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'Country women are resilient but. . . .': Family planning access in rural Victoria

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Abstract

***Objective*:** *This study examined barriers to accessing three types of family planning service (emergency contraception, termination of pregnancy and options counselling) within the Grampians region of Victoria. In addressing the challenges faced by geographically marginalised women, the intention was to contribute to feminist psychological research in the field of women's health.*

***Design*:** *The qualitative study drew on community and health psychology frameworks. Community psychology's ecological perspective takes into account the different contexts of people's lives, while the focus on psychosocial aspects of women's reproductive health behaviour places the study in a health psychology domain.*

***Setting*:** *Grampians region of Victoria, Australia.*

***Participants*:** *Eleven professionals whose employment was connected to family planning services in Victoria.*

***Interventions*:** *Semi-structured interviews.*

***Main outcome measures*:** *The study documented professionals' perceptions of facilitators and barriers to accessing family planning services in rural areas and the implications for women's psychosocial health and their ability to make timely decisions about a pregnancy.*

***Results*:** *A thematic analysis confirmed that women in the Grampians region face many barriers including lack of local services, privacy, misinformation and judgmental service providers. While these issues could arise anywhere, the problem is compounded in rural areas by limited options and rural cultural pressures.*

***Conclusions*:** *This study highlights the complexity of many rural women's reproductive 'choices', and recommends plausible strategies to tackle barriers and facilitate access to family planning services. Reproductive health research can benefit from community and health psychology perspectives that consider psychosocial and cultural contexts as well as biomedical factors.*

KEY WORDS: *abortion, emergency contraception, psychosocial health.*

Introduction

Reproductive health '. . . implies that people . . . have the freedom to decide if, when and how often to reproduce. Implicit . . . is the right . . . to be informed and to have access to safe, effective, affordable and acceptable methods of family planning'.[3] In societies where family planning is supported, women's rights to education and stable employment, relationships and economic futures are enhanced.[4]

Up to 50% of Australian women might have an unintended pregnancy,[5] and approximately one in three Victorian women will obtain a termination in their lifetime.[1] Such findings highlight a need for additional family planning options beyond contraceptive methods.

Women in urban areas might take for granted their relatively easy access to family planning information and services such as emergency contraception (EC) and termination of pregnancy (TOP). For women in rural areas, the picture can be very different. Generally, the further a rural community is from a metropolitan centre, the poorer the health outcomes and service accessibility,[6] but there is limited Australian research focusing specifically on family planning access.

Australian and international[7–9] research indicates that rural women often have to travel long distances to access affordable, confidential family planning services. Women's Health Victoria[10,11] has summarised rural women's experiences through accounts provided by health professionals in TOP clinics in Melbourne. Barriers listed include geographical isolation, confidentiality concerns, lack of (or inadequate) services and cost of travel.

While it is acknowledged that rural women likely face specific barriers in accessing family planning services, little is known about the impacts on their health and

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***What is already known on this subject*:**

- *What the state of scientific knowledge was in this area before you did your study.*
  Approximately, one in three Victorian women will have an unwanted pregnancy and obtain a termination in their lifetime.[1] Common issues that affect rural women's health include the cost and availability of transport (public and private) and a lack of education and counselling around health issues.[2] In combination, these findings point to potential challenges for rural women in regulating their fertility.
- *Why this study needed to be done.*
  Most women use family planning services during their reproductive lifetime, but many lack ready access to such services, particularly in rural areas. While it is generally acknowledged that rural communities face poorer health outcomes than their urban counterparts, there is a paucity of recent Australian research published on family planning access and its implications for women's psychosocial health and well-being.

***What this study adds*:**

- *This study provides corroborating evidence from a particular region that rural women face many barriers when accessing family planning services, including lack of local services, privacy issues, misinformation and judgmental service providers. While these issues could arise anywhere, the problem is compounded in rural areas by limited options and rural cultural pressures.*
- *These barriers are seen to increase stress and decrease self efficacy, and can deter women from accessing further family planning services.*
- *Examining access issues from a rural perspective advances research by providing important context to family planning, consistent with an ecological community psychology paradigm; interviewing a range of professionals expands the research lens from a biomedical level towards a biopsychosocial understanding favoured within health psychology. Exploring barriers to service provision is seen to have a collective benefit for women, families and communities, because it opens up conversation and erodes the secrecy that sometimes surrounds issues like abortion and the reproductive choices women make.*

well-being, how it affects their ability to make timely decisions about pregnancy or the best means to reduce these barriers. Nor has service access been examined within specific rural regions.

Psychological frameworks informing the current study

This research was informed by community and health psychology frameworks that were particularly salient to the study of health service barriers. Reproductive health goes beyond the biological to include social, cultural, political, gender and religious contexts. Health psychology adopts a biopsychosocial model of health; it assumes that health problems and behaviours such as family planning are influenced by biological, psychological or behavioural and social factors. Similarly, community psychology takes an ecological systems perspective, where behaviour cannot be considered without taking into account the different contexts within which one lives. Community psychologists emphasise empowerment of vulnerable subgroups of populations. People in rural communities in general are often left out of key decisions that might impact on them.[2] And young rural women can be further disadvantaged, possibly more concerned than adult women about anonymity and privacy, and lacking the ability to pay for services.[12]

Research aims

The impetus for the current study was a preliminary consultation with Women's Health Victoria and Women's Health Grampians (WHG) about research gaps on key health issues facing women in rural Victoria. In addressing the challenges faced by geographically marginalised women, the intention was to contribute to psychological research in the field of women's health. A decision was made to investigate the perceived barriers for women within the Grampians region of Victoria in accessing three types of family planning services: EC (misleadingly known as the morning after pill), pregnancy termination and pregnancy-related options counselling. Options counselling refers to services that explore available options regarding an unplanned pregnancy. Access was defined in terms of both timely and accurate reproductive health information and direct service provision.

The Grampians region covers an estimated 48 618 kilometres within western Victoria, with a population of approximately 225 000.[13] The major regional centre is Ballarat, 113 kilometres from Melbourne (population

approximately 95 000). WHG is the main reproductive health information service but does not deliver direct services such as EC or TOP. Public health service provision consists of hospital-based health services, bush nursing centres, stand-alone community health centres and stand-alone district nursing service.[14] Of these, the only potential TOP providers are the hospital-based services, although none formally list it as an option; there are no private TOP clinics.

Method

An obvious place to begin exploring psychosocial aspects of rural women's access to reproductive health services would be to hear from women who have faced family planning decisions themselves. However, ethical issues limited the ability to recruit women directly. The research was subject to ethics approval from Victoria University, and the need for confidentiality surrounding sensitive issues within a rural environment was a primary consideration. From the consultations, it was decided the next best option was to draw on the experiences of relevant professionals who not only hold the experiences of many women service users but could offer perspectives on the wider service system and suggest ways of reducing any identified barriers.

A qualitative methodology was used to guide the study, within a feminist framework that placed women's reproductive health rights and needs at the centre. A snowballing sampling technique was used, with the only selection criteria being that participants would have encountered women from the Grampians region seeking to access any of the three family planning services under consideration, and/or that they were considered to have expertise in the area.

The first step in snowballing is to identify 'gatekeepers'. The gatekeeper was thus WHG and potential participants were contacted via email from their list of service providers, some of whom suggested other likely contacts.

Eleven professionals participated in semi-structured interviews, nine of whom were female. Participants were drawn from a range of professions including politics, social work, general practice, psychology/counselling and nursing. Two were from a Melbourne service, and another worked in both the Grampians region and Melbourne.

The interviews documented the professionals' perceptions of facilitators and barriers to accessing family planning services in rural areas and the implications for women's psychosocial health and their ability to make timely decisions about a pregnancy.

Interview data were thematically analysed via a six-stage process outlined by Braun and Clarke.[15] The stages included familiarising oneself with the transcribed interviews, coding the data, searching for themes and finally reviewing, defining and naming the themes.

Findings and discussion

Taken together, the interviews provided a comprehensive overview of family planning services in the Grampians region, which the data analysis organised into seven themes and 13 subthemes. Only themes directly related to the original research questions are summarised here. Other themes related to more transient issues, such as the likely impact of the Victorian Abortion Law Reform which was occurring at the time of the research.

Theme 1. Barriers for women accessing family planning services in the Grampians region

The analysis confirmed that women in the Grampians region face many access barriers, as outlined below. While these issues could arise anywhere, the problem is compounded in rural areas by limited options and rural cultural pressures.

Practical barriers

Financial and geographical barriers were frequently cited by participants, including the varied and high cost of EC:

> . . . now you can pay up to $36 . . . in Melbourne you can go down the road and there is someone selling it for $10 under what you will get it here.

For rural women seeking a termination, costs can include the procedure itself, transportation and accommodation, calling metropolitan services for appointments, child care and loss of wages.

Geographical barriers referred to limited rural services, waiting lists and less opportunity to see a female doctor, as well as the strain of leaving support systems behind when travelling to Melbourne. In relation to EC, several nurses and GPs expressed concern about the limited choice of local pharmacists, particularly in terms of age and gender.

There were differing responses as to why local hospitals might not offer TOP, ranging from waiting lists and surgical times to the 'real reason' being religious objections. It was suggested that TOP might be hidden under other services:

> The unofficial answer is 'we will send you back to your GP and they will bring you in on the day patients list'. So the unofficial answer is yes and the official answer is no . . .

Another worker felt that even if a termination could be organised in a local hospital it was 'a shit place to do so . . .' It was clear that regardless of the reasons, the process of organising a TOP within the region was challenging. Similar issues of distance, cost and logistics are noted in the Australian literature.[10]

Myths and misinformation

Some participants spoke of misleading information being provided to women in the region. One pharmacy distributed EC pamphlets that were not evidence based. Elsewhere, myths about abortion leaving women infertile were still being spread, despite evidence to the contrary.[16] While misinformation also occurs in metropolitan areas, the effects in a rural environment might be more significant because the limited pool of people a woman knows mean myths travel faster and 'stick' more in the absence of disconfirming information/conversations.

> I find that staggeringly different to rural women – the reframing of myths. Because they get caught up in a complete community culture about what is right and what is wrong and everyone around them believes the same thing . . .

Psychosocial barriers

Confidentiality and privacy were raised as access barriers to both EC and TOP and were often used interchangeably. It was reported that rural women have little choice but to see someone they might know socially, unless they travel some distance to access a service.

> They come from a rural town. . .they can't tell anyone what is happening . . . they are so nervous about somebody in the town finding out . . .

Concerns about privacy clearly compound the practical problems of geographical isolation, financial burden and limited choice of service providers. The American Psychological Association's review of the effects of TOP noted that 'perceived social stigma . . . can influence . . . how they [women] feel about their decision' (p. 886).[17] Such perceptions are likely to operate at all stages of the decision-making process, from accessing health information, through to acting on that information and living with the aftermath.

Negative attitudes and judgments One reported issue was a feeling of being 'judged' by health professionals, with some doctors refusing to make referrals. As time is crucial in reaching decisions about a pregnancy, any delays can obviously compromise choice:

> . . . if you're judged in any way, you're not going to come back. Worse thing is if that person leaves and doesn't take that opportunity, then they are dealing with a bigger decision [later on] . . .

Some local doctors were suspected of deliberately delaying women's access to TOP, 'doing harm by withholding [information] . . .', forcing women to find their way to services by accident:

> We have become suspicious that GPs are actually delaying them accessing a service because of their own views on abortion so they are sending them off to get multiple ultrasounds . . .

There were also examples of doctors who agreed to perform an abortion but warned they would not do so if there was a 'next time'. Young women in particular often receive such judgments from health professionals: 'I'll give it to them this time but if they come back again I'll ring their parents'.

Some participants had noticed negative community attitudes towards TOP in rural areas. However, one Grampians region GP disagreed, saying 'I don't think that's an issue here'. Most participants considered that negative community attitudes *do not* pressure doctors against performing terminations locally if they are trained to do so. They felt that insurance premiums were a greater deterrent to Grampians-based GPs training to do TOP as they would not recover costs in a rural practice.

Diversity All rural women cannot be assumed to have the same health needs. Participants in this study reiterated this point in relation to specific and particularly vulnerable subpopulations in the region facing additional challenges to their reproductive rights, as well as living rurally. For example, as in previous research, rural teenage women in the Grampians were noted as being particularly disadvantaged, with participants noting that teenagers are constrained more than other women regarding transportation to a service, confronting moralistic service providers wanting consent from parents, denial about a pregnancy and restrictions placed on services that can be provided by school nurses. These barriers are often interconnected, as this account illustrates:

> A teenage girl – threatening suicide if she wasn't able to access [TOP] – she was over 20 weeks so obviously it couldn't be done [locally]. All the issues we have talked about came into play, low socio-economic situation, poor family support, lack of education, no money, other kids to think about, violence, denial . . . we had to access overnight childcare and she couldn't ask any family members because she didn't want them

> to know . . . the cost of going to a private clinic . . . so we had to raise that money for her in a really short time . . . You need to stay around for a couple of days to make sure nothing was wrong and then you had accommodation issues . . . it was just huge.

Some participants also noted that many young women living in the Grampians region have limited educational and employment options, which can normalise and validate the cycle of early pregnancy. And making a choice because 'there is nothing better to do' is not 'real' choice.

Rural culture While most previous research has focused on practical barriers to family planning access, this research provides additional understanding of some more subtle and hidden influences within a rural context. There were comments throughout the interviews that differences in cultural norms between city and country created extra barriers for women in accessing the support and information they needed. Wainer[2] described the close-knit and suspicious nature of rural culture; in this study communities within the region were similarly described:

> Having moved here from Melbourne I would say that women here are much more reluctant to talk about sexual issues . . . [or] to open up to a stranger who is often someone in the community . . .

This conservative culture was noted as meaning people can be wary of change, which makes it difficult to develop new services, especially in sexual health.

Theme 2. Psychosocial effects

Participants were asked about the psychosocial effects of access barriers, and how these affect rural women's ability to make timely decisions about pregnancy. Participants considered that barriers impact heavily on women struggling with or delaying a decision, with potentially overwhelming emotional effects:

> The psychosocial impact is huge with barriers, because they just don't need that at that time when they are making this incredibly difficult decision – if you add even one barrier it can absolutely tip them over the edge . . .

Grampians women were described as resilient; one participant explained how many rural women see barriers to services as the 'norm', so they just 'get on with life'. However, such barriers were also described as disempowering, and 'a huge distraction for women . . ., organising all that'. Their self-efficacy and self-esteem might be diminished, and there can be relationship and social implications.

Options counselling was not mentioned in the interviews as often as EC or TOP; however participants' comments suggested it is not a discrete service but is embedded in holistic care. Counselling issues were mostly discussed in relation to anti-choice organisations and 'false providers'[18] that deliberately mislead women into thinking they are accessing a genuine counselling service, exacerbating their distress. Concerns raised about available counselling options highlight the importance of timely and accurate information provision rather than judgmental versions of 'pregnancy counselling'. Such comments support Astbury's[4] conclusion that lack of accurate health information is more likely to induce mental distress than is an actual procedure.

Theme 3. What can be done?

Participants were invited to consider what could be done to reduce the access barriers they identified. While expanding services was considered essential (e.g. using a visiting model, increasing incentives to train in TOP, reducing the cost of EC), participants acknowledged that this might not always be possible or sufficient and advocated strategies to increase access to metropolitan services (e.g. travel assistance).

Participants also suggested that improvements to service delivery are only part of the story. Rural culture needs to be addressed too:

> It's probably partially about role models and aspirations as much as . . . well that's part of the big picture as well as assisting services.

Participants emphasised that family planning should be normalised within the health system. As previous research[19] indicates, most women do not think about TOP until faced with an unwanted pregnancy, '[they] are very much driven by information about [their] needs at the time'. If this is the case, more opportunity to share accurate information would increase women's options before they are placed in the decision-making situation.

Conclusion

This study provides corroborating evidence from one Victorian region consistent with previous findings of an overall lack of women's health and family planning services in rural communities, together with patterns specific to the Grampians region in reported barriers to accessing them. Family planning is important for maintaining reproductive health, and most women require access to these services at some point in their lives. The longer barriers continue to operate and are not openly discussed, the harder it is for women to make timely decisions about continuing a pregnancy. At such a

stressful time, the emphasis needs to be on timely, accurate, evidence-based and judgment-free advice, counselling and practical support.

Community and health psychology implications

Reproductive health research can benefit from community and health psychology perspectives that consider decision-making contexts as well as biomedical factors. Health psychology adopts a biopsychosocial model of health; the findings of this research confirm the value of such a model, with all three levels seen as feeding into family planning decisions.

When viewed through a community psychology lens, access to family planning services does not just imply physical availability of one's chosen method. It also includes the right to make decisions concerning reproduction 'free of discrimination, coercion, and violence'.[3] In other words, accessing services should be free from barriers such as excessive costs, judgments from medical professionals and coercion from partners or family members. Our title 'Country women are resilient but . . . .' refers to one participant's comment that, just because they tend to deal well with adversity, women in rural towns shouldn't have to put up with extra burdens and added distress when accessing family planning services.

Authors contributions

Julie Kruss 60% – Data collection and analysis, Heather Gridley 40% – Supervision and editing.

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