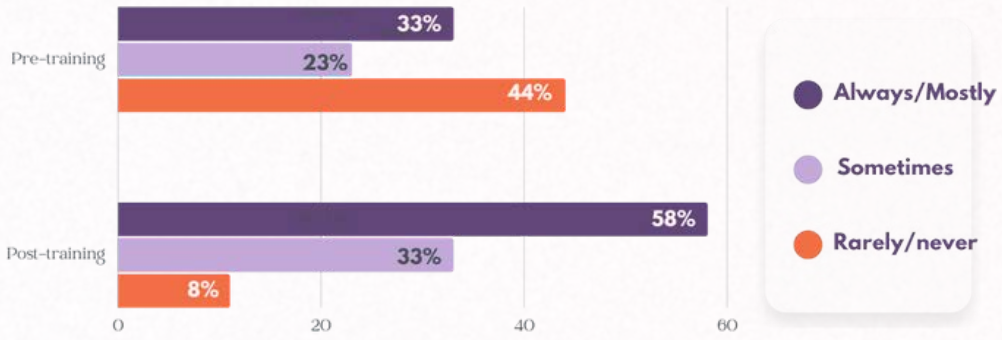
Connectedness & networking

The opportunity for attendees to grow their professional networks and meet other people involved in sexual and reproductive health provision in Tasmania was deeply valued by most participants. Participants described,

> "Knowing the lengths professionals (in Tasmania) go to protect women is heartening".

> "It was like a light. Sometimes you feel like you're alone in this stuff".

Social & professional support



While only a third of participants felt connected to other abortion providers pre-training, 58% felt often or always connected to other providers after the training.

Professionals involved in abortion provision were most likely to feel connected to (other) abortion providers, in comparison to those not involved in abortion provision. People who listed their profession as Psychologist, Social Worker or Counsellor, or "Other" were most likely to report feeling only sometimes, rarely or never connected to (other) abortion providers: all but one of those reporting disconnection, however, were not involved in abortion provision. In comparison, 86% (6/7) nurses/midwives who completed the post-training survey reported feeling often or always connected to (other) abortion providers, and most were involved in abortion provision.

Multiple interviewees described receiving referrals from other training participants since the training days and have maintained networks and relationships built through the training. They described these relationships as enabling appropriate responses and referrals for their clients needing reproductive health care.

Impacts

The networks, relationships and value that relationship building held to training participants emerged through the evaluation as one of the most valued outcomes for training participants.

While services in Tasmania, particularly around but also beyond abortion services, were otherwise described as siloed, localised and disconnected, this outcome may be of particular importance both to 1) helping SRH providers feel supported, appreciated and part of a 'team' and, 2) to facilitating a cultural shift away from secrecy and anticipated stigma, both among professionals and community members, which was seen as a key systemic/cultural barrier to accessible, quality SRH care in Tasmania by project staff and participants alike.

Pride in abortion work

There were high levels of pride in their abortion work reported by most participants (who responded to the question) both pre- and post-training (83% and 82% reporting they always or often feel proud about their work, respectively), with no significant change as a result of the training.

Impacts

Anticipated & experienced stigma

Most participants rarely or never feared the reactions of others to their abortion (related) work. Nevertheless, the proportion of participants reporting they rarely or never feared the reaction of people to their abortion-related work increased as a result of the training from 86% to 94%.

This indicates a reduction in anticipated stigma.

Participants felt more supported when disclosing their work to family and friends in comparison to disclosing to strangers: They were twice as likely to anticipate/experience supportive reactions from family and friends as compared with strangers. There were limited changes in people's feelings about reactions from friends and family pre- and post-training.

However, the training did appear to lead to reduced anticipation or experiences of negative reactions from strangers, with 20% more participants feeling they always or mostly received positive reactions to their abortion work after the training.

	Always/Often	Sometimes	Rarely/Never
I feel that when I disclose my abortion (related) work to friends or family, they are supportive of me.			
Pre-training	50%	41%	9%
Post-training	53%	27%	20%
I feel that when I disclose my abortion (related) work to strangers, they are supportive of me.			
Pre-training	25%	65%	10%
Post-training	46%	38%	15%

Impacts

Stigmatising attitudes

Prior to training, participants indicated very low levels of stigmatising beliefs about abortion seekers and almost universal support for legal and publicly provided abortions. Thus, changes on these measures were negligible.

Willingness to publicly list SRH services

While not directly relevant to this project, it may be of interest to the participating organisations to know that prior to the training, 16 participants (38%) felt they would be happy to publicly-list their abortion services and 16 were happy to list their contraceptive services (37%) on a map of SRH services in Tasmania. Post-training these proportions rose to 52% of participants involved in abortion provision stating they'd be willing to publicly list their services on an online map, and 46% stated they'd be happy to list their contraceptive services.

Of those who weren't willing to list, the majority said this was as they didn't provide relevant services, or their services were intentionally confidential.

Other Impacts

Information sharing

Several interviewees spoke about having widely shared several of the resources and much of the information provided in the training sessions - namely the service map, a video about intersectionality, the contraceptive table/handbook, and information about identifying RCA – with their wider (often state-wide) teams and organisations.

Interviewees also described that since attending the training, they had shared the knowledge they'd gained within and beyond their own organisations via workshops, resource and web-page developement. One participant said the training motivated them to "build [a screening and violence policy] from the ground up" and felt empowered to lead this process because of the training. They described the training as,

"like a trampoline. It's sprung me off".

Some interviewees who work directly with clients also reported having shared the resources they now had access to with clients directly via links, empowering clients to meet their own needs.

Partnership

The evaluation also explored the effectiveness of the partnership between WHT and CbyC, primarily via staff interviews.

Program staff described the partnership as efficient, enabling and supportive. Staff at CbyC described their WHT collaborators as competent, efficient, strengths-based, non-judgmental and very organised. WHT staff described CbyC collaborators as flexible, supportive, and really good communicators.

Time spent together in-person was found to be particularly valuable to building team cohesion and facilitating the train-the-trainer aspect of the project. The range of experiences and various strengths of individual project staff created a diverse and holistic approach to the training (content) and project.

Beyond the scope of the immediate project, the partnership led to both organisations reflecting on their own practices, content, biases and strengths, and has led to changes and expansions to work in both organisations.

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Challenges

There were a number of factors that challenged project management and efficiency, and which could be addressed in future work and partnerships. These were described as:

1. Workload management - staff turnovers and running a major conference posed capacity challenges for CbyC staff in 2022, which they felt undermined the quality of the train-the-trainer aspect of the program, and their responsiveness.

2. Shared site - both teams described the need for a Sharepoint/shared online document repository to reduce reliance on emails, improve efficiency, and be able to collaborate on documents in real time.

3. Intellectual property - there appeared to be some varied understandings about the project's funding body and intellectual property ownership. Clear communication between project staff and management around these issues could reduce any unnecessary miscommunication.

4. Training scheduling - travelling and presenting three training sessions in three regions within a single week was found to be tiring and not feasible. Future sessions should be spread over a longer time period to allow sufficient time for staff to prepare, travel and recuperate.

Needs analysis

Interviewees were invited to share what they thought were the most pressing Sexual and Reproductive Health needs in their regions and fields of work. Their answers may prove useful for WHT and CbyC when considering future activities.

Social & systemic isolation

- High rates of violence, coupled with geographical and social isolation, social conservatism, religion, low levels of health literacy and poverty were seen to force pregnancy decisions and reduce access to services, including abortion-related services, for women and pregnant people in Tasmania.
- Migrants and women for whom English wasn't their first language were described by numerous participants as particularly excluded and isolated from systems and supports in Tasmania. Navigating health systems in a context of a lack of in-language information, formal support networks and published information about pathways was seen as impacting the autonomy and health of these women.
- Adolescents were described as particularly at risk of violence and manipulation, due to low levels of reproductive health literacy and misinformation around consent.

Stigma & gatekeeping

- Many participants spoke about the lack of willingness of abortion services (managers/CEOs) in Tasmania to publicise their services due to fear of stigma, resulting in a lack of public and professional knowledge about the availability of and pathways to abortion care.
- A lack of public knowledge about pathways meant individuals working in other health services were seen to be in control of information and access, thus having the power to enable or deny abortion seekers access to abortion services based on their beliefs and preferences.
- Religion, conservativism and class, and the perceptions of the religious influence in various regions, informed people's perceptions that abortion stigma is particularly rife in Tasmania. Even providers described feeling uncomfortable even saying the word 'abortion'.
- Stigma, and the resulting lack of social and professional discourse around abortion, is contributing to misinformation about abortion in the community and among professionals.

Needs analysis

Professional support

- Participants described that there are no support services, beyond generic EAP programs, available to staff involved in abortion provision in Tasmania, and debriefing and case consultation meetings don't appear to be standard practice.
- There is limited social work/counselling support available to abortion seekers, with no funded social worker role in at least one of the main abortion services in the state.
- Participants weren't aware of post-abortion support groups or services.

Primary care

- Participants described that many GPs were unprepared and ill-informed about how to create appropriate referrals for abortion services, and which tests and information are/is needed by abortion seekers.
- Participants described that pregnancy options counselling is mandated for abortion seekers, yet many GPs – who are often the first contact for abortion seekers – lack the skills and knowledge to compassionately provide this service.

APPENDIX: Evaluation indicators

The following table includes an overview of measures and data sources used in the 2022 evaluation. These were decided in collaboration with the partnering organisations.

Indicator	Source
# people completing training	Service data
Adaptations required/ degree of change	Interviews staff
Regions serviced by training	Service data
Project completed to timelines and on budget	Service data
Partnership evaluation	Interviews staff; 'Empowerment evaluation'
#/% of relevant staff reached (in an area, sector or service)	Service data
Provider/program staff satisfaction with support received	Interviews staff; 'Empowerment evaluation'
Inclusiveness of modules (language, LQBTIQA+ inclusive, culturally safe etc)	Interviews with staff; content assessment
Satisfaction with facilitators	Pre-post survey
Most and least useful modules/content	Pre-post survey
Barriers and enablers to effective implementation	Interviews (Staff: CbyC, WHT)
#/% Training participants reporting increased confidence and skill in counselling women around abortion and reproductive coercion	Pre-post survey
#/% Training participants reporting satisfaction with the relevance and usefulness of the information provided in the training sessions	Post survey
Training participants knowledge retention/retraining needs 6 months post-training	Interviews (participants; WHT staff)
Stigma - reduction (participants)	Pre-post survey
Engagement with and confidence in doing advocacy work around repro rights (participants; WHT staff)	Pre-post survey
Uptake of new knowledge in practice (participants; WHT staff)	Interviews (participants & staff)
Barriers and enablers to implementation of new knowledge: CbyC, WHT and participant perspectives	Interviews (participants & staff)
Key learnings – what do we need to improve, change, do differently?	Interviews (staff)