I love my job … it’s more the systems that we work in: the challenges encountered by rural sexual and reproductive health practitioners and implications for access to care

Christina Malatzky and Alana Hulme

ABSTRACT
This paper focuses on rural aspects of sexual and reproductive health and sexuality. Disadvantage of access to practitioners with expertise in sexual and reproductive health and sexuality is compounded for rural residents. Retaining and supporting the rural sexual and reproductive health workforce is important in addressing sexual health inequities and promoting the sexual and reproductive rights of rural residents. However, little is known about the role-related challenges encountered by rurally-based sexual and reproductive health practitioners. We draw on 15 qualitative interviews with general practitioners and nurses with recognised expertise in sexual and reproductive health working in three rural regions of Victoria, Australia. Findings highlight the precarious state of sexual and reproductive health delivery in rural contexts and draw attention to the unsustainability of current systems for providing access to care in rural settings. Problems stem from cultural processes and assumptions within the health sector. Adapting organisational cultures and how sexual and reproductive health is structured within the health system are critical to improving access for rural residents. Our findings have relevance for other high-income, Eurocentric and metrocentric countries with public health systems and similar geographies.

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Introduction
The provision of sexual and reproductive health care by a skilled local workforce is central to supporting sexual health and wellbeing (Teffo and Rispel 2017; Botfield, Zwi, and Newman 2017). In rural contexts, access to mainstream sexual and reproductive health services is critical (Grant, Nash, and Hansen 2020; Malatzky, Mitchell, and Bourke 2018). However, a lack of health practitioners with specific expertise in sexual...
and reproductive health and sexuality means that these key dimensions of health and identity remain poorly understood (Klaeson et al. 2017; Grant, Nash, and Hansen 2020) and the relative disadvantage of access to specialist practitioners in rural settings is compounded (Malatzky, Mitchell, and Bourke 2018; Cosgrave 2020). Retaining and supporting the existing rural sexual and reproductive health workforce is important in addressing the current health inequities experienced by diverse populations living rurally and the sexual and reproductive health rights of rural residents.

Relatively little is known about the experiences of rurally-based sexual and reproductive health practitioners. International literature overwhelmingly focuses on metropolitan contexts, but clearly articulates how sexual and reproductive health care is experienced as a stigmatising practice (Bolton 2005; Lipp 2011b; Purcell et al. 2017; Hanschmidt et al. 2016; Harris et al. 2011; Lipp and Fothergill 2009; Teffo and Rispel 2017) and performed predominately by low-status professions in the health hierarchy (Purcell et al. 2017). The stigma literature points to the emotional burden involved in providing sexual and reproductive health care, which poses complex challenges for practitioners (Teffo and Rispel 2017). Yet the emotional labour sexual and reproductive health practitioners perform when working with clients has been found to play a key role in enabling the provision of sexual and reproductive health care itself (Purcell et al. 2017; Lipp 2011a). Discussion of sexual and reproductive health care delivery and associated workforce challenges must first acknowledge the particularities and complexities of rural contexts and widespread assumptions of metropolitan conditions in health sector domains (Malatzky and Bourke 2017).

In Australia, sexual and reproductive health care is influenced by both federal and state/territory sexual health policies. At both levels, there are strategies broadly focused on sexually transmitted infections (STIs), as well as strategies specific to HIV and hepatitis B and C. Nationally, sexual and reproductive health services are delivered in hospital, community health and primary care systems, with the majority of specialised testing, treatment and care services being located in metropolitan areas (Department of Health and Human Services 2020; Commonwealth of Australia 2018). STI testing occurs in primary care settings including privately-owned general practices and pharmacies as well as state-funded community health services (some of which have specific sexual health clinics) and secondary schools employing school nurses (Department of Health and Human Services 2019; Commonwealth of Australia 2018). The majority of STI and other sexual and reproductive health care needs, however, are managed in general practice by medical practitioners (The Royal Australian College of General Practitioners 2020), sometimes with the support of sexual health-trained nurses employed specifically to undertake and lead this work (Chen 2008). Australia’s national health insurance scheme, Medicare, allows medical practitioners to claim a fixed-fee benefit for services provided (although many charge higher rates and patients pay the ‘gap’). While there are some services nurses can claim in private practice, nurses employed in the public health system cannot claim Medicare benefits (Australian Government 2020).

In this article we examine the practice experiences and role-related challenges encountered by sexual and reproductive health practitioners practising in three rural regions of Victoria, Australia to develop greater insight into contemporary sexual and
reproductive health care delivery challenges for rural practitioners, and the implications for sexual health and wellbeing. We consider what these challenges mean for the retention of sexual and reproductive health expertise in rural communities and access to good quality care. Our analysis focuses on the cultural aspects of service provision in rural settings, including the implications of cultural assumptions embedded within systems and expressed through organisations that impose constraints on the rural sexual and reproductive health workforce, and the discursive techniques used to render the work, conditions and need for sexual and reproductive health care invisible. The study is rural place specific. However, given recent arguments that rural communities and health service environments internationally have more in common with each other than their metropolitan counterparts, and Australia’s leadership in the field of rural health development (Cosgrave 2018), the insights generated through this Australia-based study have relevance for health policy and practice further afield, especially in other high-income economy, Eurocentric and metrocentric countries with public health systems, such as the UK and similar geographies, such as Canada.

Methods

Nurses and general practitioners (GPs) with recognised expertise in sexual and reproductive health working across three rural regions of Victoria, Australia were invited to participate in individual semi-structured interviews. Several strategies were used to recruit potential participants including placing advertisements about the project in newsletters distributed to local health providers; distributing flyers through local women’s health services and primary health networks; and drawing on the authors’ networks as rural health researchers with local knowledge of and connections with this workforce. The study received ethics approval from The University of Melbourne (ID: 1851500.1).

Interviews took place between May and October 2018 and were conducted either via telephone or face-to-face (determined by each participant’s preference). They ranged in duration from 35 to 60 min. With the aim of developing a comprehensive understanding of the needs of this workforce, interviews explored participants’ experiences of providing sexual and reproductive health care within their rural locale, opportunities and challenges encountered in undertaking this work in-context, and how sexual and reproductive health work could be better supported or provided in rural places. Financial reimbursement of AUD50 was offered to participants to acknowledge the time and associated costs of participating in the research. All participants provided informed consent to participate in an interview and to have the interview audio recorded. For telephone interviews, consent was verbal and recorded prior to the commencement of the interview, whilst written consent was obtained before the commencement of face-to-face interviews.

Audio recordings of each interview were transcribed verbatim and later assigned a participant number. Participants were provided with the opportunity to read and comment upon the content of their transcribed interview prior to the data being analysed. Both authors independently coded each interview transcript using an inductive approach (Saldana 2009) and organised the identified codes into categories and then
themes as described by Braun and Clarke (2013) and considered these in relation to the aims of the research. The analytical work of both authors was then compared, consistencies and variations within themes across the two authors’ codebooks discussed and agreement reached about the interpretation of data underpinning each analytical category (Thorne 2016). The themes reported on in this paper were developed by integrating the analytical insights of both authors, focusing on the role-related challenges described by participants and what these imply for the rural sexual and reproductive health workforce and the provision of quality sexual and reproductive health care in rural contexts.

AH has extensive experience in the field of rural sexual health as both a researcher and public health practitioner and is cognisant of the service environments in which participants were located. CM is a sociologist and rural health researcher interested in power relations and understanding the cultures of health systems and services. These disciplinary orientations and subjective experiences informed the meanings derived from the data and how the research was interpreted. By acknowledging the manner in which meanings from social research are generated within an interpersonal context (Finlay 2006), during the analytical process we explicitly aimed to offer a clear account of our interpretations of the research. The presentation of individual participant quotations has been approached carefully to protect anonymity. From our perspective, this research extends current debates and knowledge about culture and sexual health, specifically in relation to the implications of sexual and reproductive health’s positioning within mainstream health systems, and the application of metro-assuming models of service provision for rural and sexual health inequities, and rural residents’ rights to access quality sexual and reproductive health care.

Findings

Fifteen interviews were conducted. Ten participants were nurses and most participants identified as female (see Table 1). Participants were working in different settings, including private practice, secondary school/s, community health services, or a combination of these. Eleven participants were working on a full-time basis (seven nurses and four GPs). Length of time providing sexual and reproductive health care varied from less than a year to over 30 years. All participants described having undertaken some sort of additional course or study in relation to sexual and reproductive health through providers including Family Planning Victoria, The University of Melbourne, Melbourne sexual and reproductive health Centre and the Royal Australian College of General Practitioners. Their sexual and reproductive health qualifications ranged from undergraduate modules or courses to postgraduate qualifications. Clinical study in addition to formal qualifications was also common and included completion of

| Participant category       | Male | Female | Total |
|----------------------------|------|--------|-------|
| General practitioners      | 1    | 4      | 5     |
| Nurses                     | 1    | 9      | 10    |
| Total                      | 2    | 13     | 15    |
intrauterine device and Implanon insertion courses, Pap testing, pre- and post-test counselling for HIV and hepatitis C, and medical termination of pregnancy and specialised HIV drug prescribing training. Given the risk of possible identification, whilst participant numbers and categories are assigned to the extracts below, this information is not cross-referenced with other characteristics outlined here.

**The work itself**

Participants described their work as complex, messy, sometimes uncomfortable and routinely emotionally intense. It involves ‘picking up emotion’ (P13: GP) and often uncovering ‘hidden’ or ‘under the radar’ (P3: GP) dimensions to health that can rarely be addressed ‘on the spot’ (P11: nurse). Time, care and energy are needed. Participants also spoke about the unmeasurable aspects of sexual and reproductive health work:

…there’s hardly anywhere where a young person or any person who’s feeling nervous about what’s going on in their life can come in and see a nurse who can help work out a solution for them … the problem is you can’t measure it. So you can’t say, oh look we’ve just saved seven unplanned pregnancies for teenagers … and that would have cost the government this much money not only for them now having a baby but then they would have needed perhaps support here and … you can’t put a value on it … (P9: nurse).

In this way, and consistent with the findings of urban-based studies (Purcell et al. 2017; Gott, Hinchliff, and Galena 2004; Katz-Wise et al. 2019), participants in this study identified the nature of sexual and reproductive health work as a role-related challenge that, from their experiences and observations, can lead practitioners to restrict or leave sexual and reproductive health practice. Overwhelmingly, participants’ discussion of their roles and the challenges they encountered articulated the implications of the broader health system’s devaluation of sexual and reproductive health, and the application of this system, which assumes metropolitan conditions, in and for rural contexts. Consequently, sexual and reproductive health work was not seen as valued or respected by health services and organisational cultures of dismissal – dismissal of value, need and recognition – were described. For participants, these circumstances were of greatest importance for workforce retention and access to care in rural settings. In short, while participants loved their work, they described the cultural systems and organisations in which they work as major barriers to workforce development and patient care.

**The effects of funding and organisational cultures for rural practice**

Participants explained that how sexual and reproductive health is funded in Australia assumes practitioners and healthcare users are working and located in metropolitan centres – there is little recognition of, or flexibility towards, rural contexts of service provision. The kinds of adaptions participants identified that would support the provision of sexual and reproductive health care in rural contexts are not made. These included funded positions for rural sexual and reproductive health GPs; access to free or fully-subsidised education and training for rural practitioners; regular contact with the state health department; and a general openness to different ways of delivering care in rural
contexts. Despite GPs and sexual and reproductive health nurses being pivotal points of access to care for rural residents (de Moel-Mandel, Graham, and Take 2019), GPs cannot make sufficient claims for financial support to cover the time needed to provide sexual and reproductive health care, and nurses cannot claim at all for their work (Garrett et al. 2016; Heywood and Laurence 2018). This means that few sexual and reproductive health roles are funded by health services and much of the work undertaken is insecure. For rural GPs, a gender-based pay disparity is also created by gender stereotypes and discriminatory ideas attached to sexual and reproductive health work embedded within organisational cultures. For example, one GP participant (P2) described how a male colleague felt quite comfortable to tell her that she would never be appointed full-time because training women is ‘a waste of taxpayers’ money’. The same participant went on to explain how, as a female-identified GP, she was often automatically assigned sexual and reproductive health work or, as another participant articulated, the work of ‘tears and smears’ (P6: GP) which cannot be remunerated to the same extent as other clinical work commonly assigned to her male-identified colleagues. Relatedly, nurse participants spoke about the difficulty of attracting male-identified practitioners to sexual and reproductive health given the way men in nursing are encouraged to ‘climb the ladder’ (P5: nurse) into management (Stanley et al. 2016).

All participants described how that they struggled to meet community need under the current funding conditions. When it came to access to sexual and reproductive health care and services, rurally-based residents have limited options (Garrett et al. 2016; Hulme-Chambers, Clune, and Tomnay 2018). All participants were conscious of this reality and articulated that access to care for their patients was the main reason they persisted in their work and took on additional clinical, as well as administrative and coordination workloads despite the likely burnout costs, and in the absence of formal organisational recognition or supported career advancement pathways.

… the tricky bit about being sexual and reproductive health in rural is you don’t have an option. There’s no more options … so service need goes up, but there’s no change in on-the-ground service … She doesn’t get paid any more to be a clinical supervisor, or a team leader, and she runs that service, does all the reporting, does everything, gets paid no extra, or no acknowledgement of that role … this whole kind of what’s the plan, and who is going to do what, but that’s also us as nurses having to do that. There’s no manager for us going, okay, clinic is going to be down a day, what the plan is, is this … There’s not that … It’s just another added thing that you’ve got to manage amongst your full clinical day (P1: nurse).

We often creep over that [the number of services they are supposed to deliver per day] because we just feel sorry for the women – and feel like they [need a service] … But I’m conscious of burning out my staff … the coordination of unplanned pregnancy is falling to us … it’s up to us to sort them. To distribute them to the various services. I’ve talked over and over – I’ve emailed, phoned, tried to meet with the head of obstetrics and gynaecology here to say, you need to provide a public surgical abortion list. Even if it’s once a fortnight – and he won’t even reply to emails or phone calls or anything. So that’s been a really big stress at the moment for us. Because our MTOP [medical termination of pregnancy] service is at capacity … That’s been really stressful. Because we’ve no increased staffing capacity to be handling – to be coordinating it (P2).

Participants reflected how it was up to them as individual practitioners to ‘push’ (P5; P12; P7: nurses) for service provision, and they did so with little institutional
support or acknowledgement. The additional workload for rural practitioners under these conditions was a substantial source of frustration for participants, not least because they were aware of other suitably qualified and passionate practitioners in the local area who were working to ‘get their foot in the door’ (P1) but could not be utilised or retained due to a lack of funding. This was particularly the case for sexual and reproductive health nurses who, whilst being unable to claim for services provided under Medicare, were understood by participants, including GP participants, to be well positioned to provide patients with the time, care and expertise needed to address sexual and reproductive health issues. Participants described how the current under-funding of and support for sexual and reproductive health effectively leads to sexual and reproductive health practitioners’ time and labour going unrecognised and undervalued within their organisations, making it difficult to retain already few on-the-ground staff.

Of most concern to participants was how this erasure of recognition, value and need for sexual and reproductive health care at system and service levels negatively affected access and the quality of care provided to rural residents. For example, participants described the way in which rurally-located residents experienced time delays and complications.

[A client] presented today. She’s had about seven appointments now, and we’ve managed to get her a spot for tomorrow. She’s spent three hours this morning pretty much running around, picking up all the scripts she needs to go to Day Surgery tomorrow to have it all done. I’m just like – I had a medical student with me and [they] goes, my god, that’s so complicated. All she wants is a surgical termination. I’m like, I know, and it will cost her 600 bucks, whereas if they had been quicker, she could have had an MTOP. Or if [a large public health service] were providing public lists … they would have got it done (P5).

Another participant explained how these service access issues and their resulting consequences were compounded by a lack of understanding and valuing of sexual and reproductive health work, which could be remedied by adequate staffing:

…it might take them [women-clients] three goes to get to our service… If in that GP practice there was a nurse… we would alleviate a whole range of time issues, a whole range of trauma for women, and a whole range of, I suppose, a lack of service understanding, or lack of understanding of the service… (P8: nurse).

Several participants articulated how current funding structures and resulting workplace cultures were in tension with ideals of respect for the patient and responsive care in fundamental ways. Participants identified a business rather than public service model to healthcare delivery as a cause of the barriers they encountered to providing timely sexual and reproductive health care in rural settings. As these participants expressed, sexual and reproductive health care in rural contexts does not fit a profit model and leads practitioners to risk burnout.

… we have to be flexible… if we were rigid, so if we said to someone, oh, I’m sorry, you’ve seen your GPs, you’ve done all your investigations, you know what you want, but we actually haven’t got an appointment for two weeks, that just wouldn’t – that’s not being responsive and… we wouldn’t be providing a service that was responsive to the clients if we did that. So, we do have to be flexible. But on the same token, we also have
a need to look out for each other and for ourselves as well so that we don’t burnout… (P5)

…the idea that the current model of GPs working to increase throughput to generate a higher income for the health centre or to meet targets of whatever their contract is, etcetera, is contrary to what one needs to do in this sort of area where you want to give people time, you want to be respectful, where some of the key most difficult issues only come out halfway through or at the end or at a review appointment. So, there’s a real tension between the model of using a Medicare system that rewards people for seeing a high number of people per hour and people who spend time with patients generate less money for the centre and less money overall means, by Medicare, means that you’re actually creating a system that doesn’t reward or doesn’t value best practice… (P15: GP).

Participants were clear in describing their personal commitment to service provision and quality of care as their central reasons for remaining in sexual and reproductive health practice. However, the consequences for workload were also keenly expressed.

The rural service environment

Participants described many pressures of sexual and reproductive health work specific to a rural service environment. For example, they explained the impact on practitioner/service workloads and access to care when a local service ceases to operate in a rural region or uses the presence of others who provide sexual and reproductive health services to deflect responsibility for also providing those services. Participants expressed how providing sexual and reproductive health services in rural contexts ‘should be something all [providers] do’ (P3). Generally, as a group of practitioners, participants were clear about what they understood as a moral or ethical responsibility to provide the sexual and reproductive health care needed by the community they served. This sense of responsibility was heightened by the limited number of health providers in rural communities (Peters 2020), not all of whom are willing to provide the kind of care needed. For example, some participants expressed concern about how the personal beliefs of some local medical practitioners blocked women’s decisions to terminate a pregnancy:

I don’t know whether it’s different cultures coming through, so the cultural beliefs…obviously understanding to respect the cultural beliefs. However, we’re talking about medicine. Medicine is above cultural beliefs. So, if your cultural belief stops you from asking a particular set of questions, you’re completely alienating someone’s healthcare. It’s my concern… (P13).

Such situations illustrate the impact of a misfit between the personal beliefs of practitioners and the politics of sexual and reproductive health care provision, which Newman et al. (2011) have highlighted in relation to HIV care, for service provision in rural contexts. Other participants spoke about a kind of conservativism in some rural communities, which they understood to limit rural residents’ access to sexual and reproductive health care in the context of already-restricted access:

…they [practitioners in rural areas] don’t really go into that [sexual and reproductive health] area…not telling them about their options…it’s definitely there [a conservative environment] and then there’s limited choice. What do women do or what does anyone
do I suppose. It’s not like you can go around the corner to the next GP surgery or anything – you might have to go to another town. You might have to go to the city (P7).

Some participants explained how they attempted to talk with medical practitioners who opposed pregnancy termination because of personal beliefs about the importance of having an appropriate plan for supporting women who may want this procedure:

… I sat them down and said, you need to have a process what are you going to do to help that woman… Your job is to help her, so you need to have a process… So, she doesn’t feel judged and she feels that she’s being assisted. She doesn’t even have to know your opinion. Because if you go, I don’t believe in that, it’s shutting it down (P13).

Other aspects of the service environment in rural contexts that create challenges for practitioners and are not currently accommodated for, either by the broader health system or health services identified by participants, included the isolated nature of rural practice. As participants explained, a sexual and reproductive health practitioner in a rural clinic can be ‘on [their] own’ (P3); there may not be anyone locally to contact for assistance or support:

… being so rurally isolated, it is hard for me, like as I say, when something’s not going right to call on somebody that’s really experienced in that… whereas if you work in, say, family planning down in [a city location], you’d walk out and there’d probably be all these experienced people in the office next door or the office next door… while the doctors are fantastic and very supportive, there’s also that isolation factor which you just learn to deal with (P12).

There can also be little contact between practitioners working in the same setting or with the same group of potential health service users, which can compound this sense of being alone. One participant explained how when you are on your own rurally, it is not always clear who the best point of contact is outside your location which, given the limited sexual and reproductive health expertise in most rural communities (Hulme-Chambers, Clune, and Tomnay 2018; Garrett et al. 2016), can create an additional sense of isolation.

The specific context in which practitioners work in rural environments also makes the emphasis on and need to train in metropolitan centres deeply problematic. For example, participants were acutely aware of the consequences of leaving their rurally-based clinics for any length of time. Participants described how there was rarely other staff made available by local health services to cover their work so, in their absence, there is a restriction on the care that can be delivered to clients in need. While online professional development can mitigate the need to travel away from their practices, participants emphasised the pitfalls of this approach, with the requirement to do ‘it in your own time’ affecting ‘self-care and a healthy work/life balance’ (P15).

Even amongst this passionate cohort of practitioners, the additional work – clinical, administrative, strategic, relational and emotional – undertaken to improve access was described as exhausting, and many voiced doubt about the sustainability of a model that relies so heavily upon the labour of individual sexual and reproductive health practitioners to ensure access to care. This is especially the case given the lack of institutional support for implementing succession plans for those in the sexual and reproductive health workforce who may be preparing to leave practice, that several participants described. Overall, participants were clear in saying that if a skilled rural sexual and reproductive health workforce is wanted – as it is needed – the broader
health system and local employers need to accept that fiscal investment will have to be greater.

Discussion

The three key themes identified in this study highlight the precarious state of sexual and reproductive health in rural Australian contexts. The practice experiences of participants and the role-related challenges they described draw critical attention to the unsustainability of current systems for providing access to good quality sexual and reproductive health care. All participants agreed that remedying this situation through structural innovation (Botfield, Zwi, and Newman 2017) and deep-seated cultural change at system and organisational levels is needed to protect the rights of rural residents to sexual and reproductive health care, improve the sexual and reproductive health of rural residents, and prevent the reproduction of existing health inequities.

The broader organisational cultural attitudes about and practices towards sexual and reproductive health work identified by participants effectively function to dismiss the importance, value of, and need for sexual and reproductive health care in rural health services. The work of sexual and reproductive health practitioners is relegated to the periphery of service delivery and is not prioritised within the culture of rural health services. Instead, historically-influenced differences between high and low status occupations within the health hierarchy based on the (gendered) bodily work performed (Purcell et al. 2017) are (re)created and reinforced. In this sense, the workplace cultures of health services hinder the development and delivery of sexual and reproductive health care in rural contexts and perpetuate the long-standing stigma associated with sexual and reproductive health issues (Bolton 2005; Lipp and Fothergill 2009; Hanschmidt et al. 2016; Harris et al. 2011; Teffo and Rispel 2017). The gender implications of these organisational cultural dynamics were illustrated in participants’ descriptions of how particularly (female) gendered practitioners are routinely assigned to the ‘dirty work’ (Purcell et al. 2017, 79) of sexual and reproductive health, which, under current funding arrangements, leads to differences in renumeration and the reinforcement of gender inequities in the rural health workforce.

The findings of this research reveal the current terrain of power, informed by cultural processes, within health service organisations that sexual and reproductive health practitioners must negotiate to perform their daily work. Participants were seeking to provide care, not as Purcell et al. (2017, 90) describe, ‘for care’s sake, but…[as] a means of facilitating the completion in a timely manner of the practical body work tasks…’ involved in sexual and reproductive health. This required shouldering the substantial burden of not only clinical, but emotional, administrative and strategic work to ensure access, often for those made most vulnerable in communities, as practitioners. The amount and complex nature of the work currently being carried by sexual and reproductive health practitioners needs to be recognised by health organisations, especially amongst leadership teams, and translated into tangible support and advocacy for sexual and reproductive health care provision. Individual rural practitioners, as well as services, have a responsibility to their local communities to
provide sexual and reproductive health care (Malatzky, Mitchell, and Bourke 2018; WHO 2017), something that participants’ accounts suggest is not currently honoured.

This research identifies the funding structures underpinning service delivery as key enablers of the current rural health service environment. Funding models reflect cultural beliefs and priorities at the systems level. The way that sexual health is currently funded renders invisible the significant labour and workload of practitioners providing sexual and reproductive health care in rural environments, and also the need for this care. These structures, as cultural artefacts, reflect and (re)produce the status of sexual and reproductive health within the health sector and compromise access to sexual and reproductive health care for rural residents. There was agreement amongst all participants that, to improve the sustainability of the rural sexual health workforce, and thereby access to quality sexual and reproductive health care, a fundamental shift is required in the way sexual and reproductive health work is funded and thus delivered in rural environments. The unique ways in which rural context, as a dynamic, relational process that is “‘worked’ and ‘worked within’ by those who inhabit it…” (Reagan et al. 2019, 84) informs community need and, consequently, should also inform service delivery models. It was clear from the practice experiences and role-related challenges articulated by participants that the current application of the same funding structures used in metropolitan contexts to rural contexts (re)produces serious sexual health inequities and undermines the quality of sexual and reproductive health care provided. All participants struggled to meet community need with current staffing and, in the absence of structural adjustments for the rural context of service provision, attempted to somehow plug the gap through their own capacities. In effect, the few practitioners with sexual and reproductive health expertise in rural communities risk burnout to compensate for structural and organisational deficiencies (Eisenstein 2018) and cultural assumptions of metronormativity, leaving longevity of access highly vulnerable to even slight personnel changes.

This was powerfully illustrated in the tension participants described between current funding arrangements and the tenets of delivering respectful, good quality health care. To compensate for the implications of this tension, including patients with an often desperate and time-sensitive need for sexual and reproductive health care being left with nowhere to go, participants described working overtime (in a broad sense), even when the costs to individual and small-team wellbeing were great. In this respect, participants relied almost exclusively on relational/small-team support from immediate colleagues and networks to assist in negotiating the tension created between funding arrangements not-fit-for-context and the need to provide the best possible care to patients. Paradoxically, the commitment of on-the-ground sexual and reproductive health practitioners in rural contexts to their work allows the system to maintain the status quo.

The findings of this study are specific to three rural regions in one state of Australia; nationally, there are jurisdictional variations in the structure and operation of public health services. However, it is our contention that the central issues identified about the challenges of providing sexual and reproductive health care in rural contexts are likely to resonate in other contexts with similar metrocentric biases, gender norms, complex public health systems and patterns of rural settlement (Cosgrave 2018). Essentially, these issues are underpinned by cultural processes and assumptions at the
systems level. Thus, our research findings have broader relevance for the (in)equitable delivery of sexual and reproductive health care in the general context of rurality and its rich diversity. They provide evidence for, and support calls by, rural scholars in different service sectors (Downes and Roberts 2018; Cosgrave 2020) that, to be effective and sustainable, models of service delivery in rural communities need to be formed and earthed in the uniqueness of rural contexts. Developing ways of working and delivering sexual and reproductive health care that are fit-for-context is critical to ensuring access to high quality sexual and reproductive health care for rural residents in the future. For example, participants’ descriptions of working in rural contexts allude to the need for sexual and reproductive health care models of service provision to be responsive to the cultural, environmental and social dimensions of rural living. Unpredictable environmental and health conditions that impact rural communities and the ensuing social, community and economic disruption caused (Malatzky et al. 2020) can mean that sexual and reproductive health care is needed in a more urgent manner than previously. In these circumstances, access to local sexual and reproductive health services is crucial (Grant, Nash, and Hansen 2020). Furthermore, the work of sexual and reproductive health nurses, and the community health sector more broadly, needs to be funded differently in rural contexts given the role of these practitioners in the broader rural health workforce and service environment in many high-income economies, especially those with geographically dispersed populations (Cosgrave 2020).

Imposing ways of working designed for metropolitan places on rural settings is an expression of geographical narcissism (Fors 2018) and undermines rather than supports the provision of sexual and reproductive health care in rural environments, and relatedly, global health equity objectives to achieve universal access to healthcare (Botfield, Zwi, and Newman 2017; WHO 2017). As well as highlighting the unsustainable load rural sexual and reproductive health practitioners currently bear, this research emphasises how many of the solutions lie with on-the-ground practitioners. Participants in this study were well placed to advise and inform the development of cultural, organisational and structural innovations – they have the ideas to propose different ways of providing access and quality care. What they need is voice and negotiation power within their own organisations, and openness at the systems level to advance models for sexual and reproductive health care delivery designed specifically for rural contexts.

**Conclusion**

To address the under-examination of the particularities and complexities involved in providing sexual and reproductive health care in rural contexts, and the rural dimensions to sexual and reproductive health and sexuality more broadly, this research examined the practice experiences of sexual and reproductive health practitioners in three rural regions of Victoria, Australia. Participants’ responses suggest that currently there are serious challenges in providing access to quality sexual and reproductive health care in rural settings. These challenges, which include under-staffing and under-resourcing and lack of forward-planning for workforce and service provision innovation, stem from deep-seated cultural biases, and organisational and structural deficiencies evident in other metrocentric, high-income economy countries which,
within rural contexts, (re)produce sexual health inequities. Organisational cultures that dismiss the value and need for sexual and reproductive health care, along with the application of funding models not designed to suit rural environments, have serious implications for on-the-ground sexual and reproductive health practitioners and access to care for rural residents. The implications of these broader health and cultural systems for sexual health and wellbeing, problems around sexual and reproductive health, sexual and gender inequalities in health, and sexual and reproductive health rights made visible in this research, need to be addressed through political action directed by the expertise and practice experiences of rural sexual and reproductive health practitioners. From our findings, practitioners are passionate about advancing models for sexual and reproductive health care delivery that will work for rural communities and have the necessary understanding of local rural service environments to inform the design of such models with local communities.

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ORCID

Christina Malatzky http://orcid.org/0000-0002-9078-9601
Alana Hulme http://orcid.org/0000-0001-9243-0371

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