CSIRO PUBLISHING

SPECIAL ISSUE | RESEARCH PAPER
https://doi.org/10.1071/PY22134

Australian Journal of Primary Health

LA TROBE UNIVERSITY

What women want from local primary care services for unintended pregnancy in rural Australia: a qualitative study from rural New South Wales

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ABSTRACT

Background. Under the generalist model of health care in rural Australia, general practitioners (GPs) are often the first point of contact for women seeking health services for unintended pregnancy, including pregnancy decision-making support and options advice, antenatal or abortion care. Rural women are more likely to experience unintended pregnancy in Australia, yet little is known about how well local rural primary healthcare services currently meet their needs. **Methods.** To address this gap, this qualitative study explores through in-depth semi-structured interviews, the experiences of 20 rural women managing an unintended pregnancy, and their expectations of, and satisfaction with, the quality of care they received. The Framework Method was used to organise data and conduct an inductive thematic analysis. **Results.** Three themes related to management of unintended pregnancy in a rural primary care setting were identified: (1) women expect informed and efficient care once services are reached; (2) women desire greater choice and aftercare; and (3) comprehensive reproductive health should be part of rural primary care. Participants indicated an awareness of the limitations of the rural health system, yet a firm expectation that despite access delays, all of their reproductive health needs would be met. Choice, time efficiency, and aftercare were identified as gaps in the current primary care service experience. A desire for greater attention to rural reproductive health, including improved contraception, was also emphasised. **Conclusions.** Rural women with unintended pregnancy experienced gaps in service quality and described a lack of woman-centred care in their local rural health setting. This study offers insight into how rural primary care providers can better support women to make decisions about and reach their preferred services for unintended pregnancy.

Keywords: abortion, early pregnancy, healthcare access, primary care, reproductive health, rural health, unintended pregnancy, woman-centred care.

Received: 28 June 2022
Accepted: 28 September 2022
Published: 26 October 2022

Cite this:
Noonan A *et al.* (2022)
Australian Journal of Primary Health
doi:10.1071/PY22134

Introduction

An Australian national population-based survey published in 2016 reported rural women[1] are 1.4-fold more likely to experience an unintended pregnancy (Rowe *et al.* 2016); that is, a pregnancy that is unexpected, mistimed or unwanted (Finer and Zolna 2016). This is in the context of around one in three women in Australia experiencing an unintended pregnancy in their reproductive lifetime, of which one- quarter are unwanted (Taft *et al.* 2018). Deciding how to manage an unintended pregnancy involves considering two possible outcomes and associated reproductive healthcare pathways; continuing the pregnancy and antenatal care, or not continuing the pregnancy and abortion care. Pathways to antenatal and maternity health services in Australia are well established and supported

[1]This manuscript uses the word 'women', but the authors wish to acknowledge that people who do not identify as women also experience pregnancy and may also need abortion services.

by national policy (Council of Australian Government (COAG) Health Council 2019; Dahlen *et al.* 2022). There is no current equivalent for abortion care.

Rural women in Australia are entitled to the same rights to reproductive health care as their urban counterparts, yet in reality, barriers to accessing preferred health services, especially abortion, are disproportionate, complex and costly (Doran and Hornibrook 2016). In a study examining access, equity and costs of induced abortion in Australia, the strongest predictor of late presentation (beyond 9 weeks) was living ≥4 h from the abortion clinic (Shankar *et al.* 2017). Access barriers are well documented in relation to abortion care in Australia (Dawson *et al.* 2017; Hulme-Chambers *et al.* 2018; Fix *et al.* 2020; Ireland *et al.* 2020; Cashman *et al.* 2021; Mazza *et al.* 2021); however, little is known about the role of local generalist primary care providers in rural settings as the first point of contact for women seeking advice or services for unintended pregnancies.

As abortion has been decriminalised in all states and territories in Australia (Subasinghe *et al.* 2021), politico-legal barriers no longer inhibit providers in freestanding clinics, hospitals or primary care to deliver abortion services. Before 2013, surgical abortion was the main option available. The subsidisation of the combined mifepristone and misoprostol medication (MS 2 Step) under the Pharmaceutical Benefits Scheme (PBS) has enabled expansion of early medical abortion (Dawson *et al.* 2017). The availability of medical abortion through primary care (and more recently at-home telehealth services) is being recognised as an important way to reduce inequity of access to abortion services (Mazza *et al.* 2021). As a result, primary care providers are more involved than ever before in supporting women managing unintended pregnancy.

The increase in options for abortion care is potentially a positive step for rural women who have limited access to specialised services based in large urban centres and rely on a rural generalist model of health care (Australian Institute of Health and Welfare 2019; Malatzky and Hulme 2022). Yet, chronic workforce shortages and high staff turnover in the rural Australian healthcare system mean that primary care services can be sporadic, with long wait times, sometimes up to 6 weeks, for patients to secure appointments (Doran and Hornibrook 2016; Sivertsen *et al.* 2022). For something as time critical as abortion, this heightens the importance of rural primary care providers having sufficient knowledge and expertise to meet women's needs. In this study, we explore through in-depth interviews how women living in rural NSW experience managing an unintended pregnancy, including their expectations of local primary care providers, preferences and priorities, and satisfaction with the services they received.

Methods

Recruitment strategy

Participants were recruited through online social media posts on Facebook community noticeboards of regional cities and towns across Central to Far West NSW from July 2021 to February 2022. Approvals were sought from the administrators of over 20 different Facebook rural community noticeboards prior to the posts. Additional strategies included local radio interviews, endorsement by rural social media influencers and posters in women's health clinics in the region.

Participants were invited to text 'Yes Hear My Story' to a member of the research team. Those interested were then sent the Information Statement and consent form and the interview was organised.

Interviews

Participants were interviewed via phone or video conference. The duration of interviews ranged from 30 to 80 min. To be eligible for the study, participants had to have experienced an unintended pregnancy (irrespective of pregnancy outcome) in the past 5 years, and live or have lived in Central to Far West rural NSW during that time. All recruitment materials were produced in the English language only.

The semi-structured interview guide is available in Appendix A in Supplementary File S1.

Data analysis

All interviews were audio-recorded and transcribed verbatim for thematic analysis. Names of people, locations and health providers were removed to protect confidentiality of participants, particularly given the increased possibility of re-identification in a specific rural community.

A working analytical framework was developed after interim analysis of the first 10 transcribed interviews, in accordance with the seven stages of the Framework Method (Gale *et al.* 2013). Interview transcripts were read and coded independently by two members of the research team (AN, JT) after 10 interviews were conducted, and four additional questions were subsequently added to the interview schedule to explore emergent themes. The same process of cross coding was undertaken again with the following eight interview transcripts, by which stage consensus was reached on the data analysis. With no new themes arising in the final two interviews, the researchers agreed that data saturation had been achieved. Identified themes were cross-checked by researchers, GL and KB, and consensus was reached by the entire research team on thematic results.

All data were then imported into NVivo (QSR International) for indexing, final review of all transcripts and data management.

Ethics approval

Ethical approval for the study was granted by the University of Sydney Human Research Ethics Committee (HREC 2020/194). All participants provided full and informed consent prior to joining the study.

Results

Participant response rate

Of a total of 24 individuals who expressed interest in participating, all except one met the eligibility criteria, and three did not respond after eligibility confirmation. Thus, 20 participants were interviewed from July 2021 to February 2022.

Characteristics of the participants

Study participants came from various regional, rural and remote locations in NSW and diverse socio-economic and educational backgrounds (Table 1). All participants were born in Australia. In addition, all participants identified as being women, and three participants identified as being Aboriginal.

Table 1. Socio-demographic characteristics of study participants.

Participant characteristics (n = 20)	N
Age (years)	
Range	22–40
Median	32
Pregnancy outcome	
Abortion	10
Medical|surgical	*8|3*[A]
Birth/continued pregnancy	10
Remoteness area by postcode[B]	
Inner regional (RA2)	9
Outer regional (RA3)	6
Remote (RA4)	1
Very remote (RA5)	4
Education level	
Did not complete secondary	1
Secondary	1
Vocational (TAFE Cert/trade cert)	3
Tertiary/University degree	15
Time spent living in rural area	
Between 1 and 5 years	2
Between 6 and 15 years	9
All my life (>15 years)	9
Socio-economic status (SEIFA ISRAD)[C]	
Quintile 1 (least advantaged)	7
Quintile 2	7
Quintile 3	6
Quintile 4	0
Quintile 5 (most advantaged)	0

[A]One participant had two attempted early medical abortions then had a surgical abortion.
[B]Remoteness is categorised using the Australian Statistical Geographic Standard (ASGS) Remoteness Areas (2016). Source: Australian Bureau of Statistics (2022).
[C]SEIFA ISRAD is an abbreviation of Socio-Economic Indexes for Areas (SEIFA), Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). Source: Australian Bureau of Statistics (2016).

Findings

This study explores the experience of 20 Australian women in managing an unintended pregnancy in a rural health setting. Four participants stated they knew immediately that they would continue the pregnancy, and shared their experiences seeking antenatal care. Of the remaining 16 participants, all considered abortion as a possible option for their unintended pregnancy. Six of these 16 participants ultimately decided to continue the pregnancy, whereas 10 ended up choosing and seeking an abortion.

Three main themes were identified from the data. These were: (1) women expect informed and efficient care once services are reached; (2) women desire greater choice and aftercare; and (3) comprehensive reproductive health should be part of rural primary care. The first theme described the expectations that the participants had about the availability of services within the rural health setting and the quality of these services once reached. The second theme focused on participants' articulation of their healthcare preferences and how well these were met during their experience. The final theme described participants' experientially informed desires and ideas for improvement of reproductive health services in rural primary care.

Theme 1. Women expect informed and efficient care once services are reached

Almost all participants sought initial health advice from a local GP for their unintended pregnancy. Almost all participants also expressed awareness of the characteristics of the rural health system in Australia, in particular, the reduced number of local health services compared to the city. Securing an appointment to see a specific GP with expertise in women's reproductive health – or simply a female GP – was not easy and often involved long wait times.

One participant said, 'Getting in to see the GP that you want to see can be impossible. The GP that I ended up seeing now, she normally has at least a six week wait…' (RW002) Continuity of GPs was also raised, with one participant saying, 'We have a rolling cascade of doctors, I guess, because people come out and do their one or two years in rural, and off they go'. (RW010)

Another participant said at the time of her unintended pregnancy, 'we only had one GP in town that was accredited to prescribe the medical termination pills and he wasn't here all of the time either, so you sort of had to catch him on his whatever two weeks . . . ' (RW007)

Although inconvenient, these delays in accessing GPs did not come as a surprise, given almost all participants had lived in rural locations for >5 years.

However, for one participant who had recently moved to a rural location when she discovered she was unexpectedly pregnant, finding a rural GP who would see her was a struggle. She said:

> There isn't any women's health clinic around, and I've actually found finding a GP so difficult, and very stressful, because it's really hard to get in – like if you're trying to find a new GP, everyone seems to be full and they're not taking any new patient. would have rang [sic] about 10 different GPs in different towns, up to 100 kilometres away from me, and they either said, you're far away, we can't take you on, our books are full. Yeah, it was just so hard. (RW019)

Over half the participants did express their dissatisfaction, and in some cases, shock and dismay, that after withstanding delays to enter the local health system, it then failed to meet their needs. In particular, participants described interactions with healthcare providers who were unprepared or seemingly unwilling to provide information or advice. This was particularly the case for participants seeking pregnancy decision-making support or advice about available abortion services.

One participant who was not sure what to do with her pregnancy and wanted advice about pregnancy options said, 'I feel like if you're a GP you probably – having people coming in when they're pregnant would probably be a thing that you would be prepared for. So that kind of threw me that she was so uncertain, she seemed so uncertain about what to tell me'. (RW002)

Another participant expressed her surprise and frustration at not being able to get the answers she was seeking from her local GP. She said, 'My first doctor that I had an initial consultation with didn't really have any answers for me and she had to go and speak to another doctor and find information before she came back to me'. (RW004)

For another participant, the doctor's unwillingness to assist her beyond a pregnancy test for a possible abortion, or provide her with a referral, caused significant distress. She said, 'that's what actually kind of set me off on a bit of a just absolute kind of shock spiral because I just thought, you think when you go to a GP that you'll get the help and referral and advice that you need'. (RW005)

Yet, another participant who did not feel comfortable asking direct questions of a GP wanted clear information about her options but didn't get it. She said, 'I just wish that somebody had given me a pamphlet or something that had all this information in it, so that I could go and research it and access it and make that really informed decision'. (RW019)

Conversely, one participant said she felt initially affronted when her local GP mentioned abortion, but was subsequently glad that she did. She said, 'At first I was a little like, oh I feel like she was kind of like, just have an abortion. But then afterwards when I came home and thought about it, I was like, actually she's the first doctor that I've ever been to that at least has mentioned it'. (RW014)

The time-consuming process of finding local health services that had adequate expertise intensified the sense of time passing, and the pregnancy progressing, for at least half the participants. Participants seeking an abortion expressed a desire for efficiency; for the process to occur swiftly and cause minimal disruption to their lives. Several also voiced concerns about the stress of running out of time to have a medical abortion, especially when surgical abortion meant travelling long distances and incurring higher expenses.

One participant described the situation in this way;

> I'd kind of used up about a week in between seeing that first – well it may have been even like two weeks in between seeing that first GP, not really knowing what to do, going and doing the test, confirming that I was pregnant and then finding out about the women's health clinic and then getting an appointment there. So, by this point I was kind of already at like six weeks, so it was starting to get quite time critical. (RW005)

Another participant said, 'I was stressing out, thinking, I don't want to get to the point where I'm too far along, and then it's just going to be such a harder process'. (RW016)

The stress caused by the combination of first seeing a local GP, then waiting for appointments to meet the criteria for an at-home telehealth abortion, and then waiting for the abortion medication to arrive was described in detail by one participant. She said:

> I was eight weeks when it finally – because you're waiting for the medication. It gets really desperate... the further along that you get, you can't have a medical termination by a certain point, you have to go and have a surgical. I was petrified of the thought of a surgical, because the whole thing just – no, I don't really want somebody scraping out my uterus, that just freaks me out. (RW001)

Theme 2. Women desire greater choice and aftercare

In telling their stories, participants articulated their preferences and priorities for health services, whether that be for abortion or antenatal care, and how well these were met in their experience. The ability to make choices about

abortion services was voiced not only by those participants who had an abortion, but also by those who did consider an abortion but ended up continuing the pregnancy.

For some participants, receiving information from a healthcare provider about all possible options for abortion services was of utmost importance. This not only helped them find the services they needed, but it also meant they were able to explore and discuss their options in a confidential setting.

One participant spoke of her reliance on the local GP's knowledge of appropriate referral pathways for an abortion. She said, 'When my GP said, oh, talk to these people, I think even if they'd treated me like rubbish, I would have had no choice, because I wasn't going to – I know that some people do post [questions] on Facebook, but I was really trying to keep that to myself'. (RW001)

Another described discussing her options with a women's health nurse after being turned away by a local GP. She said:

> What she was saying was the only option I had was to do the at home – oh what's it called – medical termination . . . I'm pretty sure she said that the surgical termination is not available there unless it was an emergency, or something had gone wrong. So, it was kind of like that was the only option or I think I was going to have to get sent to either Adelaide or Mildura. (RW005)

Although personal preferences varied, the participants also emphasised being able to choose the abortion method that suited them the most, rather than accepting the only option that might be available locally but that did not necessarily meet their needs.

For example, one participant spoke about the convenience of early medical abortion and its positive impact on her experience. She said, 'the shining light was, was the fact that we could go through something that wasn't as invasive, we could be at home with the kids and sort of be in control of the situation'. (RW016)

Conversely, another participant felt she was not offered the possibility of an early medical abortion (EMA). She said:

> I wasn't offered any medication that could cause a chemical termination I think it's called. Because I was so early on in my pregnancy, I could have been offered that but at no point did anyone offer that to me. Yeah, and I was pretty disappointed. (RW009)

For others, it was the choice of where the service was provided, with some participants wanting local services, others preferring to travel to avoid inadvertent exposure of their pregnancy in a small community, and others favouring the convenience of telehealth.

One participant said, 'I was happy with the medication, yeah. Yeah, I would have felt uncomfortable – because again I worked at my local hospital – to go and get that procedure done here'. (RW018)

Another participant said:

> I think having alternative options is really important because any rural – any township in a rural and remote area – everyone's going to know everyone and you know even having the option where you could refer to someone in a different location but things [sic] being done by telehealth just to allow for that confidentiality. (RW009)

Another said that an early medical abortion via telehealth meant she could stay on her remote property without travelling huge distances or spending at least a week away from her farm duties and finding care for her children. She said, 'there was just no option to go to the city'. (RW003)

Among those participants who continued their pregnancy, several described feeling frustrated at the limited options available for local antenatal care, especially for higher risk pregnancies.

One participant who wanted but could not receive antenatal care in her local town said, 'Honestly, it's a little bit frustrating. I get that we only have small hospitals here and we can only manage certain things. But things that restricted me, if everything was normal, from having a pregnancy here was my BMI was too high, so that already ruled me out'. (RW006)

Yet, another participant was disappointed her local GP did not offer any alternatives other than referring her to the local hospital. She said, 'There was no talk on alternative ways such as home birth, or any information about accessing other services, such as doulas, any private doulas or anything like that. It was just the generic go through the public system and here's the number, off you go'. (RW019)

Another described how her own experience of feeling unable to make choices about her care during a complicated pregnancy and labour had motivated her to encourage other women in remote areas to make sure their choices were heard. She said:

> So since all of that I became quite an advocate in [remote town] for pregnant women and would sort of talk to them about, how are you going to have this? Let them know that you can speak up, you can talk about it. If you're not comfortable with something say it, that's okay.' (RW017)

A more comprehensive approach including follow up or aftercare, both physical and psychological, was desired by at least eight of the participants, including one who continued her pregnancy.

One participant suggested 'to have the option of going to have that chat [referring to pregnancy decision- making support] and just say, hey, I'm not doing too good, but I'm

okay on my decision, but I just feel like I need to talk to somebody' (RW015) might be helpful to some women.

In contrast, however, another participant felt well supported by the nurse providing her care, but noted that this support was not part of the package of services for abortion, just the willingness of one primary care provider to go the extra step to provide better aftercare. She said, 'I'm pretty sure I had the nurse's personal mobile because she gave me her mobile number to ring her if anything went wrong ... she was amazing, the service was amazing in that regard, but I just mean in terms of the structure of it just didn't seem like it had structure'. (RW005)

For one woman who chose to continue her pregnancy but had mixed feelings about it, the emphasis on celebrating a pregnancy by family and friends caused her significant stress. She said, 'I think that women who go through to get a termination might have some access to some mental health care, which I didn't really get. In retrospect, probably would have helped me at the time'. (RW002)

Another participant who continued her pregnancy felt that more aftercare should be provided to women after birth. She said:

> I feel like every woman that gives birth should – I guess you can't make it mandatory, but it would be nice if they had a mandatory five sessions with a social worker or a psychologist, just to process things that do come up, or just to talk through what happened and everything, because I have spoken to other mums, and these things, it's such a big thing to go through, it's such a shock to your system. (RW019)

Theme 3. Comprehensive reproductive health should be part of rural primary care

All participants, irrespective of their personal choices for their unintended pregnancy, stated that abortion services should be part of mainstream rural health care and readily available to all women who need them. Primary care was mentioned by seven participants as an appropriate setting for these services.

For example, one participant said, 'you'd think in this day and age it would be something that a GP would be able to prescribe'. (RW013)

Another participant voiced her frustration at the pervasive stigma about abortion, including among healthcare providers. She said, 'Termination is not taboo. Termination is not illegal, so it should be something that is just up front as much as getting your flu shots'. (RW015)

One participant posed the following scenario as a solution for the future:

> I think the first thing would be just those women's health clinics where they can at least do the medical termination and at least access all of that, I think that would be just the bare minimum of what should be available, but ideally there should be some sort of system where people can get access to the surgical one without paying and things like that or paying to drive somewhere. (RW005)

Other aspects of reproductive health, such as finding a suitable contraceptive, also remained challenging for most participants. Some spoke of the need for more comprehensive information from rural primary care providers to help them identify options that best suited their needs.

One participant reflected upon the different experiences seeking advice about contraception in the city and in a regional town. She described this in the following way:

> I remember GPs in the city loving talking about reproductive health and contraception options ... Yeah and that being like a conversation that they were keen to have. Rather than me struggling to initiate it and then – and it taking a lot of effort from me to find the answer. (RW002)

Another participant expressed her frustration at the limited options she felt were available to rural women. She said:

> When you're talking about rural women who, if they go to their GP and they're like, contraception, what are my options, the GP says, well, you can take the pill or you can get an IUD, that's basically it now. Women go, well, I don't want to take something that's going mess up my body and I sure don't want a – as I said – fishhook inserted into my uterus, so I guess that we'll just wing it. That's what happens. (RW001)

This sentiment was shared by another participant who said, 'I was interested in contraceptive options that were non-hormonal and I was told that that wasn't really available out here so that's possible what led to the first unintended pregnancy anyway'. (RW007)

Discussion

In this study, 20 women from rural NSW shared in detail their experiences of managing an unintended pregnancy in a rural primary care setting. Four participants spoke of their immediate intention to continue the pregnancy. The remaining 16 participants described their experiences and expectations of the rural health system in terms of the availability and quality of services for early pregnancy decision-making support and abortion. Having limited access to primary care appointments was already known as a characteristic of rural life for all but one participant. However, more than half the participants expressed their dissatisfaction with the inability or unwillingness of rural primary care providers to offer pregnancy decision-making

support and abortion services once they were finally reached. With abortion care being time-critical, this gap in provision of rural health services is problematic. Time efficiency, choice about which services were most suitable to their personal circumstances, and the importance of receiving aftercare were the three improvements our participants identified the current system requires. Finally, participants also shared their hopes for reproductive health to be better integrated into rural primary care; where abortion would be part of mainstream health services, and better contraceptive options available to rural women to prevent more unintended pregnancies.

Other studies in rural Australia have focused on women's experiences of abortion services once reached and the perspective of service providers about the delivery of care, including provision via telehealth (Doran and Hornibrook 2016; Dawson *et al*. 2017; Hulme-Chambers *et al*. 2018; Fix *et al*. 2020; Ireland *et al*. 2020; Cashman *et al*. 2021; Mazza *et al*. 2021; Malatzky and Hulme 2022). These studies have also found results similar to ours, that multiple systemic challenges exist for rural women when accessing services. Our study findings demonstrate that rural women have sound knowledge of the structural limitations of the rural health system; however, their clear message was that they expected health service providers to be well informed and able to respond to their reproductive health needs when required.

Australia's Commonwealth Department of Health has mandated 'Woman-centred care' and the associated values of access, choice, safety and respect, as a national strategic priority for improving antenatal and maternity health care in Australia (Council of Australian Government (COAG) Health Council 2019). With roots in feminist principles and midwifery, woman-centred care seeks to reposition women at the centre of decision-making about their care, and to respond to a woman's individual needs and circumstances during pregnancy and birth (Rigg and Dahlen 2021; Dahlen *et al*. 2022). Yet, the current strategy does not include those women wishing to seek advice about pregnancy options, including abortion, in early stages of pregnancy. Equitable access to abortion is also mentioned in the National Women's Health Strategy 2020–30 as a key measure of success in women's sexual and reproductive health (Australian Government Department of Health 2019). Yet, our study findings demonstrate that access to abortion is not the sole issue for rural women managing unintended pregnancy.

Rather, the missing link is how to translate these policies into a rural health workforce that is supported to train in and deliver informed and efficient woman-centred care, irrespective of the pregnancy outcome. Rural women's experiences in this study still reflect a health system that is yet to fully adapt to or embrace these ambitions. Change will require a multi-pronged approach. First, it will require upskilling, encouraging and supporting primary care providers to incorporate abortion services as part of their regular scope of practice, and inclusion of abortion in the rural generalist medical curriculum. Second, nurse or midwife-led models of abortion care need to be explored further as a feasible alternative or additional service provision pathway for rural women, particularly in areas where GPs are hard to reach, overburdened, unable or unwilling to offer these services themselves. Finally, any improvements must include input from rural women themselves – the consumers of these services – to ensure local primary care services meet their needs and expectations.

Limitations of this study

There are several limitations of this study. First, given its geographic specificity to Western New South Wales (NSW), the findings of this study are not representative or generalisable, but only reflect those experiences of participants with access to NSW-based services. However, our successful community-based recruitment strategy enabled an exploration of women's interactions with multiple services, as well as the experiences of not being able to find care. This provides a different view of the primary care setting in rural areas than studies recruiting participants from a point-of-care. The diversity of voices, varied degrees of geographic remoteness and socio-economic backgrounds of participants are strengths of the study.

Conclusion

In rural Australia, the primary care community of GPs and women's health nurses are the crucial first point of contact for the often-urgent need for pregnancy decision-making support and abortion services for women managing unintended pregnancy. This study demonstrates the salience of woman-centred care and its values of safety, respect, access and choice as a rights-based framework that can help guide improvements in service quality and woman-centred care for all women at all stages of pregnancy, no matter where they live.

Supplementary material

Supplementary material is available online.

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Data availability. Due to the requirement to protect confidentiality, data used to generate the results of this study are not available. The data that support this study cannot be publicly shared due to ethical or privacy reasons.

Conflicts of interest. The authors declare no conflicts of interest.

Declaration of funding. This research was supported by a PhD scholarship awarded to the first author by the SPHERE Centre for Research Excellence in Sexual and Reproductive Health for Women in Primary Care, which is funded by the National Health and Medical Research Council (APP ID 1153592).

Acknowledgements. We thank all the rural women who participated in this study for their willingness to share their personal stories, for their generosity of time, and for their support for research.

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