Understanding models for delivering sexual health services in rural Victoria

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Prepared by:
Alana Hulme Chambers, PhD
Centre for Excellence in Rural Sexual Health
Department of Rural Health
With notification rates of sexually transmissible infections (STIs) continuing to rise in Australia, improving access to sexual health services is important as part of a comprehensive STI control strategy.

In the Victorian context, sexual health services are delivered in a range of settings with the majority of services located in urban areas. There is little research about rural sexual health service models, which could be useful to those seeking to establish such a service, particularly in a primary health context.

The aim of this project was to explore and compare different models for sexual health service delivery, in the primary health context, in rural Victoria in order to understand how different sexual health service models work, for which population groups, and in what contexts.

A multiple case study design was used to plan a project that would incorporate the perspectives of service delivery professionals and sexual health service clients. Sexual health service nurses working in three different service models were invited to participate in semi-structured qualitative interviews (n=4). The aim of these interviews was to gain a rich and in-depth understanding of each sexual health service. Surveys were undertaken with consenting clients from two of the sexual health services. The purpose of the surveys was to gather data from the client perspective about important elements of sexual health service delivery.

Findings from the interviews with the sexual health nurses indicated the importance of factors that relate to structural elements of service delivery. These include:

- Strong organisational understanding and support for the service,
- Adequate funding for service delivery
- Location in a setting that makes it as easy as possible for clients to access the service
- Flexibility in service delivery so that nurses are able to respond appropriately to fluctuations in service demand.
- Good connections to a range of other sectors and services in terms of cross-service and/or sector referrals, timely service delivery, and advocacy for the service by external supporters.

Clients of the sexual health services indicated the following aspects of sexual health services were important to them:

- Low/no cost service provision
- Caring, non-judgmental staff
- Suitable location in terms of opening hours, accessibility to public transport
- Private and confidential service provision

For organisations seeking to establish a rural sexual health service, the findings of this project indicate a number of issues that need to be considered in relation to organisational understanding of sexual health as an important health issue, staffing of a sexual health service, location of a service, and service funding.

This project has provided a rich insight into different service delivery models and the lived experiences of nurses delivering services as well as those of service clients, and what is important to them. Their perspectives have allowed the development of a range of considerations that will be useful to other organisations, stakeholders and communities seeking to improve access to sexual health services in their communities.
Notification rates of syphilis, chlamydia and gonorrhoea continue to rise in Australia (Kirby Institute, 2017). Sexually transmissible infections (STIs) have health, social, and economic implications at individual, community and societal levels (Dune et al., 2017). A comprehensive STI control strategy includes targeted community-based interventions, promoting and providing prevention measures, adequate partner notification systems and accessible and effective clinical services within an enabling environment (Steen et al., 2009).

Sexual health services are an integral part of a comprehensive STI control strategy. Understanding how different service delivery models operate is important for ensuring services that are accessible and equitable. There are a number of ways that sexual health services can be delivered and a number of factors to consider in service delivery such as service provider and setting in which services are delivered. Practice nurses have been recognised as capable and appropriate sexual health service providers, however they are often underutilised in this regard (Abbott et al., 2013). Service location is important, especially for populations who have less access to public transport (Olsen et al, 2012). Sexual health services that respond to needs of particular groups, such as young people, in appropriate ways are more likely to be acceptable to communities when communities are educated about the need for the service (Denno et al., 2015).

In the Victorian context, sexual health services are delivered in a range of settings including sexual health-specific services in standalone locations, in general practice, within community health services and family planning services. In addition, outreach services exist for a range of population groups including young people in schools, and homeless populations. Sexual health services within primary healthcare settings in regional areas are relatively uncommon, with around seven such clinics servicing around 1.4 million regional Victorians (Australian Bureau of Statistics, 2016).

There is little research about rural sexual health service models. However, in rural areas there are fewer GPs, rural sexual health services are fewer in number, and rates of STI infections in rural areas are higher (Schofield et al., 2012; Yeung et al., 2014). This may be due to a range of factors including geographical location, limited choice of health care professionals, concerns about confidentiality and stigma, acceptability of the existing service, and cost. These factors are all linked in some way to models of sexual health service delivery (Cox, 2011; Tomnay et al., 2014).

The aim of this project was to explore and compare different models for sexual health service delivery, in the Victorian rural primary health context, in order to understand how different sexual health service models work, for which population groups, and in what contexts.
The aim of this project was to articulate how rural sexual health service delivery models operate in order to identify key considerations for organisations seeking to establish such services.

Three key questions guided this study:
1. How do rural sexual health services differ in operation?
2. What are the critical elements for effective operation from both the clinician and client perspectives?
3. What are the implications for others who want to establish a rural sexual health service?

The overall philosophical framework for the research design and site selection methodology was guided by pragmatism. Pragmatism is a research philosophy that provides a link between quantitative and qualitative research whilst focusing on producing research that is practical, actionable and useful in real world settings (Johnson and Onwuegbuzie, 2004; Sharp, 2016). Some of the strengths of pragmatism include acknowledging the importance of the physical world as well as the cultural and psychological worlds in which people exist, and a preference for action over philosophising (Johnson and Onwuegbuzie, 2004).

Case study design
A multiple case study design was selected as a means for answering the research questions. Case studies have been noted as offering a flexible and practical research approach within clinical settings (Payne et al., 2007).

Case study design enabled in depth examination of three deliberately-selected rural sexual health services to explore similarities and differences between service delivery models, and learn more about the contextual conditions that were pertinent for each service’s operations (Yin, 2003). This decision to undertake purposeful sampling was made in line with the philosophy of pragmatism: the services approached for invitation into the study were done on the basis that each provided a descriptively rich and comparative perspective of rural sexual health service delivery (Anaf et al., 2007). Further, the audience for this research was intended to be organisations, funding bodies, and policy makers with a stake or interest in rural sexual health service delivery. As such, the research needed to be credible, practically useful and relevant to these audiences (Patton, 2002). Finally, the research needed to be gathered within time and budget limitations; choices that need to be accounted for in the description of a research design (Emmel, 2013).

A mixed methods sequential exploratory design was selected to guide data collection relating to each case study site as multiple data sources enable particular perspectives from which to understand the phenomenon under study (Bryman, 2006; Sharp et al., 2012). This approach was based on the research questions and the desire to understand the operations of each service from the viewpoints of both service providers and clients. Neither data had priority; both were equally important sources of information by which to address the research questions (Bryman, 2006).
Research participants

Sexual health service nurses from each site were invited to participate in semi-structured qualitative interviews (n=4). The aim of these interviews was to gain a rich and in-depth understanding of each sexual health service. Questions focused on each service’s historical beginnings, a typical working day, and barriers and enabling factors to service delivery. In addition, a more quantitative component was conducted at the end of the interview process where each participant was asked about key organisations and or professionals with whom they regularly worked with in order to deliver an effective sexual health service. This portion of the interview involved working through a comprehensive stakeholder checklist of every organisation within the health, education and welfare sector located within a 100 kilometre radius from each sexual health service and the participant saying whether they worked regularly (with regular to mean weekly, fortnightly or monthly) with any of those organisations. The aim of this process was to better understand who nurses worked with most often in relation to sexual health service delivery.

Interviews were audio recorded, transcribed and coded using a qualitative analysis program (QSR-NVivo, v10). In the early stages this was an inductive coding process, looking for possible patterns and themes in the data (Patton, 2002). Two members of the research team undertook this process independently. Once these patterns and themes were compared, and discussions were had around the small number of instances where coding had differed, the data was then analysed by the lead researcher using a deductive process, where the themes and patterns were compared to the interview question themes. This process was done manually and without computer software to enable the lead researcher to feel confident in her understanding of the data. Data from the stakeholder checklist was quantitatively categorised into sectors using Excel, which enabled insight into which sectors, and organisations in those sectors, participants interacted with most often, as a means of gathering data to answer all three research questions.

The quantitative phase of the data collection process involved surveying consenting clients from the two non-mobile sexual health clinics, Ambler and Pottsville sexual health clinics. The nurse from Hillside sexual health clinic felt that this process would be very difficult to undertake in a mobile environment and declined to participate in this section of the study. The purpose of the surveys was to gather data from the client perspective about important aspects of sexual health services. The survey phase consisted of two survey collection periods, each four weeks in length. The first was from February - March 2016, and the second was March - June 2016. The nurses from these clinics provided each client aged 16 years and over with a plain language statement about the study. Those clients who consented to participate were provided with a closed-ended, anonymous survey that comprised 10 questions. Question topics included: reasons for using health services, barriers and enablers to service use, most important aspects of clinical service provision, services used most often for sexual health service provision, reasons for using the sexual health service, and basic demographics.
Consent was obtained by clients ticking a box about consent on the front of the survey. Clients were provided with a private area in which to complete the survey, and in this area was a sealed box in which to deposit it. At the end of the survey period, 44 surveys from Ambler clinic clients and 32 surveys from Pottsville clinic clients were completed (n=76). The sexual health clinic client survey data was analysed using SPSS (v22) to generate descriptive statistics in order to understand general trends in the quantitative data.

**Data analysis**

With a mixed methods research process, data analysis can occur at either a single or multiple points in time (Creswell and Plano Clark, 2011). In this study qualitative and quantitative data was analysed separately and then considered together to understand how each data set supported or challenged the others in relation to the research questions. As the intention was to build a broad picture of sexual health service delivery, this was an appropriate way to consider the different data sets as well as minimising any potential validity threats in connecting the data (Creswell and Plano Clark, 2011).

Ethics approval was received from the University of Melbourne Human Research Ethics Committee (1443439.2).
Interview findings

Four sexual health nurses agreed to an individual interview. Nurses were asked to describe the sexual health service delivery model in which they worked, and the key enablers and constraints in delivering sexual health services. The following section outlines the three distinct sexual health service delivery models. Each case study has been de-identified to protect the confidentiality of the services.

Sexual health service case studies

Sexual health service 1: “Pottsville Sexual Health Clinic” (PSHC)

Pottsville sexual health clinic (PSHC) is located in Pottsville, a regional town with a population of nearly 40,000, located approximately 250 kilometres from Melbourne, the capital city of Victoria. Pottsville is characterised by a history of social disadvantage, with a significant percentage of social housing in relation to total dwellings, a high percentage of one-parent families, and a suicide rate higher than the Victoria average (Victorian Department of Health, 2013).

PSHC is located in the Pottsville Community Health Service alongside a general medical practice, dental clinic, and allied health, mental health and health promotion services. PSHC has been operating for nearly seven years and is a bulk billing, nurse-led clinic. There are two part-time female sexual health trained nurses, Annabel and Tessa, who together comprise one fulltime position, which is state-government funded. A general practitioner (GP) from the bulk billing medical clinic located in the community health service supports the nurses and leads the provision of services outside of the nursing scope of practice, four days per week. PSHC is a very busy clinic offering services including sexual health screening, testing, contraception, counselling and medical termination of pregnancy (MToP). MToP demands much of the nurses’ time as service demand is high; on some days MToP consultations impact on the capacity to offer walk-in services to people without an appointment. In addition, the PSHC nurses are in demand from local schools to provide outreach sexual health information and education as well as undertake administrative work associated with providing clinical results and client follow up information.
Sexual health service 2: “Ambler Sexual Health Clinic” (ASHC)

Ambler sexual health clinic (ASHC) has been operating in Ambler for just under a year. Originally a women’s health clinic located within the Ambler District Health Service, ASHC is now operating as a sexual health service in its own right, providing a broader suite of clinical sexual health services.

Ambler District Health Service (ADHS) is a primary health service that has been operating for many years in Ambler, a regional town with a population of around 27,000, located approximately 250 kilometres from Melbourne. Ambler has a mixed socio-economic profile. The most common occupations are professionals and tradespersons, and over 50% of the population is employed fulltime (Australian Bureau of Statistics, 2011).

The percentage of social housing in relation to total dwellings is higher than the Victorian average, as is the suicide rate in Ambler. However, the percentage of one-parent families is the same as the Victorian average (Victorian Department of Health, 2013).

Community, allied health and health promotion comprise the main services delivered by Ambler District Health Service, in addition to a bulk billing medical clinic. ASHC is a nurse-led clinic with two part-time female sexual health trained nurses, Jane and Melanie, comprising a fulltime workload that is state-government funded. Like PSHC, there is one GP in that supports the sexual health nurses. As a relatively new sexual health clinic, the workload for ASHC is not frantic at this point in time. This enables the nurses to not only meet the clinical workloads including sexual health screening, testing, contraception and health promotion and education, but to also provide an outreach clinic in a neighbouring smaller town and in a local secondary school, on a weekly basis. ASHC has recently commenced offering MTOP.
Sexual health service 3: “Hillside Sexual Health Clinic” (HSHC)

Hillside sexual health clinic (HSHC) is a mobile clinic, with no fixed physical location, that has been operating for around six years and is state-government funded. Led by a female sexual health nurse practitioner, Grace, who is employed on a fulltime basis by a large regional health service, HSHC operates from a variety of locations in different towns including mental health, housing and community health settings. HSHC operates across a large geographic area with some locations being up to 100 kilometres away from the regional town where HSHC is based. Most of the locations that HSHC travels to are socio-economically disadvantaged and in recent years have experienced a loss of agricultural sectors that have traditionally provided employment, as well as debilitating environmental conditions including drought. These towns have experienced reduced services as economic prospects and, subsequently, residents, have moved away. Public transport to these smaller towns is almost non-existent.

The services offered by HSHC include sexual health screening, testing, contraception, counselling and referral to MTOP providers. A key role for the nurse practitioner has been to develop and maintain effective linkages and referral pathways with various local GPs and gynaecologists so that clients experience timely and appropriate referral for services outside of the nurse’s scope of practice. The client profile for HSHC varies dramatically depending upon where the service is based on a particular day and may range from school-based young people to sex workers. In addition to the clinical services offered, the sexual health nurse practitioner undertakes a great deal of health promotion and education within schools and settings where young people congregate. This is often delivered in collaboration with other community and welfare services as a means for integrating services for the benefit of clients.
Key stakeholder connections

Nurses were asked to identify their key stakeholder connections across a range of different sectors. Stakeholders were defined as people that nurses connected with regularly in relation to sexual health service delivery including clinical service delivery, referrals, and giving talks and presentations. Table 1 below outlines the connections each sexual health service had across different sectors.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Pottsville SHC</th>
<th>Ambler SHC</th>
<th>Hillside SHC</th>
<th>Total number of connections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>44</td>
<td>10</td>
<td>27</td>
<td>81</td>
</tr>
<tr>
<td>Education</td>
<td>12</td>
<td>1</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Welfare</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Government</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>63</strong></td>
<td><strong>11</strong></td>
<td><strong>33</strong></td>
<td></td>
</tr>
</tbody>
</table>

Key findings from this identification of key connections are:

- Of all clinics, Pottsville SHC reported the most connections.
- Overall, the most connections for all sexual health clinics were with health sector stakeholders. Of these:
  - The most common connections were with sub-regional general practices. These are general practices serving catchments of between 10,000 and 30,000 people.
  - The next most common connection reported was with small rural general practices serving catchments of between 5,000 and 20,000 people.
  - The third most common connection was to local and small rural health services serving catchments of between 5,000 and 20,000 people.
- Pottsville SHC reported the greatest number of stakeholders in relation to sexual health service delivery.
- In relation to education, the most common connections were with sub-regional secondary schools.
- Welfare sector connections were infrequent and were to sub-regional youth and welfare services.
- Government connections were few and were with local government or local department of health offices.
Key constraints and enablers to sexual health service delivery

In addition to describing their service delivery model and key connections, sexual health nurses were asked to identify the key enablers and constraints to delivering sexual health services. Overall, nurses identified more enablers than constraints (see Table 2). The following section outlines these findings in more detail.

**Table 2: Key constraints and enablers to sexual health service delivery**

<table>
<thead>
<tr>
<th>Constraints</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal</strong></td>
<td><strong>Internal</strong></td>
</tr>
<tr>
<td>Funding</td>
<td>Collegial and management support</td>
</tr>
<tr>
<td>Lack of organisational understanding about role</td>
<td>Flexibility to respond to service demand</td>
</tr>
<tr>
<td>Spatial location</td>
<td>Monitoring of service quality</td>
</tr>
<tr>
<td>Funding</td>
<td>Good relationships with other services</td>
</tr>
<tr>
<td></td>
<td>Positive community perceptions</td>
</tr>
<tr>
<td></td>
<td>Support from CERSH</td>
</tr>
</tbody>
</table>

**Key constraints**

**Funding**

Funding was the main external constraint to service delivery discussed by sexual health nurses. They described a disparity between service demand and financial support, the implications for which included having to see more clients for no extra funding or trying to find time to source other funding streams.

“…the money stays the same regardless of the service you provide or…how many people are coming through your door” (Nurse A)

Funding was an ongoing constraint that appeared to loom over the nurses’ role, including in relation to their own employment sustainability.

**Lack of organisational understanding about role**

A lack of organisational understanding about the role of sexual health nurses was described as a key internal constraint to service delivery. Unlike other nurse-led services for more prevalent health conditions like diabetes, sexual health was described as a more niche health issue. Because of this, organisational colleagues knew little about the work undertaken by sexual health nurses, nor much about the context in which the nurses operated including who key stakeholders were, or understanding funding arrangements for different services involved in sexual health service delivery.

“We're almost a bit stand-alone...our managers, while they provide fabulous administrative support, they don't really understand the context of sexual reproductive health and blood born viruses, so it's very difficult for them to, I suppose, to go on our behalf to stakeholders... because they really don't, that's not the area they work in, they don't understand that context.” (Nurse A)
Spatial location

The location of sexual health service delivery was discussed by all nurses as an internal constraint, but an inconsistent one in that it did not constrain service delivery for all clients. Nurses discussed the potential for some young people to have difficulty in making contact with a service where an appointment was needed and operated within business hours. These young people were likely to have a range of issues relating to other determinants of health including housing and family support.

“...I think it [location] can also be a barrier sometimes for people - especially really vulnerable young people...” (Nurse B)

The sexual health nurse who worked in a service that operated out of a number of settings including a youth service noted that spatial location was less of an issue for her clients.

Key enablers

Collegial and management support

Support from management and colleagues was described as the key internal enabler to service delivery by all nurses. Support took the form of backfill if nurses took leave, support from clinical colleagues in relation to the nature of the work, and management being open to listening to and acting upon issues that constrained service delivery, including changing policies if needed.

“If I'm not there she [trained colleague] will see those clients, which makes me really happy again, and it's not having to find another wage” (Nurse C)

Nurses felt these forms of support were available because colleagues and management, despite having limited understanding of the nature of the work, appreciated the importance of the service for the clients and the need for that particular form of service provision to exist.

“...they [management] understand the need for it, they can see the need for it and they can see that it services the community and what a great job we do. So they are very active in advocating that that service stays open”. (Nurse B)

“...management have been really supportive of it [sexual health service] from the outset... They don't want to see it go, so they then try and accommodate and support where they can” (Nurse A)
KEY FINDINGS

Flexibility to respond to service demand

Autonomy in being able to respond flexibly to service demand was another key internal enabler to service delivery identified by sexual health nurses. This was particularly important when working with clients that had difficulties in keeping regular appointments and meant that these clients’ needs were met rather than being turned away and risking them not making contact again with the service.

“...anyone I will see opportunistically. So if someone rings me and says can I see you, I will organise my day so I either see them that day or the next day” (Nurse C)

“...if we say you're too late come back - they wouldn't - for some young people they won't come back...it's really important to see them then and there”. (Nurse A)

Monitoring of service quality

The final internal key enabler identified by sexual health nurses as important to service delivery was being able to monitor their own service quality. This helped the nurses to not only ensure they were meeting service accreditation standards but also meeting the needs of clients. Nurses monitored client satisfaction through inviting clients to complete surveys about the service as well as noting whether clients used the service regularly.

“I've been putting out the little community health generic questionnaires around satisfaction surveys and they're coming back as positive” (Nurse C)

“...we have to meet certain standards for accreditation, so our processes tie in with the broader medical practices standards as well”. (Nurse B)

Good relationships with other services

Sexual health nurses described how both strategic and working relationships with other health services helped in providing coordinated service delivery to clients. Nurses talked about mutual support for services and how referral processes had been developed which were for the benefit of both organisations. This had the ultimate outcome of service availability for clients, but also of having a recognised sexual and reproductive health presence in the local community.

“From a strategic point of view I suppose we just certainly don't work with them, but we have partnered with them because of some of the services we do they will refer to us, we refer to them. So we do have really good working relationships” (Nurse B)
KEY FINDINGS

Positive community perceptions

Recognition and use by the community was identified by sexual health nurses as a key external enabler to service delivery. Nurses noted that a number of clients used the service on recommendation from friends or family. For nurses, this helped demonstrate the need for and quality of the service.

“Definitely the way in terms of coming for women’s health stuff which is always word of mouth is the best thing. You can advertise and advertise and people don’t see it unless someone says, go and see XXX she’s really good” (Nurse D)

Support from CERSH

The final key enabler to service delivery acknowledged by sexual health nurses was support from CERSH. Support was described in terms of service advocacy locally as well as to the Department of Health and Human Services. Support was also seen in terms of workforce development opportunities facilitated by CERSH that helped nurses to update or learn new skills and gain knowledge.

“...certainly from an advocacy point of view, they’ve [CERSH] been pivotal in helping us deliver what we do. But also to make a case for, helping us make a case to the department to continue to deliver what we do”. (Nurse B)

Survey findings

Sexual health service clients that attended appointments at Pottsville and Ambler clinics were invited to complete a short, anonymous survey about their sexual health service experiences. Those who agreed to participate were asked to respond to a range of questions about their views on sexual health services in general and then about the sexual health service they were attending that day. In total, 76 surveys were completed by clients of two sexual health services. Survey responses are outlined and explained below.

90% of respondents were female  
Age range: 16-69 years  
Average age: 34 years
KEY FINDINGS

Sexual health service use enablers
Survey respondents were asked about enablers to sexual health service use. Clients were able to select multiple responses. Overall, low/no cost services were identified as the most important enabler to service use. Caring, non-judgmental staff, a private and confidential service and service location being easily accessible were also identified as important in enabling service use.

Important attributes for sexual health services
Survey respondents were asked about the most important attribute that should be included in sexual health services. Clients were asked to select only one response. Sexual health services being private and confidential was identified as the most important attribute whilst being able to obtain an appointment easily was, overall, seen as important.

Sexual health-related services used in the last 12 months
Clients were asked about the sexual health service they had used the most in the last 12 months. Just over half of survey respondents identified the service they were attending as the service most used. 30% identified their GP, whilst 15% indicated that they didn’t usually seek out a service.
**Frequency of service use**

Nearly half of survey respondents indicated that they used a sexual health service a few times a year. For a quarter of survey respondents, this was their first appointment at the sexual health service they were attending that day.

**Reasons for sexual health service appointment**

Clients were asked to identify the reasons for their current appointment. Clients were able to select multiple responses. The most common response was to get a check-up, followed by getting advice and contraception.
The aim of this project was to explore and compare different models for sexual health service delivery in rural Victoria in order to understand how different sexual health service models work, for which population groups, and in what contexts.

Findings from the interviews with the sexual health nurses indicate the importance of factors that relate to structural elements of service delivery. These include:

- Strong organisational understanding and support for the service,
- Adequate funding for service delivery
- Location in a setting that makes it as easy as possible for clients to access the service
- Flexibility in service delivery so that nurses are able to respond appropriately to fluctuations in service demand.
- Good connections to a range of other sectors and services in terms of cross-service and/or sector referrals, timely service delivery, and advocacy for the service by external supporters.

Clients of the sexual health services indicated the following aspects of sexual health services were important to them:

- Low/no cost service provision
- Caring, non-judgmental staff
- Suitable location in terms of opening hours, accessibility to public transport
- Private and confidential service provision

Clients also indicated that they had used other services such as GPs, pharmacies and school nurses for sexual health-related needs.

Good connections between sexual health related services would help rural communities to know which organisations were offering sexual health services and work together to ensure these were consistent and complementary.

In the broader context of rural sexual health service delivery, it appears that the services involved in this project are providing variety in how services have countered some of the barriers to accessing sexual health services in rural areas in relation to geographic location, concerns about confidentiality, choice of health care professionals and cost. In particular:

- Pottsville sexual health clinic is located within a community health service, providing no-cost appointments, is open five days per week, located near public transport and with two part-time nurses and a GP supporting the nurses.
- Ambler sexual health clinic offers sexual health services in both outreach and in-house capacities. This service is also open five days per week, with no-cost appointments and with two nurses and a GP supporting the clinic.
- Hillside sexual health clinic is a mobile clinic, staffed by a nurse practitioner and operating from a range of locations in various small rural towns. This service has well developed referral pathways with various services in each town, or in larger regional centres so that clients can access the same types of sexual health services offered by in-house clinics.
DISCUSSION

Implications for establishing a rural sexual health service

For organisations seeking to establish a rural sexual health service, the findings of this project indicate a number of issues that need to be considered:

Organisational issues:

- Is there adequate understanding of sexual health service requirements amongst management and staff? Is there a need for education amongst this group prior to lobbying for a sexual health service component to be considered in the service delivery mix?
- Does the organisation have connections to other relevant sectors and services that may need to be involved in the delivery of a holistic sexual health service?

Staffing:

- Are there appropriately qualified nursing staff that are available to work in a sexual health service? If training or professional development is required, are there ways for this to be accessed?
- Is there a GP available and amenable to supporting sexual health nurses in their clinical work? Does the GP need further training to deliver particular services e.g. MToP?

Service location

- Is the location of the organisation easily accessible on foot or by public transport?
- Is the organisation open various times of the day, and days of the week? How often would the sexual health service operate on these days, and at what times?
- Is there potential to offer sexual health services from other locations so as to cater for a range of potential clients?
- Does the location offer privacy and confidentiality for potential clients?

Funding

- What types of funding are available to support a sexual health service and what is the nature of this funding (e.g. limited, recurrent)? Other considerations linked to funding are capacity to employ nursing staff, and capacity to generate any funding through Medicare.
- Will there need to be a charge for using the sexual health service? If so, how low can this charge be? Is there potential for some population groups to use the service at no cost?

This project was limited through the involvement of a very small number of nurses, meaning that that experiences of service delivery are not generalisable. However, the aim of this project was to provide an overview of different types of rural sexual health service delivery models, key considerations in their operation and implications for others who may want to establish a service. This project has provided a rich insight into different service delivery models and the lived experiences of nurses delivering services as well as those of service clients, and what is important to them. Their perspectives have allowed the development of a range of considerations that will be useful to other organisations, stakeholders and communities seeking to improve access to sexual health services in their communities.


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Contact:
Dr Alana Hulme Chambers
Centre for Excellence in Rural Sexual Health (CERSH)
Department of Rural Health, The University of Melbourne
E: alana.hulme@unimelb.edu.au

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