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Women's Sexual and Reproductive Health Needs in the Murray Region

FINAL REPORT PREPARED FOR MURRAY PHN

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Executive Summary

Background

Good sexual and reproductive health is an essential component to every woman's health and wellbeing. However, many indicators point to poorer sexual and reproductive health outcomes in rural and regional areas compared to those for metropolitan areas. Some areas of Victoria have little or no access to the information, services and support that women require to reach and maintain optimal sexual and reproductive health. This project is a joint initiative of Women's Health Loddon Mallee (WHLM), Women's Health Goulburn North East (WHGNE), and the Murray Primary Health Network (MPHN), that aims to better understand women's sexual and reproductive health needs and give voice to women's experiences across the total catchment area of the MPHN. The report examines the factors that impact on sexual and reproductive health outcomes, the current service system, and the lived experience of women in the MPHN catchment to better understand sexual and reproductive health services, systems and support across the total MPHN catchment area.

Key Area 1: Needs Assessment

This section examines the sexual and reproductive health indicators and needs of women in the MPHN region of Victoria.

1.1 Sexual and Reproductive Health Profile

The Sexual and Reproductive Health Profile is based on the development of a data table organised across four main domains: demographics, social determinants, lifestyle and behavioural determinants and sexual and reproductive health indicators. The data table is explored through a narrative that examines key aspects of the data, to gain an understanding of the diverse needs and intersecting determinants of women's sexual and reproductive health across the MPHN catchment.

1.2 Sexual and Reproductive Health Service Mapping

Sexual and reproductive health service mapping has been undertaken by both WHLM and WHGNE. This section provides WHGNE's service guide and comprehensive service directory for Goulburn and North East Victoria (GNE) region, as well as the current understanding of services across the Loddon Mallee (LM) region, highlighting key strengths and areas of opportunity across the Murray catchment.

1.3 Rapid Review of Local Emerging Models of Care

This section introduces some of the emerging models of sexual and reproductive health care in the context of the needs of women in the total MPHN catchment of Victoria. An overview of literature that describes a range of models of care that have been used in rural areas across the western world is presented. This includes nurse-led models, technology assisted sexual and reproductive care and Well Women's Clinics.

1.4 Review of Innovative and Flexible Models of Care

Innovative and flexible models of care are presented in this section through local case study examples from across regional Victoria. This includes Gateway Health's nurse-led model of Medical Termination of Pregnancy services, Bendigo Community Health's sexual and reproductive health hub and Melbourne Sexual Health Centre's TESTme services.

1.5 Summaries of Regional Sexual and Reproductive Health Strategies

During this project, WHLM and WHGNE were both in the development phase of regional Sexual and Reproductive Health strategies. This section summarises the key priorities and objectives of the respective strategies.

Key Area 2: Women's Voices

This section presents Storylines: Her Voice Matters, the phase of the project that gives voice to women's lived experiences of sexual and reproductive health across the MPHN catchment.

2.1 Development of 'Storylines: Her Voice Matters'

The Development of Storylines: Her Voice Matters outlines the background of this phase of the project, and presents the reasoning for utilising storytelling as the process for capturing women's experiences of sexual and reproductive health. It also describes the various tools and processes that were developed and used to capture women's experiences.

2.2 Implementation of 'Storylines: Her Voice Matters'

This section describes how the Storylines: Her Voice Matters phase of the project was implemented; engagement and recruitment, methodology, results and themes are discussed. The analysis of 62 regional women's experiences are grouped into five key themes: workforce knowledge and skills; impacts of sexual and reproductive ill health on women; availability and access; sexual and reproductive health literacy and systems and environments, and explored through narrative.

2.3 'Her Voice Matters' Implementation Guide

This section provides a guide for planning and implementing Storylines: Her Voice Matters, as well as a facilitation guide for utilising the visual storytelling tools developed for this project.

Key Area 3: Evaluate to Enable

Evaluate to Enable presents project workers' reflections including limitations, enablers and key learnings, to evaluate the effectiveness of the project and future improvements for sustainability.

Key Area 1 recommendations:

- Ensure sexual and reproductive health services and health promotion programs are prioritised to meet the demographic needs of women in the Murray PHN catchment, or varying priority needs of women across the lifespan. Targeted interventions should focus on particular ages and stages, such as menopause information and education, as most local government areas (LGAs) in the catchment show the highest population female age group is between 45 and 64 years.
- Ensure sexual and reproductive health services are financially accessible as almost 50% of women in the MPHN catchment earn below the weekly minimum wage.
- Promote service coordination between the family violence and sexual and reproductive health service systems, due to the high rates of family violence in the MPHN catchment and the link between controlling behaviours and adverse effects on sexual and reproductive health.
- Promote the importance of cervical screening and where cervical screening is provided to increase the uptake of cervical screening across the MPHN catchment, with a focus in LGAs with comparatively low uptake.
- Progress the 'Welcoming Doors for Women' project in the Loddon Mallee region, and in areas of Goulburn North East Victoria that are poorly serviced.
- Gain understanding of what sexual and reproductive health services are delivered by GPs across the MPHN catchment, particularly the availability of long acting reversible contraception (LARC) insertion and removal, and medical termination of pregnancy services (MTOPs).
- Increase provision of surgical termination of pregnancy services (STOPs) across the MPHN catchment to improve access, (in line with the Victorian women's sexual and reproductive health key priorities 2017-2020, page 17) and develop appropriate and accessible referral pathways for women.
- Investigate and resource innovative and flexible models of care for the delivery of sexual and reproductive health services in regional areas.

Key Area 2 recommendations:

1. Workforce development led by MPHN targeting GPs, primary health, Child and Maternal Health nurses, midwives and sexual and reproductive health specialists. Targeted sexual and reproductive health education and training that is rights based and responsive to the multiple and intersecting forms of disadvantage and inequity experienced by women living in Loddon, Mallee, Goulburn and North East Victorian regions.

Priority areas:

- Menstruation
- Endometriosis
- Polycystic Ovarian Syndrome (PCOS)
- Contraception Options
- Pregnancy choices counselling and referral, including medical and surgical abortion services.
- Women, disability and sexual and reproductive health
- Women from refugee and culturally and linguistically diverse (CALD) backgrounds: sexual and reproductive health and cultural awareness.
- Young Women

2. Deliver rights based women's sexual and reproductive health education and training in MPHN communities.
Targeted education and training for priority populations to build knowledge, understanding and awareness of sexual and reproductive health and services availability, including women with disabilities, women from refugee and CALD backgrounds and young women.

3. Work in strategic partnerships to address sexual and reproductive health service gaps and priorities for women living in Loddon Mallee, Goulburn and North East Victoria regions, including increasing women's access to timely and affordable medical and surgical abortion services based on best practice models.

- Understanding of referral pathways, both locally and in neighbouring areas to provide women with choice and anonymity.

4. Increase knowledge of and access to practice nurses and evidence based nurse led models of sexual and reproductive health care and services.

- Resource accessible, innovative and flexible nurse led models of care.
- Increase knowledge about primary health care nurses and referral pathways in health care and community settings.

5. Create sexual and reproductive health information and support resources that are accessible for all women.

- Resources that provide rights-based information in Easy English, in a range of accessible formats appropriate for girls and women of all abilities and diversities.
- Resources that promote services that support women's safety, privacy and choice.
- Resource priorities: menstruation, Endometriosis, PCOS, menopause, contraception options, and pregnancy choices and options including abortion.

6. Build and support cross sector partnerships between government, health, education and community services to plan and deliver place based collective action aimed at improving access to timely, safe, affordable and inclusive sexual and reproductive health care, services and treatment, in the communities where women live.

Key Area 1: Needs Assessment

1.1 Sexual and Reproductive Health Profile

To examine the sexual and reproductive health needs of women in the Murray Primary Health Network region of Victoria, a profile of women's health has been developed. This included the development of a summary data table below, with following narrative examining key aspects from the data table. The sexual and reproductive health profile is organised across four main domains: demographics, social determinants, lifestyle and behavioural determinants, and sexual and reproductive health indicators, as demonstrated in the table on page 10 below.

Evidence of Need Data Sets

The Catchment

Women's Health Goulburn North East (WHGNE) and Women's Health Loddon Mallee (WHLM) are the two regional women's health services working across the Murray PHN catchment. WHGNE covers the municipalities of Moira Shire, The City of Greater Shepparton, Strathbogie Shire, Benalla Rural City, Wangaratta Rural City, Murrindindi Shire, Mitchell Shire, Mansfield Shire, Alpine Shire, Indigo Shire, Towong Shire and The City of Wodonga, a region of 40,380 square kilometres (Regional Development Victoria, 2018). Women's Health Loddon Mallee covers the municipalities of Mildura Rural City, Swan Hill Rural City, Buloke Shire, Gannawarra Shire, Loddon Shire, Campaspe Shire, City of Greater Bendigo, Mount Alexander Shire, Mount Alexander Shire and Central Goldfields Shire (Central Goldfields Shire is not in the Murray PHN catchment), a region of 58,961 square kilometres (Regional Development Victoria, 2018). Due to recent name and boundary changes for state and federal funded health services, the WHGNE regional catchment is described in this report as 'Goulburn North East', rather than 'Hume Region', or 'Ovens Murray'. This term aligns with WHGNE's name, encompasses the same total area and number of LGAs as for 'Hume' but avoids confusion between the region covered by WHGNE and combined regions of WHLM (except for Central Goldfields Shire) and WHGNE included in the Murray PHN catchment.

DEMOGRAPHICS							
Total Population	Total Males	Total Females	Total Aboriginal or Torres Strait Islander	Aboriginal or Torres Strait Islander Males	Aboriginal or Torres Strait Islander Females	Age Group Total	Age Group Females

SOCIAL DETERMINANTS OF SEXUAL AND REPRODUCTIVE HEALTH										
SEIFA Socio-economic indexes for areas	Incidence of Family Violence	Incidence of Sexual Offences	Unpaid Domestic Work	English Proficiency	Home Internet Access	Home Internet Access	Country of Birth	Employment Status	Income	Mother's Index Rank

LIFESTYLE & BEHAVIOURAL DETERMINANTS							
Smoking Rates	Incidence of Alcohol-Related Harm	Fruit and Vegetable Consumption	Physical Activity Rates	Rates of Anxiety and Depression	Psychological Distress	Community Connectedness Index	Personal Wellbeing Index

SEXUAL AND REPRODUCTIVE HEALTH INDICATORS							
Total Fertility Rate	Birth Rate	Teenage Fertility	Cervical Screening	Chlamydia Rate	HIV Rate	Gonorrhoea Rate	Hepatitis B Rate

Demographics

There are 142,489 women living in the Goulburn North East (GNE) region (about 4.72% of Victoria's female population at the time), including 2,899 Aboriginal and Torres Strait Islander women (Murray Exchange, 2016). There are 158,088 women living in the Women's Health Loddon Mallee (LM) region (about 5.44% of Victoria's female population at the time), including 3,322 Aboriginal and Torres Strait Islander women (Murray Exchange, 2016). A total of 300,577 women live in the Murray PHN catchment (about 10.16% of Victoria's female population at the time), including 6,221 Aboriginal and Torres Strait Islander women (Murray Exchange, 2016). The population of women within each of the LGAs within the Murray PHN catchment is summarised in Table 1.

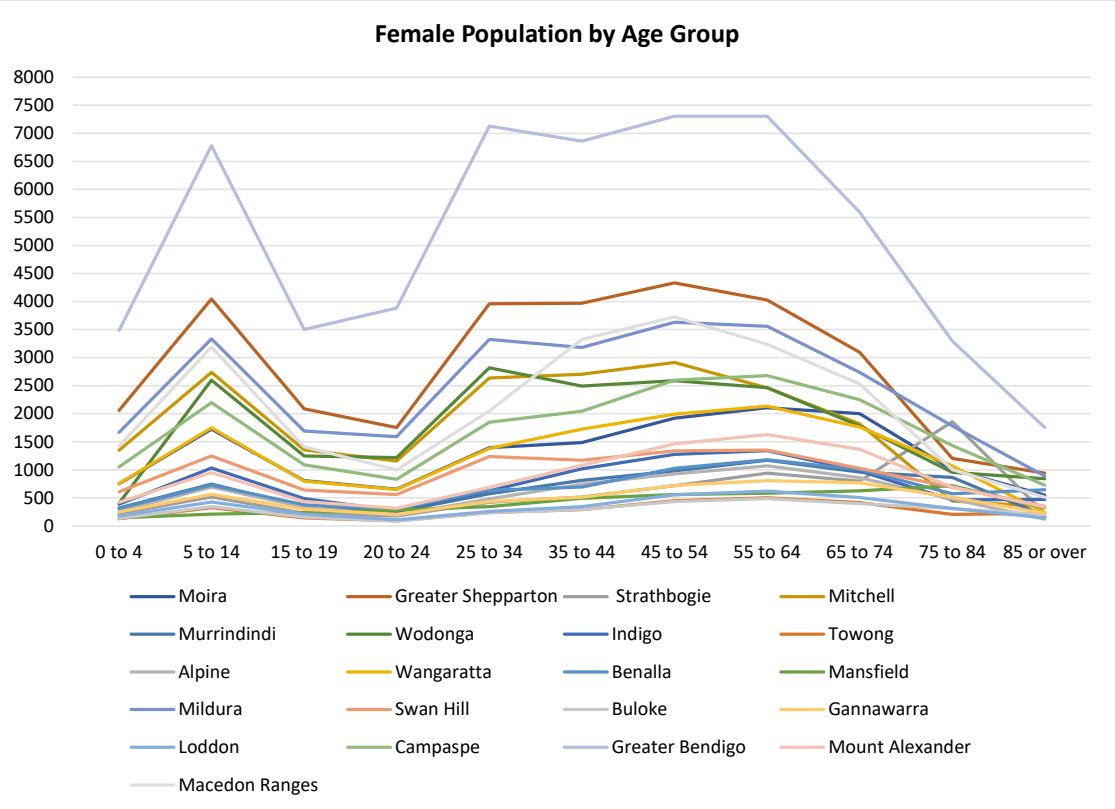
Table 1: Total Female Population by LGA

LGA	Total Female Population	Aboriginal and Torres Strait Islander Female Population
The City of Greater Shepparton	32125	1103
Mitchell Shire	20350	324
The City of Wodonga	20050	527
Wangaratta Rural City	14665	190
Moira Shire	14598	250
Indigo Shire	8097	108
Benalla Rural City	7149	114
Murrindindi Shire	6771	88
Alpine Shire	6265	58
Strathbogie Shire	5198	53
Mansfield Shire	4314	37
Towong Shire	2907	47
Mildura Rural City	27398	1093
Swan Hill Rural City	10217	439
Buloke Shire	3066	28
Gannawarra Shire	5293	96
Loddon Shire	3668	65
Campaspe Shire	18765	429
City of Greater Bendigo	56891	938
Mount Alexander Shire	9375	88
Macedon Ranges Shire	23415	146

Female population by age

Sexual and reproductive health is an important issue for all women across the lifespan (Women's Health Victoria, 2009). Some sexual and reproductive health experiences will be more pertinent depending on the life stage of the woman. For instance, most women experience menopause between the ages of 45 and 55 (The Better Health Channel, 2017) and the average age of childbirth among Australian women is 30.3 (AIHW, 2015). Therefore, age is an important demographic when considering sexual and reproductive health planning.

For most LGAs in the MPHN catchment, the highest population female age group is between 45 and 64. In contrast the lowest female population age group across most LGAs is 15 to 24. A notable exception to this trend is Wodonga, which has a highest female population group of 25 to 34, followed by 5 to 14, making the LGA a comparatively young demographic. Greater Bendigo is also an exception to the trend, with the female population group of 20 to 24 increasing from the 15 to 19 group. In contrast the 20 to 24 population group declines in all other LGAs, while Strathbogie Shire's female population spikes in the 75 to 84 age bracket making it an older demographic.



Social Determinants of Health

According to the World Health Organisation (WHO), social determinants of health are

"the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels" (WHO, 2006).

Social determinants of health such as income, education and gender have a direct relationship with sexual and reproductive health (Taylor and Vu, 2013). According to the 2016 census, 45.7% of women 15 years and older across Victoria earn below the minimum weekly wage of $0-$649. The GNE region percentage is slightly higher at 47% and slightly higher again in the LM region at 48.6%.

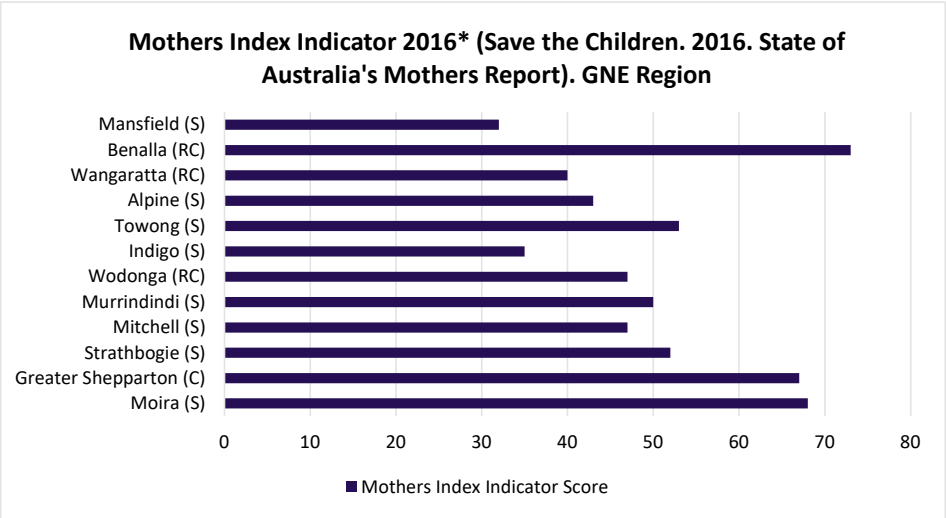
This figure varies slightly across LGAs. In the GNE region, just over 50% of women in the LGAs of Towong and Benalla earn below the weekly minimum wage. In contrast 42.9% of women in The City of Wodonga earn below the minimum weekly wage, followed by Mitchell (43.5%) and Indigo Shire (43.9%). Although these numbers are high, they represent the LGAs in the GNE region with the least number of women earning below the weekly minimum wage.

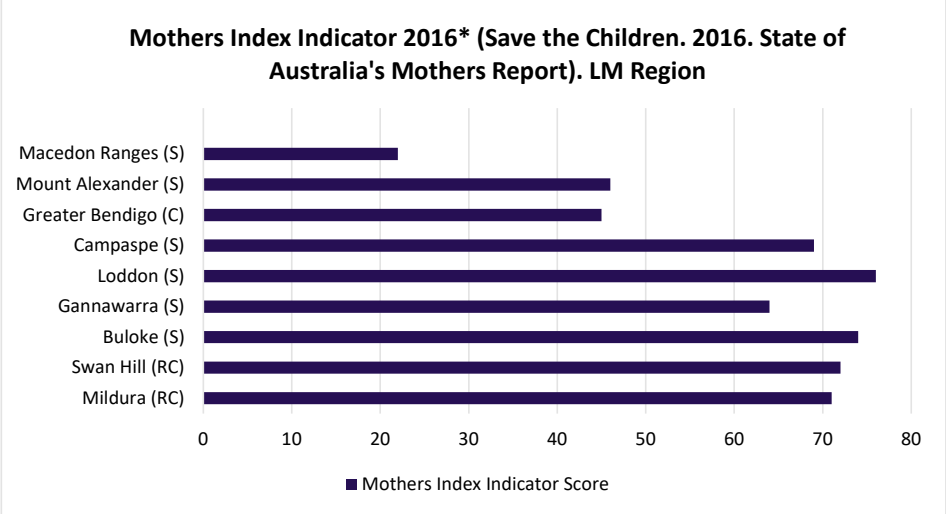
In the LM region, just over 50% of women in the LGAs of Loddon, Gannawarra and Buloke earn below the weekly minimum wage. In contrast 41.9% of women in Macedon Ranges Shire earn below the minimum weekly wage, followed by Swan Hill (43.9%) and Greater Bendigo (45.3%). Although these numbers are high, they represent the LGAs in the LM region with the least number of women earning below the weekly minimum wage.

Educational attainment is positively correlated with better health literacy and socio-economic status (Friis K et al. 2016). Educational attainment varies across LGAs in the GNE and LM regions. State-wide 40.4% of women aged 15 and over have completed Year 12 or equivalent compared to 33.8% of women in the GNE region and 32.2% of women in the LM region. The percentages of women with a qualification (including a certificate, Postgraduate Degree, Graduate Diploma, Graduate Certificate Level, Bachelor's Degree, Advanced Diploma or Diploma) is similar to Year 12 attainment. Less than 50% of women aged 15 and over across the GNE and LM regions hold some form of qualification.

Mothers Index Indicator

The Mothers Index Indicator measures a mother's health, educational attainment, her family's socioeconomic status and the wellbeing of her children (Save the Children, 2015). It does not measure family violence. The scale ranges from 1 (being the best place for a mother to live), to 79 (being the worst). As can be seen on the bar charts below, most LGAs in the Murray PHN catchment sit relatively high on the scale. This indicates a number of challenges and inequities across these LGAs for mothers and their children.





* Scores are ranked from 1 to 79 (1 being the best place for a mother to live) to give the overall Mothers Index rank for each LGA.

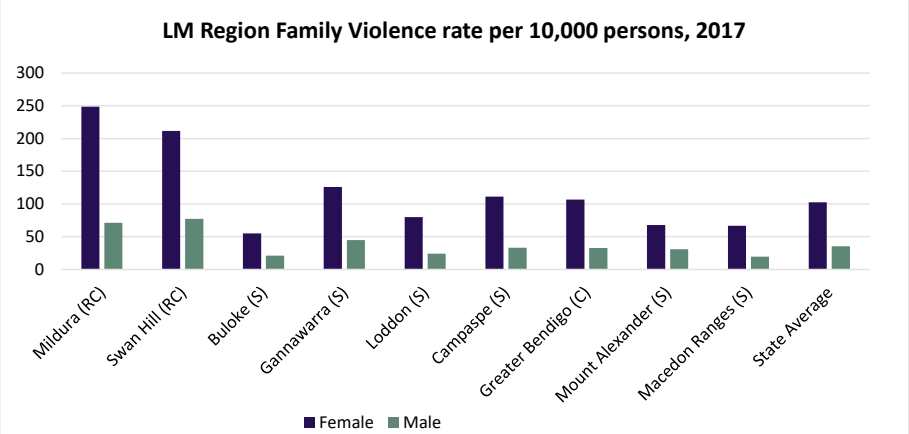
Family Violence and Sexual Offences

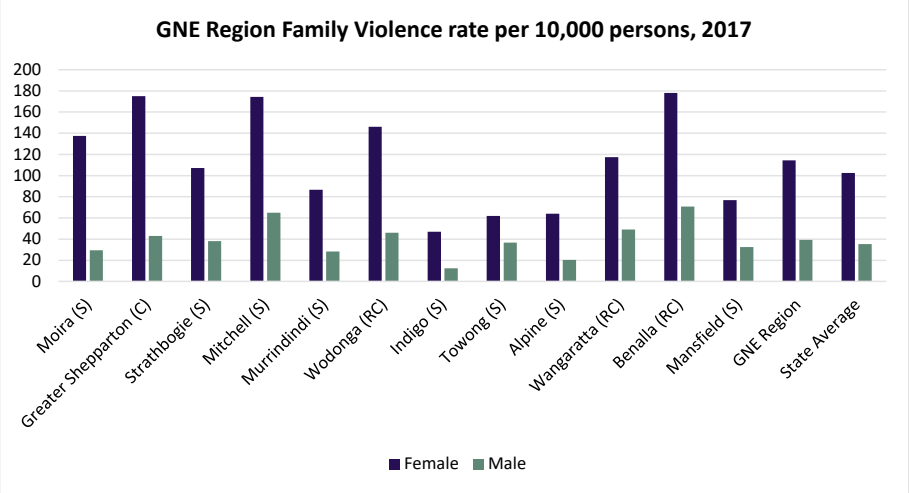
Sexual offences are acts and intent of acts against another person of a sexual nature that are non-consensual. This includes rape, sexual offences against children, indecent assault and other sexual offences (Women's Health Atlas, 2016). One in five Australian women has been coerced into unwanted sex (Visser, Smith, Rissel, Richters & Grulich, 2003).

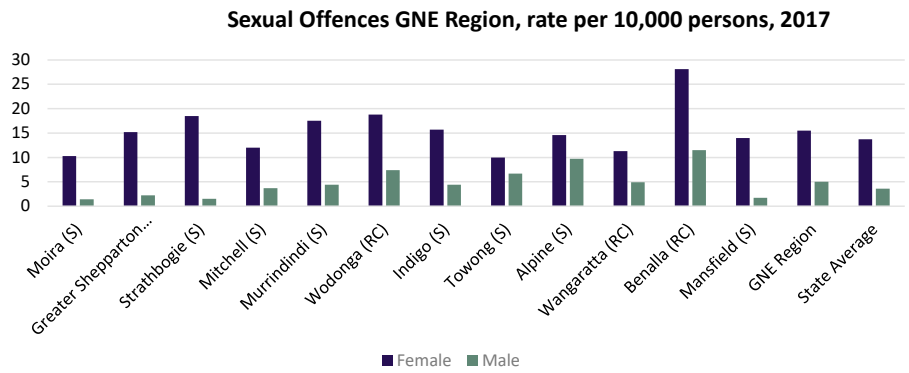
Family violence is a broader term than domestic violence as it refers to violence between intimate partners as well as violence between family members. It includes violent and threatening behaviour or any other form of behaviour that coerces or controls a family member or causes that family member to be fearful (Our Watch 2018). Research has found that most incidents of family and sexual violence go unreported therefore the figures reported herein are likely to be an underestimate of actual incidents of family and sexual violence (Dunkley & Phillips 2015).

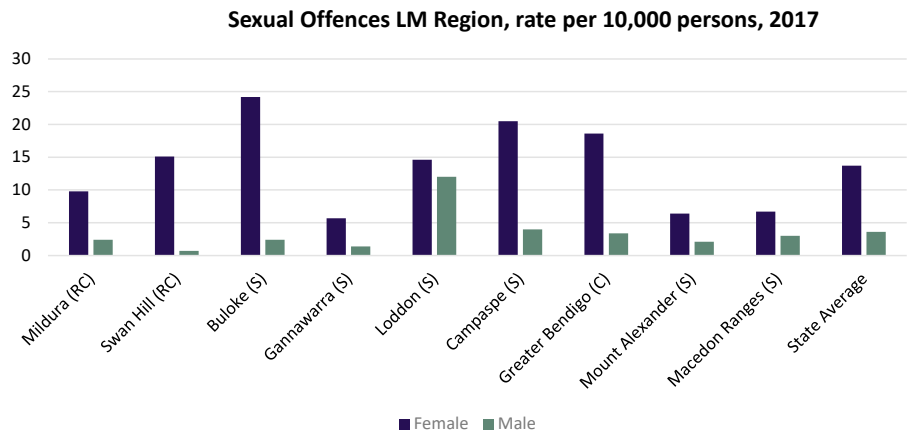
In the GNE region, the LGAs of Moira, Greater Shepparton, Strathbogie, Mitchell, Wodonga, Wangaratta and Benalla all have family violence rates (per 10,000 persons) higher than the state average. In the LM region, the LGAs of Mildura, Swan Hill, Gannawarra, Campaspe and Greater Bendigo all have family violence rates (per 10,000 persons) higher than the state average, with Mildura and Swan Hill more than twice the state average.

There are strong links between sexual and reproductive health outcomes and violence against women (Moore, Frohwirth, Miller, 2010). Controlling behaviours, which usually co-occur with physical and sexual violence can limit a woman's ability to control her sexual and reproductive decision-making and access to health care, which can have adverse effects on a women's sexual and reproductive health (WHO 2013). Related to this is sexual and reproductive coercion, which refers to a range of sexualised and pregnancy-controlling behaviours such as refusal to use condoms, birth control sabotage, forced intercourse/ rape, pregnancy, progression of pregnancy, or termination, which are against the wishes of the woman (Children by Choice, 2017).


LM Region Family Violence rate per 10,000 persons, 2017
300
250
200
150
100
50
0
Mildura (RC)
Swan Hill (RC)
Buloke (S)
Gannawarra (S)
Loddon (S)
Campaspe (S)
Greater Bendigo (C)
Mount Alexander (S)
Macedon Ranges (S)
State Average
Female
Male


GNE Region Family Violence rate per 10,000 persons, 2017
200
180
160
140
120
100
80
60
40
20
0
Moira (S)
Greater Shepparton (C)
Strathbogie (S)
Mitchell (S)
Murrindindi (S)
Wodonga (RC)
Indigo (S)
Towong (S)
Alpine (S)
Wangaratta (RC)
Benalla (RC)
Mansfield (S)
GNE Region
State Average
Female
Male

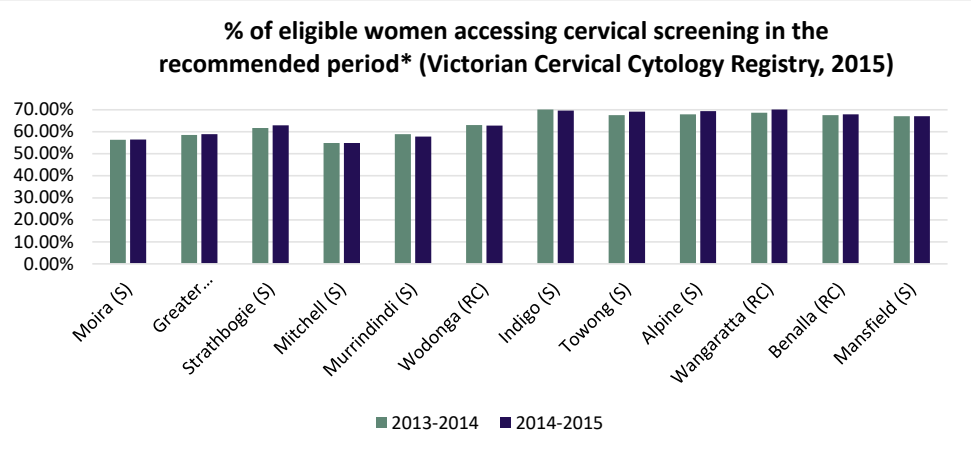

Sexual Offences GNE Region, rate per 10,000 persons, 2017
30
25
20
15
10
5
0
Moira (S)
Greater Shepparton...
Strathbogie (S)
Mitchell (S)
Murrindindi (S)
Wodonga (RC)
Indigo (S)
Towong (S)
Alpine (S)
Wangaratta (RC)
Benalla (RC)
Mansfield (S)
GNE Region
State Average
Female
Male

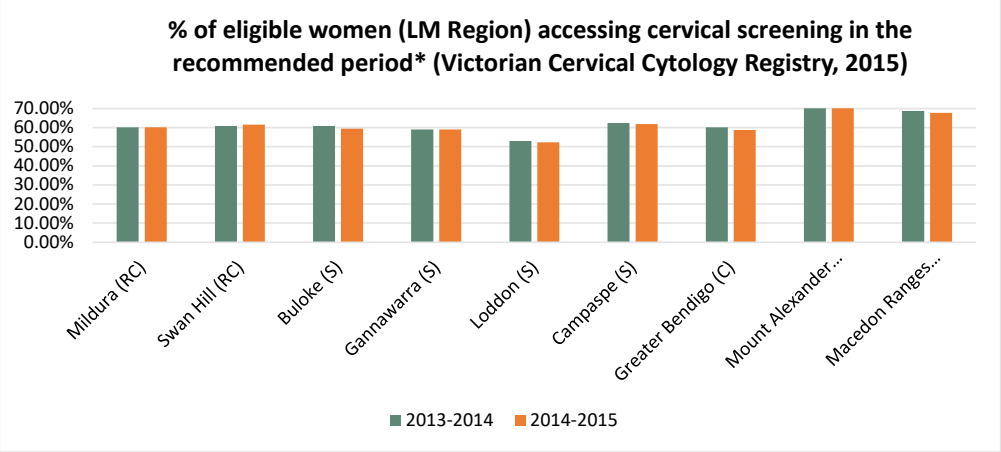

Sexual Offences LM Region, rate per 10,000 persons, 2017
30
25
20
15
10
5
0
Mildura (RC)
Swan Hill (RC)
Buloke (S)
Gannawarra (S)
Loddon (S)
Campaspe (S)
Greater Bendigo (C)
Mount Alexander (S)
Macedon Ranges (S)
State Average
Female
Male

Sexual and Reproductive Health Indicators

Cervical Screening

In the 2014 to 2015 period, 64 per cent of eligible women in the GNE region and 61.2 per cent of eligible women in the LM region (aged 20-69 years) had a pap smear once in the two-year period recommended by the national cervical screening program. This is slightly higher than the state average of 60.5 per cent from the same time period. This figure varies greatly across LGAs, with some such as Loddon, Mitchell and Moira experiencing low uptake ranging from 52 to 57 per cent. This is similar (as seen in the table below) to the proportion of women accessing cervical screening over a four-year period which has remained relatively stable. According to the Cancer Council of Victoria, 70 per cent of women who developed cervical cancer did not have regular Pap tests (Cancer Council Victoria, 2017). It is therefore important to increase the uptake of cervical screening across the Murray PHN catchment, with a particular focus in LGAs with comparatively low uptake. The new National Cervical Screening Program that looks for HPV (human papillomavirus) presents an opportunity for increased health promotion efforts in this space.

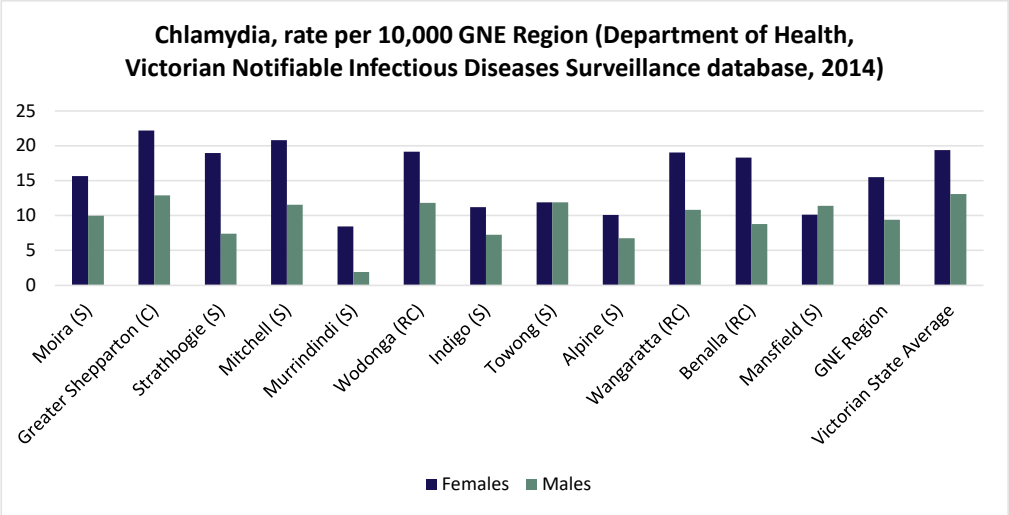


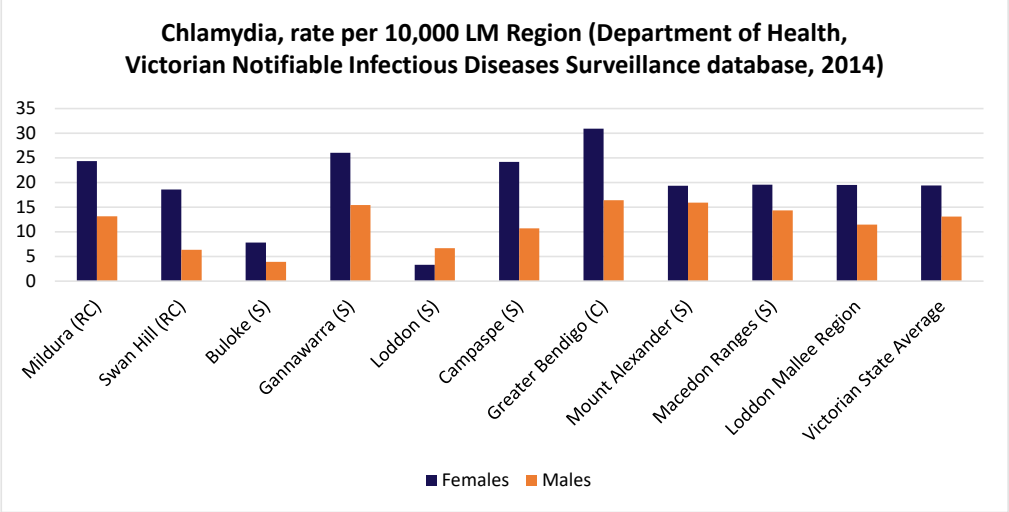


*The recommended period by the National Cervical Screening Program at the time of this data collection was once every 2 years.

Chlamydia

Chlamydia is responsible for 50% of sexually acquired pelvic inflammatory disease cases, which can lead to infertility (Better Health Channel, 2017b). In 2017 there were 21,026 cases of chlamydia diagnosed amongst Victorians, including 1115 cases in the LM region and 839 cases in the GNE region (DHHS 2018). In 2014, the chlamydia rate per 10,000 women in GNE was 15.5, lower than the Victorian rate of 19.4 for the same time period. However, a number of LGAs experienced similar or higher rates of chlamydia than the Victorian State average. Across the Murray PHN catchment, Greater Bendigo had the highest rate of 30.91 per 10,000 women, followed by Gannawarra (26.05), Campaspe (24.2), Greater Shepparton (22.17), Mitchell (20.79) and Wodonga (19.4).

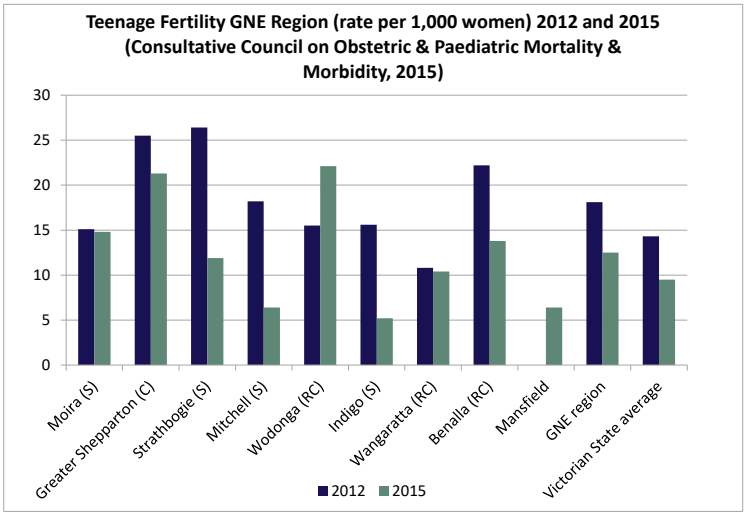


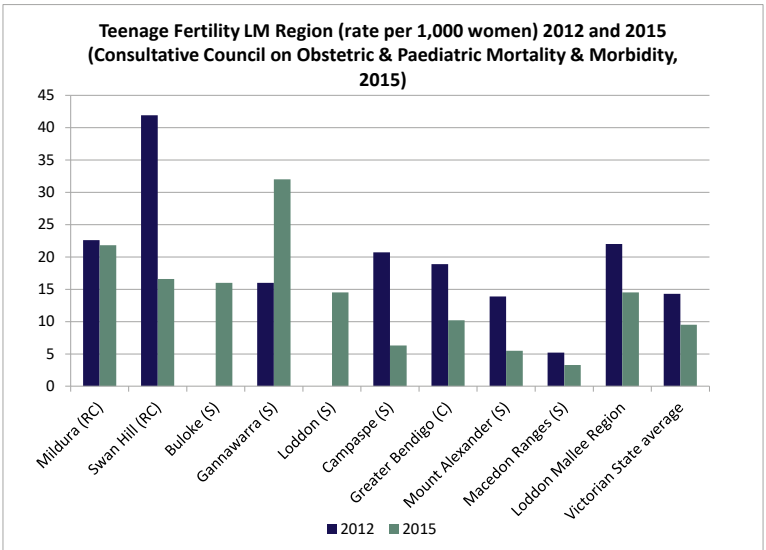


Birth Rates

The total fertility rate (average number of children a woman bears in her lifetime) in the GNE region is 2, and 2.1 in the LM region, which is similar to the Victorian state average rate of 1.9 and the Australian average rate of 1.8 (2016). Across all states and territories in Australia, birth rates were highest for women aged 30-34. During 2016, a rate of 21.8 babies per 1,000 women were born within the GNE region and a rate of 22.0 babies per 1,000 women were born in the LM region, both slightly less than the Victoria state average rate of 24.2.

The teenage fertility rate (rate of live births to women under the age of 19) has seen an overall decrease since 2012, with Wodonga being the only exception in the GNE region and Gannawarra being the only exception in the LM region, both experiencing an increased rate. It is often assumed teenage pregnancies are accidental, however some teenagers plan to become pregnant, or neglect to use contraception understanding pregnancy is a possibility (Women's Health Queensland, 2011). Women disproportionately carry the responsibility of unplanned pregnancy. Teenage pregnancy can often result in negative outcomes such as not completing education, which can have long-term impacts on job security and earning potential and higher complication rates both during pregnancy and delivery (Women's Health Queensland, 2011).





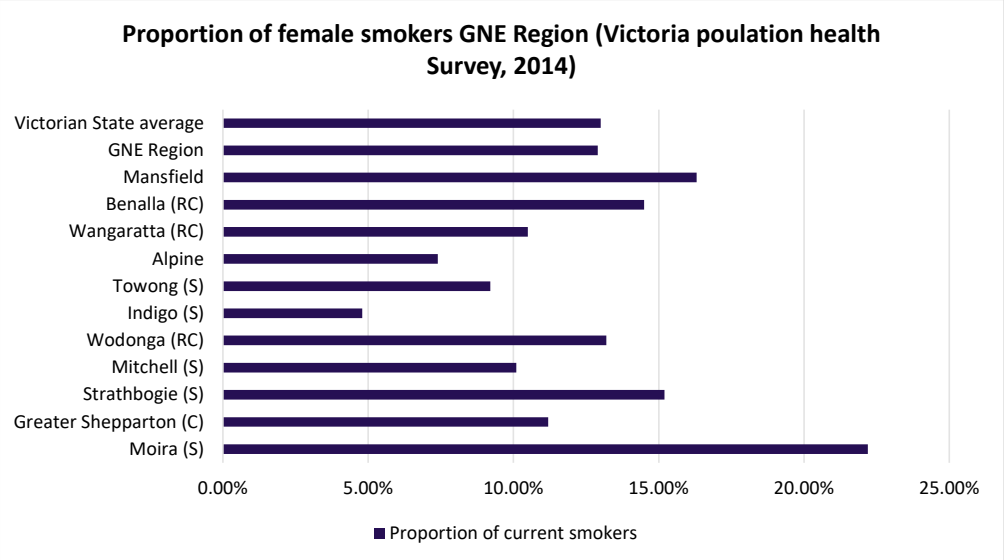
Lifestyle and Behavioural Determinants

Pre-Obese or Obese Percentage

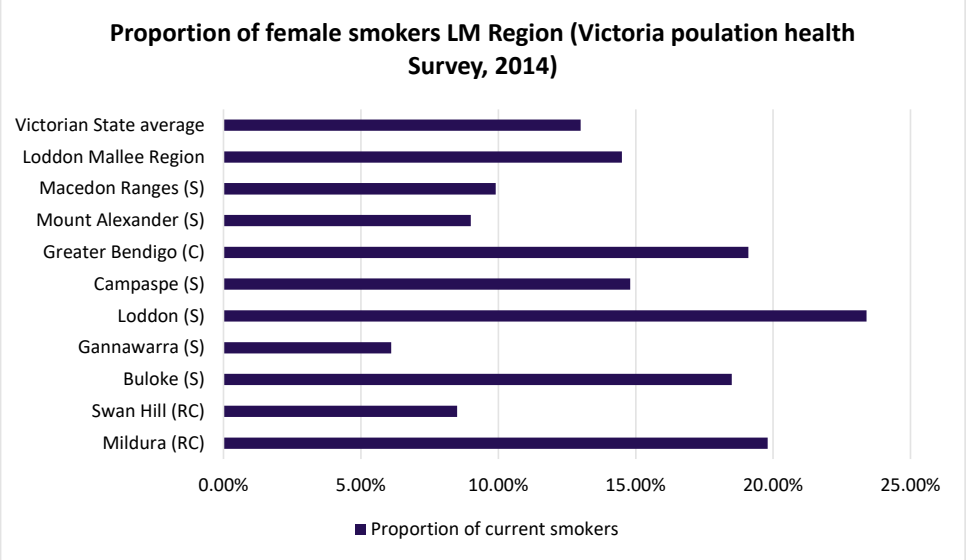
According to the 2015 Victorian Health Population survey, 34.7% of women in the GNE region and 34.4% of women in the LM region were in the normal weight range according to their BMI. Women who were pre-obese (overweight) or obese accounted for 46.3% of women in the GNE region and 47.4% of women in the Loddon Mallee region. These proportions are considerably higher than the 31.5% of obese or pre-obese woman across Victoria. Due to the self-report nature of this data, these figures are likely to be an underestimate (Victorian Health Population Survey, 2015). Obesity is a preventable condition that increases the risk of many diseases. Obesity is an important component of sexual and reproductive health as the condition can impact fertility and lead to pregnancy complications (Karoutsos, Karoutsou & Karoutsos, 2018).

Smoking

Smoking has negative impacts on sexual and reproductive health for men and women. Smoking can increase risk of miscarriage, stillbirth, premature birth, low birth weight, cleft palate and cleft lip, and infertility (Better Health Channel, 2017c). The foetus can also be harmed if the non-smoking mother is exposed to second-hand smoke. Once the baby is born exposure to second-hand smoke in their first year of life can increase risk of ear infection, respiratory illnesses, sudden infant death syndrome (SIDS) and meningococcal disease (Better Health Channel, 2017c). At the time of the 2014 Victorian population health survey, the LGAs in GNE with the highest proportions of female smokers aged 18 or older greater than the Victorian female proportion of 11.6 % were Moira (22.2%), Murrindindi (20.4%), Mansfield (16.3%), Strathbogie (15.2%), Benalla (14.5%) and Wodonga (13.2%). In the LM region, the LGAs of Loddon (23.4%), Mildura (19.8%), Greater Bendigo (19.1%), Buloke (18.5%), Central Goldfields (16%) and Campaspe (14.8) had higher proportions of smokers than the Victorian state average.



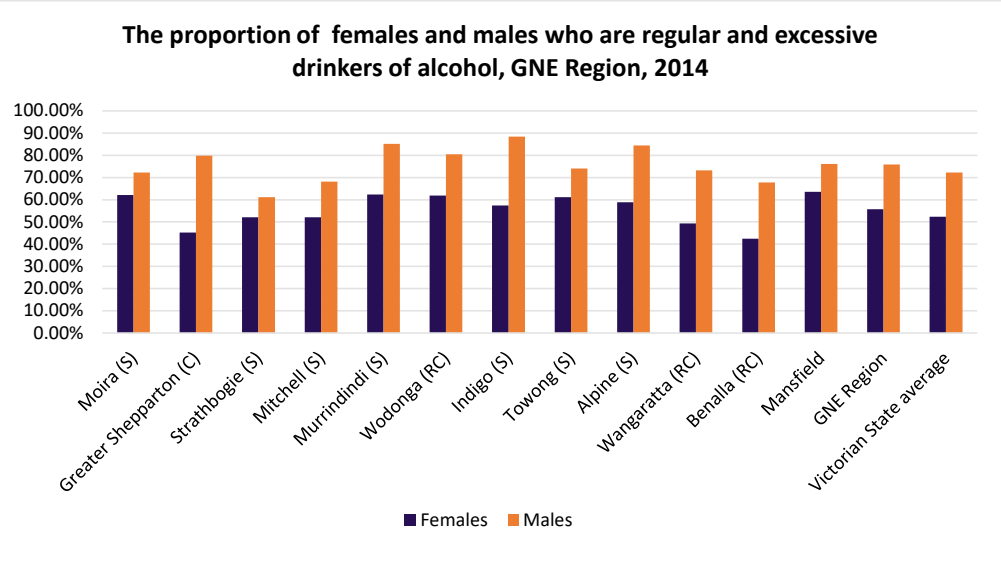
Smoking

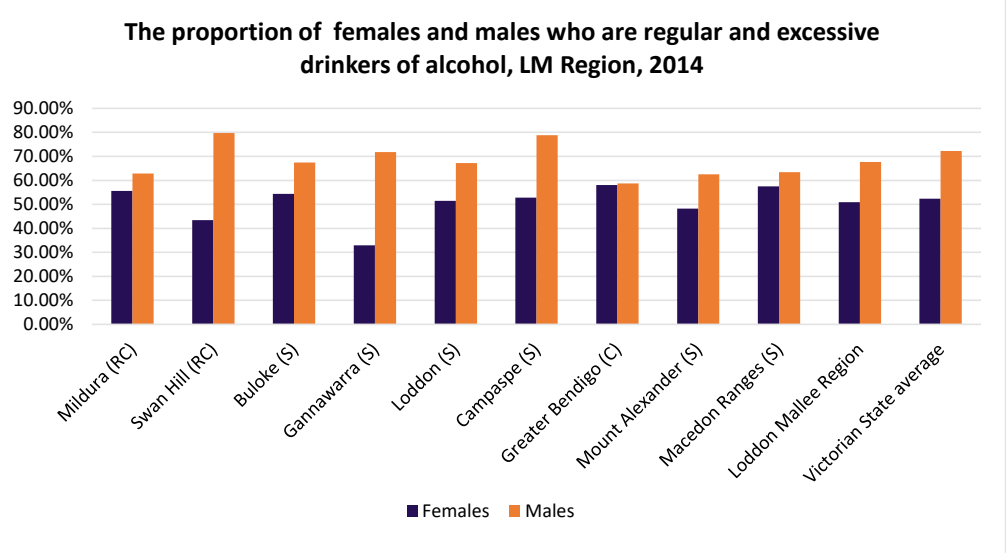


Alcohol

Alcohol is not an underlying cause of violence against women, however it is a significant risk factor in men's violence against women, with evidence showing it contributes to increased severity and frequency of violence (Dunkley & Phillips 2015 and ANROWS 2018). Young women under the influence of alcohol are more vulnerable to unwanted sex, unsafe sex and sexual assault (National Institute on Alcohol Abuse and Alcoholism, 2015). Women develop damage at lower levels of alcohol consumption over a shorter period of time. Women are more susceptible to alcohol-related organ damage, including breast cancer and osteoporosis. Alcohol consumption increases the risk of breast cancer by 9%, with each additional alcoholic drink per day being relevant to risk level (WHV 2018). Over 50% of women living in the GNE and LM regions were at an increased lifetime risk of alcohol related harm due to regular, excessive drinking of alcohol at the time of the 2014 Victorian population health survey. Of the twelve LGAs in the GNE region, Mansfield (63.6%), Murrindindi (62.3%), Moira (62.1%), Wodonga (61.9%) and Towong (61.2%) have the highest proportions of females at increased risk of alcohol related harm. In the eleven LGAs in the LM region, Greater Bendigo (58%), Macedon Ranges (57.5%), Mildura (55.6%), Buloke (54.4%), Campaspe (52.8%) and Loddon (51.5%) have the greatest proportions of women with increased risk of alcohol related harm due to regular excessive drinking. As this was a self-report survey, this proportion may be subject to response bias and therefore be an underestimate (Lavrakas, 2008).

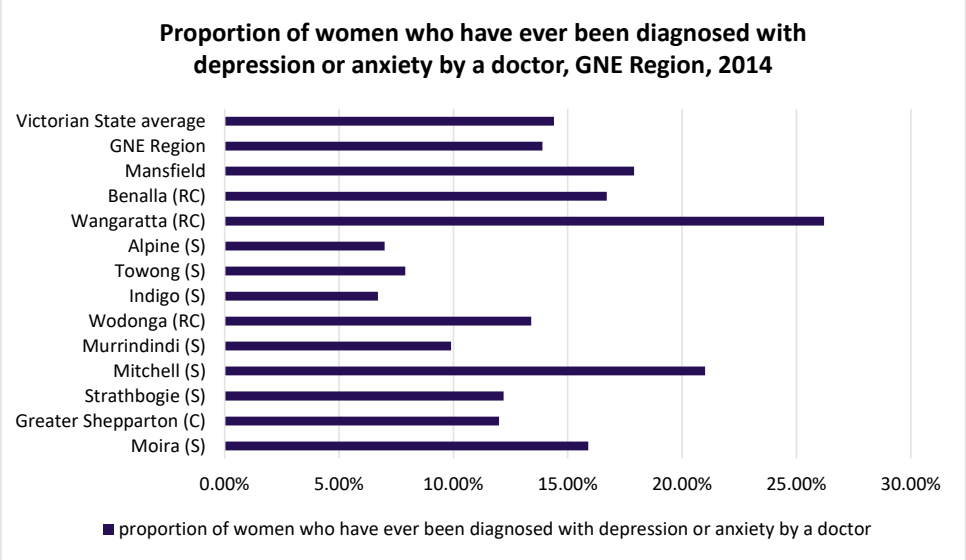
Alcohol

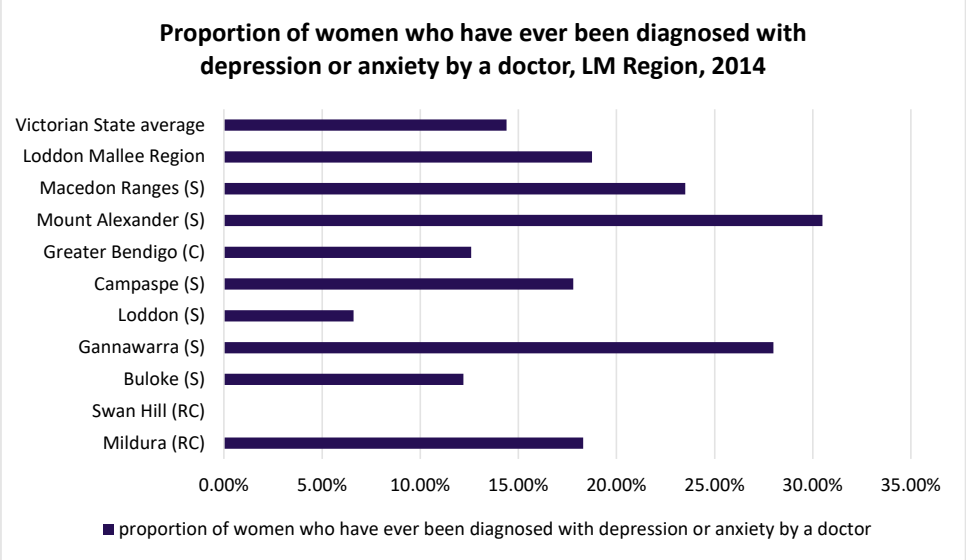

The proportion of females and males who are regular and excessive drinkers of alcohol, GNE Region, 2014
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Moira (S)
Greater Shepparton (C)
Strathbogie (S)
Mitchell (S)
Murrindindi (S)
Wodonga (RC)
Indigo (S)
Towong (S)
Alpine (S)
Wangaratta (RC)
Benalla (RC)
Mansfield
GNE Region
Victorian State average
Females
Males


The proportion of females and males who are regular and excessive drinkers of alcohol, LM Region, 2014
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Mildura (RC)
Swan Hill (RC)
Buloke (S)
Gannawarra (S)
Loddon (S)
Campaspe (S)
Greater Bendigo (C)
Mount Alexander (S)
Macedon Ranges (S)
Loddon Mallee Region
Victorian State average
Females
Males

Psychological distress

Five LGAs within the GNE catchment and four LGAs in the LM region reported higher levels of diagnosed anxiety and depression in the 2014 Victorian population survey than the state average for women of 14.4%. LGAs in the Murray PHN catchment reporting the highest proportions of women diagnosed with depression or anxiety at this time include Mount Alexander (30.5%), Gannawarra (28%), Macedon Ranges (23.5%) and Mildura (18.3%) in LM, and Wangaratta (26.2%), Mitchell (21%), Mansfield (17.9%), Benalla (16.7%) and Moira (15.9%) in GNE.





Recommendations:

- Ensure sexual and reproductive health services and health promotion programs are prioritised to meet the demographic needs of women in the Murray PHN catchment or varying priority needs of women across the lifespan. Targeted interventions should focus on particular ages and stages, such as menopause information and education, as most local government areas (LGAs) in the catchment show the highest population female age group is between 45 and 64 years.

- Ensure sexual and reproductive health services are financially accessible as almost 50% of women in the MPHN catchment earn below the weekly minimum wage.

- Promote service coordination between the family violence and sexual and reproductive health service systems, due to the high rates of family violence in the Murray PHN catchment, and the link between controlling behaviours and adverse effects on sexual and reproductive health.

- Promote the importance of cervical screening and where cervical screening is provided, to increase the uptake of cervical screening across the Murray PHN catchment with a focus in LGAs with comparatively low uptake.

- Progress the 'Welcoming Doors for Women' project in the Loddon Mallee region, and in areas of the Goulburn North East region that are poorly serviced.

- Gain understanding of what sexual and reproductive health services are delivered by GPs across the Murray PHN catchment, particularly the availability of long acting reversible contraception (LARC) insertion and removal, and medical termination of pregnancy services (MTOPs).

- Increase provision of surgical termination of pregnancy services (STOPs) across the Murray PHN catchment to improve access, (in line with the Victorian women's sexual and reproductive health key priorities 2017-2020, page 17) and develop appropriate and accessible referral pathways for women.

- Investigate and resource innovative and flexible models of care in the Murray PHN catchment for the delivery of sexual and reproductive health services in regional areas.

1.2 Service Mapping of Sexual and Reproductive Health Services (SRHS)

Goulburn North East

Women's Health Goulburn North East has compiled a service guide and comprehensive service directory:

- Sexual and Reproductive Health Services- Detailed Directory – Detailed information about services available for women and girls living in Goulburn North East Victoria.
- Sexual and Reproductive Health Services- Quick Look Guide – two page guide showing services and contacts for women and girls living in Goulburn North East Victoria.

(Please note that WHGNE SRHS directory and guide will be audited by WHGNE in 2019).

Loddon Mallee

At the beginning of this project, it was the intention of WHLM to produce a service directory and sexual health guide specific to the Loddon Mallee region (LMR). However, this approach was not suited to the nature of the sexual and reproductive health services in LM. Below is an overview of the services available in the region.

- Emergency contraception: is available from 98% of pharmacies in the LMR.
- Availability of long-acting reversible contraception (LARC): IUDs are stocked in 82% of pharmacies within the LMR. A further 16% do not have IUDs in stock but will order them in when a script is presented. Implanon is stocked in 88% of pharmacies within the LMR. A further 11% do not have Implanon in stock but will order it in when a script is presented. It is unknown how many services and service providers are available across the LMR for the insertion and removal of LARC.
- Termination of pregnancy services: Availability of Medical Termination of Pregnancy (MToP) and Surgical Termination of Pregnancy (SToP) services is limited in the LMR and referral pathways are often unclear. MToP services are only available in Bendigo, Castlemaine, Swan Hill and Mildura, leaving much of the LMR with low availability and accessibility to these services. MToP is also available to women through telehealth options.
- Lists of sexual and reproductive health service providers including community health services, well women's clinics/women's health clinics, hospitals and maternity services across the LM region have been compiled.

Work is continuing in this area to progress this in the Loddon Mallee region. Rather than using a mapping approach, it is proposed that a strengths approach will be used to determine where best practice is currently in place and seek to promote similar models in areas with low availability. WHLM refers to this model as 'Welcoming Doors for Women,' in that best practice models will ensure a person/woman centred and holistic approach to health care, ensuring that women feel safe, respected, supported and comforted in the health system and within the services they seek.

Recommendations:

- Progress the 'Welcoming Doors for Women' project in the Loddon Mallee region, and in areas of Goulburn North East Victoria that are poorly serviced. ('Welcoming Doors for Women' refers to best practice models that ensure a person/woman centred and holistic approach to health care, ensuring that women feel safe, respected, supported and comforted in the health system and within the services they seek).

- Gain understanding of what sexual and reproductive health services are delivered by GPs across the Murray PHN catchment, particularly the availability of long acting reversible contraception insertion and removal, and medical termination of pregnancy services.

- Increase provision of surgical termination of pregnancy services across the Murray PHN catchment to improve access (in line with the Victorian women's sexual and reproductive health key priorities 2017-2020, page 17) and develop appropriate and accessible referral pathways for women.

1.3 Rapid Review of Local Emerging Models of Care

Introduction

Urban and rural disparities in health are well documented and often related to health behaviours, service access, structural barriers, and socioeconomic conditions. Likewise, sexual and reproductive health outcomes in rural areas are poorer, with higher rates of unintended pregnancy, teenage birth-rate, and sexually transmitted infections. Attributed to issues related to service availability, confidentiality, and cost, a range of innovative models of sexual and reproductive health care have been developed to address these issues for women living in rural and regional areas. The following section will introduce some of the emerging models of sexual and reproductive health care in the context of the needs of women in the Murray PHN catchment of Victoria. Here we present an overview of literature that describes a range of models of care that have been used in rural areas across the western world. There were limitations to retrieving information due to access to data sources/journals. Grey literature available in the public domain was sourced along with a range of open access journals. As such, a formal literature review was not undertaken.

Nurse-led models

To address issues related to access, cost and preference for female healthcare providers, nurse-led models for sexual and reproductive health services offer an advantageous solution for practitioners and communities to improve health outcomes in rural areas. The majority of Australians seek and receive healthcare from a general practice (GP) but with limited choice of GPs in rural areas, and reduced availability of bulk-billing practices, GP service delivery for sexual and reproductive health services is sometimes problematic.

Increasing the involvement of primary health nurses in the provision of sexual and reproductive health services has been explored to increase the availability of termination of pregnancy services, for the insertion and removal of long acting reversible contraception devices, and to screen and test for sexually transmitted infections. By up-skilling practice nurses (PNs) through appropriate education and training, PNs have the capacity to take on new roles and deliver more services. This can create more positive patient outcomes by increasing choice for patients as well as facilitating access to services in a timely manner. Additionally, the majority of practice nurses in Australia are female, which has the potential to redress the barrier of low availability of female healthcare providers, particularly in rural areas.

In the context of sexual and reproductive health, expanding the role of practice nurses to include services such as STI screening, contraceptive and STI counselling, insertion and removal of contraceptive implants, and fertility and pregnancy advice and support (including referrals for termination), offers the opportunity to improve access to sexual and reproductive health services in primary care settings. Fleming and colleagues (2018) demonstrated the inclusion of intrauterine device insertions in registered nurse scope of practice appeared to be feasible and was well-received by a cohort of registered nurses in NSW.

Limitations were identified such as the time constraints associated with training, and access to clinical support mechanisms such as mentoring, practice sessions and observation. However, registered nurses who participated in the study reported that it was a logical inclusion to their scope of practice and provided professional satisfaction and improved skills that were beneficial in areas beyond IUD management.

Nurse-led sexual and reproductive health models have potential to increase access to medical termination of pregnancy (MTOP) in regional Victorian locations. Women living in rural areas of Australia are at considerable disadvantage with respect to termination services citing the main barriers as distance to services and financial constraints related to both distance and accommodation along with cost of service (Doran & Hornibrook, 2014). A key strategy to improve access to termination of pregnancy services is to increase the involvement of primary health care nurses in the provision of medical abortion (Graham & Taket, 2017). This approach is routinely and successfully implemented in many countries and would suit the state of Victoria, where medical abortion care is already in the scope of practice for registered primary care nurses. In a recent survey conducted with general practitioners and primary health care nurses from regional and rural Victoria, 50% of non-providing GPs, and 77% of nurses showed interest in becoming an MTOP provider (Moel-Mandel, Graham & Taket, 2017). Reasons for not wanting to provide the service were related to legal uncertainties, procedural and safety concerns and a lack of training. The study concluded that MTOP provision at primary care level, delivered by a range of health care providers, was a viable solution.

A nurse-led model of MTOP service delivery, with general practice support, has been successfully implemented in North East Victoria (See Gateway Health, next section), and demonstrates a successful, accessible and affordable model. This model of MTOP delivery requires a good working relationship with GP and pharmacy and enables nurses to provide the majority of the assessment, monitoring and review of the client. The limitations of this approach are related to the availability of skilled professionals who are motivated, supportive and willing to develop an integrated service model appropriate for the needs of the local community (Tomnay, et al., 2018).

Technology-assisted sexual and reproductive health care

Telehealth models of care offer an innovative way to provide sexual and reproductive health services to a range of population groups, with wide application with young people and people that are rurally located. Telehealth has been effectively used for health promotion, sexually transmitted infection testing and treatment, and to provide medical termination of pregnancy.

Technology-based interventions can effectively promote sexual health among young people. Studies have routinely demonstrated that technology-based interventions were shown to improve condom use, abstinence, safer-sex knowledge, and safer sex attitudes and norms. However, effects weakened after 6-months, indicating that impacts were either short-lived, or other influences emerged.

Videoconferencing for rural domestic and sexual violence survivors has been another effective application of technology, especially for those located in rural areas. Through a partnership with a university-based mental healthcare clinic, with specialised skills in sexual violence, abuse survivors were counselled using videoconferencing facilities. Targeting women who were unable to access the specialist counselling services, a study into the effectiveness of the service demonstrated that the participating clients displayed decreases in depression and PTSD symptoms (Steinmetz & Gray, 2017).

It is difficult for rural youth to participate in adequate sexually transmitted infection (STI) testing because of barriers to sexual health services, including a limited choice of health care professionals in rural areas, concern over confidentiality and privacy, cost and poor transportation options (Garrett, et al., 2012). A free telemedicine service, TESTme, offered telephone and video conferencing consultations to young people under 26 years old living more than 150km from Melbourne. Following consultation, a home-testing chlamydia kit was sent to clients, and following testing, those who tested positive had treatment posted to them. The clients that participated in the TESTme trial indicated that if the telehealth service was not available, only 30% would have gone to their local doctor about their sexual health concern. The main reason for non-utilisation of local services were lack of access to a female health care professional, convenience, confidentiality concerns and cost (Garrett, et al., 2012).

Along with providing health promotion and STI screening services, telemedicine has been introduced in Australia to enable women to access medical abortion without visiting an abortion provider. Following analysis of the first 18 months of operation, a telemedicine service offering MTOP was deemed to be effective, safe, inexpensive and satisfactory to clients. It disproportionately served women in parts of Australia with limited access to abortion facilities (Hyland, Raymond & Chong, 2018).

Well Women's Clinics

Well Women's Clinics/Women's Health Clinics (including options counselling) is a model of care offered across the Loddon Mallee region. These clinics are offered in the community health setting and focus on person-centred care through providing longer appointment times for women to discuss their sexual and reproductive health holistically.

Pregnancy choices clinics (unplanned pregnancy options counselling) is a significant service delivered by many of these clinics. Pregnancy choices clinics provide up to date information and non-directive support to women who have an unplanned pregnancy. Local referral pathways are known by the Women's Health Nurse, and women are referred according to their decision to continue or terminate the pregnancy. *These services are currently at risk as FPV no longer offer unplanned pregnancy options counselling training. Therefore, there is no accreditation requirements to practice options counselling. Currently a Faith-based clinic/service operates in Bendigo offering this service, which may not offer women non-directive support and information.

1.4 Review of Innovative and Flexible Models of Care

The following section presents innovative and flexible models of care and practice through highlighting case-study examples from across regional Victoria.

Gateway Health

Clinic 35, Gateway Health's sexual and reproductive health clinic, was supported by Centre for Excellence in Rural Sexual Health (CERSH) to integrate a nurse-led model of care for medical termination of pregnancy (MTOP).

The clinic is run by Sexual Health Nurses (SHNs) who have advanced skills and knowledge, and work autonomously with the support of a multidisciplinary team, and or medical director. The SHNs at Clinic 35 coordinate the pathway for MToP by undertaking the initial consultation, facilitating unplanned pregnancy options counselling, making a detailed physiological assessment, and ordering required investigations in consultation with the medical team/director (Coelli, Davidson, Orr, 2018). Clients are then rebooked with the SHN and Medical Director to confirm eligibility and to prescribe MToP. Three weeks after the prescription, clients are then followed up by the SHN.

Between January 2015-September 2016, Clinic 35 saw 223 women for pregnancy choices counselling. The women were aged between 14-46 years and had travelled between 1-1367 kilometres to attend the Clinic (CERSH 2017). More than 80% of women who attended the clinic chose to terminate their pregnancy, following appropriate pregnancy choices counselling (CERSH 2017). No adverse events were recorded during this period. Data about contraceptive use was available for 195 of the women, with 143 reporting no contraception (CERSH 2017). Over 70% of women using no contraception at the time of pregnancy, initiated hormonal contraception post presentation to the MToP service (CERSH 2017).

Clinic 35 can provide access to MToP for the cost of a PBS script and further reduced cost with a health care card. The nurse-led clinic is an innovative use of the nursing workforce and demonstrates that MToP can be provided safely to Australian women in rural communities using an accessible and affordable service model. It also demonstrates that sexual and reproductive health services, including MToP delivery, can be easily integrated into a larger primary health care setting utilising a nurse-led model with GP support.

Bendigo Community Health Service (BCHS) pilot

Bendigo Community Health Services became regional Victoria's first women's sexual and reproductive health hub, increasing access to sexual and reproductive health services and information through work force expansion and capacity building. This has meant more doctors and more nurses and reduced waiting lists for services. Most importantly, consultation times are longer ensuring time is taken to listen to women and help address the things they need support for. There is also a big focus on sexual health information and education, both in consultations and community settings, empowering women to have choice and make informed decisions about their health and wellbeing.

This more flexible and accessible model of care "operates in a model of mutual respect and regard" (Kim Sykes, CEO, Bendigo Community Health Services), providing a safe place where women can come and talk about any aspect of their sexual and reproductive health and wellbeing.

Melbourne Sexual Health Centre: TESTme

TESTme is a free telemedicine service of Melbourne Sexual Health Centre (MSHC) that offers testing for Chlamydia and Gonorrhoea for rural Victorians aged 25 years and younger, rural Victorian men who have sex with men and Aboriginal and Torres Strait Islander people. The service was developed in response to increasing STI rates in Victoria and the barriers some people in rural/regional Victoria experience in accessing sexual health services.

TESTme aims to provide a service that is easy to use, free and confidential through offering telephone consultations. Following consultation, a home-testing kit is sent to clients, and following testing, those who tested positive are contacted by the TESTme nurse to discuss results and the possibility of having the treatment posted to them. The service was initially started as a 12 month pilot project, but is now an important part of the MSHC services.

Echuca Regional Health Enhanced Maternity Care Program

A strong partnership between Echuca Regional Health (ERH) and Njernda Aboriginal Corporation has seen collaborative practice develop between the organisations and ERH's Enhanced Maternity Care Program (EMCP). The partnership enables Njernda midwives to refer clients directly into the EMCP, which provides additional support and education during pregnancy to those experiencing considerable social or medical issues (Campaspe PCP 2017).

Changes were also implemented to better enable service coordination, including an Aboriginal newborn flowsheet to ensure that service pathways are activated with Njernda and the Shire of Campaspe Maternal and Child Health team (Campaspe PCP 2017). This coordinated approach ensures that Njernda are notified of all births enabling postnatal care to be monitored.

Grampians MTOP GP study

In 2017, Women's Health Grampians and the University of Melbourne conducted a survey with GPs and Practice Nurses working in the Grampians Pyrenees and Wimmera regions to explore GPs' views on the services in the region and their referral practices when women present with an unplanned pregnancy (Keogh, Croy, Newton, Hendron and Hill 2017). The study found that there were very limited abortion services in the region, poor knowledge on medical abortion and tele-abortion services, and inconsistencies in both GP and Practice Nurse awareness of services, including no clear referral pathways, and difficulty accessing information (Keogh et al. 2017). GPs that highlighted their interest in providing MTOP also highlighted a range of barriers including a lack of ultrasound facilities, lack of clarity about back-up hospital services for MTOP and a lack of knowledge as to whether pharmacists would be willing to stock the drugs. These findings are easily transferrable to other regional settings including areas across the Loddon Mallee and Goulburn North East Victoria regions.

The study results indicate there is scope for many service system improvements to support women with unintended pregnancy in the Grampians region.

Recommendations from the study include:

- Improving referral pathways for medical and surgical abortion
- Improving health care providers' knowledge of medical and tele-abortion
- Provision of support to GPs willing to provide medical and/or tele-abortion to set up a trial service, develop clinical protocols and explore support for ultrasound availability, emergency backup and pharmacy medication
- Promoting the provision of accurate and comprehensive information on all available options for women facing unintended pregnancy through government, regional and local community information communication networks.

CERSH: Workforce Development

The Centre for Excellence in Rural Sexual Health (CERSH) works across the Loddon Mallee and Goulburn North East regions with the purpose to design, implement and evaluate programs that provide practical solutions for the improvement of sexual health in both regions. One of CERSH's priorities is the Rural Workforce aiming to support clinical workforce and interagency capacity in delivering sexual and reproductive health services.

CERSH has coordinated training opportunities across the Loddon Mallee and Goulburn North East regions for service providers and health professionals, particularly around unplanned pregnancy and abortion pathways and MTOP service delivery. CERSH has also developed ten free and accredited online learning modules on rural sexual health care that are available on their website and allocate RACGP and CDP points accordingly.

CERSH also established and coordinate the Victorian Rural Clinical Network for Unintended Pregnancy and Abortion. This is a collaborative network that provides leadership, peer learning and clinical service development for unplanned pregnancy and abortion in regional and rural contexts. The network assists in building the capacity of the rural sector to develop and deliver responsive and inclusive services and systems for women experiencing unintended pregnancy and abortion.

1.5 Summaries of Regional Sexual and Reproductive Health Strategies

Women's Health Loddon Mallee

The Sexual and reproductive Health regional strategy is currently in its final stages of development.

Summary:

Her Health Matters: A regional approach to sexual and reproductive health in the Loddon Mallee Region (LMR) is a strategy that aims to improve sexual and reproductive health across the LMR. Her Health Matters is designed to guide collaborative action across the region to improve women's sexual and reproductive health.

The four strategic priorities of Her Health Matters were informed by the sexual and reproductive health priorities identified by the Victorian Government (2017) and following consultation, were modified to reflect and embrace the needs of the region.

Her Health Matters strategic priorities:

1. Fertility, Pregnancy and Birth- Improved knowledge, skills and capacity to manage fertility, pregnancy and birth across the LMR.

2. Reproductive Choices- Improved access to contraception and termination of pregnancy services across the LMR.

3. Reproductive System Health and Care- Loddon Mallee women experiencing conditions or transitions related to the reproductive health system have improved access to informed services and feel understood and supported to manage their health.

4. Sexual Health and Wellbeing- Loddon Mallee women feel confident about accessing respectful and culturally safe sexual health services for testing, treatment and support, regardless of their gender identity, cultural identity, ethnicity, age, sexual orientation, disability or geographical location.

Women's Health Goulburn North East

Sexual and Reproductive Health Plan is currently under development.
Sexual and reproductive health (SRH) was identified as a key priority in the Women's Health Goulburn North East (WHGNE) Integrated Health Promotion Plan (2017 to 2021) with implementation of the Victorian Women's Sexual and Reproductive Health Key Priorities 2017-2020 established as an objective. To develop the plan, WHGNE considered current regional demographic, social determinants, health and lifestyle data in greater detail and mapped current services and health promotion activities to identify gaps, areas for improvement and opportunities for regional collaboration in program development and delivery. In addition, participation in the Storylines: Her Voice Matters project enabled women's lived experience of SRH in Goulburn North East (GNE) to be 'heard', to spotlight local needs for women, and the intersecting issues influencing women's SRH health in the GNE region. While analysis of gendered quantitative data demonstrated broad patterns of ill health and disadvantage, women's lived experience of SRH highlighted local needs aligned with the state wide strategy, and priority groups and LGAs for targeted regional action.

Summary:
WHGNE Sexual and Reproductive Health Plan-Goulburn North East 2018-2021

Sexual and Reproductive Health Plan Objectives:

1. Access to safe and inclusive services - Women living in Goulburn and North East Victoria can access timely and affordable sexual and reproductive health services that are respectful, inclusive and culturally safe, regardless of the woman's gender identity, cultural identity, ethnicity, age, sexual orientation, disability or residential location.

2. Live free from all forms of violence - Women in Goulburn and North East Victoria live in communities that do not condone violence against women, including all forms of sexualised violence.

3. Foster supportive environments – Women's sexual and reproductive health is supported in all environments including workplaces, schools and communities.

4. Access to abortion services - Women living in Goulburn and North East Victoria have timely and affordable access to medical and surgical terminations.

5. Build primary prevention – Women of all abilities living in Goulburn and North East Victoria can access targeted sexual and reproductive health prevention information and initiatives.

Key Area 1 – SUMMARY & RECOMMENDATIONS

The Murray Primary Health Network (MPHN), Women's Health Loddon Mallee (WHLM), Women's Health Goulburn North East (WHGNE) partnership was specifically established to enable the focus on women's sexual and reproductive health needs and priorities in the MPHN catchment. Agreed methodology was to collect and analyse relevant quantitative data to establish a profile of women's health across the MPHN catchment; undertake service mapping and a rapid review of emerging models of care to identify service provision, strengths and gaps in the region and collect women's stories as their lived experience to identify priorities for women living in the MPHN catchment. As such, our shared goal was to provide MPHN with broad recommendations based on summary evidence and information for each area of the project, which could be used to guide further analysis and collaboration to inform MPHN catchment wide actions.

1. Quantitative data by LGAs across the MPHN catchment, service mapping and review point to broad patterns of disadvantage, inequity and need for women living in the MPHN catchment and spotlight priority areas for catchment wide planning and reform.

2. Stories shared by 62 women living small towns and regional centres across the MPHN catchment, including women in marginalised and/or disadvantaged population groups: women with disabilities, refugee and CALD women, women on low incomes, geographically isolated women and young women, provide rich detail not captured in quantitative data to inform priority issues for collective action. Coding and analysis of all women's stories highlight the multiple factors in rural and regional areas and their intersections, that influence women's access to SRH care and services across the MPHN catchment and the potential links to SRH health ill health and health indicators captured in data sets.

3. As the project coincided with the development by WHLM and WHGNE of new SRH plans in Loddon Mallee (LM) and Goulburn North East (GNE) regions, relevant quantitative and qualitative data was analysed further by each women's health service to identify key priorities for women living in their respective regions, with objectives, actions and target groups informed by service gaps and evidence of greatest disadvantage in local government areas (LGAs).

4. Continued collaboration between project partners MPHN, WHLM and WHGNE would enable MPHN report recommendations to be examined in relation to WHLM and WHGNE regional SRH plans and strategies, and opportunities identified for further partner collaboration to support catchment wide recommendations.

Recommendations:

- Ensure sexual and reproductive health services and health promotion programs are prioritised to meet the demographic needs of women in the Murray PHN catchment, or varying priority needs of women across the lifespan. Targeted interventions should focus on particular ages and stages, such as menopause information and education, as most local government areas (LGAs) in the catchment show the highest population female age group is between 45 and 64 years.

- Ensure sexual and reproductive health services are financially accessible as almost 50% of women in the MPHN catchment earn below the weekly minimum wage.

- Promote service coordination between the family violence and sexual and reproductive health service systems, due to the high rates of family violence in the MPHN catchment and the link between controlling behaviours and adverse effects on sexual and reproductive health.

- Promote the importance of cervical screening and where cervical screening

  is provided to increase the uptake of cervical screening across the MPHN catchment, with a focus in LGAs with comparatively low uptake.

- Progress the 'Welcoming Doors for Women' project in the Loddon Mallee region, and in areas of Goulburn North East Victoria that are poorly serviced.

- Gain understanding of what sexual and reproductive health services are delivered by GPs across the MPHN catchment, particularly the availability of long acting reversible contraception (LARC) insertion and removal, and medical termination of pregnancy services (MTOPs).

- Increase provision of surgical termination of pregnancy services (STOPs) across the MPHN catchment to improve access, (in line with the Victorian women's sexual and reproductive health key priorities 2017-2020, page 17) and develop appropriate and accessible referral pathways for women.

- Investigate and resource innovative and flexible models of care for the delivery of sexual and reproductive health services in regional areas.

Key Area 2: Women's Voices

2.1 Development of 'Her Voice Matters'

Storylines: Her Voice Matters, is a joint initiative of Women's Health Loddon Mallee (WHLM), Women's Health Goulburn North East (WHGNE) and the Murray Primary Health Network (MPHN), that aims to give voice to women's sexual health and reproductive (SRH) needs and experiences across the Murray PHN catchment. It is a collaborative, enquiry-based approach using co-design methodology to accurately represent the lived experience of all women in our region regardless of age, stage of life, financial status, ability/disability, country of origin and sexual orientation (Baljeet S. 2017).

Storylines: Her Voice Matters utilises storytelling as a tool to assist women to share their experiences of SRH. Each story becomes part of a bigger story that will help build a picture of how to improve the quality, access, and type of health support for women (Evans M. & Therrey T. 2013). Story is the universal tool that enables humans to express, understand and connect. It enables individuals to process and express emotion and make meaning from their experiences. Visual storytelling adds the element of visual imagery that assists individuals to find the words to tell of their experience. Story crafting is a reflective process that is accessible for all women and enables people to make sense of their experiences and deepen their connection to who they are and what they stand for.

The Storylines: Her Story Matters approach uses story as a tool in 3 key areas:

Self-Awareness: self-discovery, inner reflection, personal history, emotional processing and intelligence.

Meaning Making: persuasion, messaging, making sense, re-storying, vision & values, metaphor, illustration.

Trust: vulnerability, openness, authenticity, trust, connection, emotion.

Story gathering provides insights into culture, emotions and attitudes, while simultaneously allowing people to speak and listen, which deepens connection, belonging and understanding. Story gathering also allows the creation of a shared story, for celebrating, preserving and learning. The experiences that participants share provides an opportunity to understand and gather information from a woman's lived experience. The project also has the deeper purpose of gathering individual women's stories to tell a much larger story; the story of women's experience of sexual and reproductive health across the region to inform system response and reform (Brason L. 2015).

This project has a focus on intersectionality, so that the starting point is at diversity instead of commonality. The project aims to bring a range of women's voices to the centre of analysis, rather than positioning them at the margins to be defined by their 'difference from' the centre. Using an intersectional approach encourages practitioners to make the links and connections between various forms of discrimination and will help ensure equality is achieved for all groups of women. This means balancing universal strategies with specialist, tailored approaches for women who experience intersectional disadvantage, including Aboriginal women, culturally and linguistically diverse women, women with disabilities, sexuality diverse women and gender diverse people, and women living in rural areas (Women's Health Victoria, 2016). Using a storytelling approach fosters intersectionality and allows experiences to be heard in whatever form is appropriate for the storyteller.

Storylines: Her Voice Matters has a focus on reaching diverse women who have 'lived experience' and valuing their contribution. The project values the engagement of women's groups who are already meeting to share and learn from one another. These groups offer a safe and respectful environment for story gathering and telling. Some of these groups include women who identify as:

- LGBTQI,
- Aboriginal or Torres Strait Islander,
- newly arrived women/refugees,
- culturally and linguistically diverse women,
- rurally isolated women,
- young women,
- women with disabilities,
- women who are financially disadvantaged,
- women who are incarcerated,
- women who work in the sex industry,
- women who have lived experience of family and intimate partner violence, and
- older women.

Storylines: Her Voice Matters was developed as a visual storytelling tool designed to assist women to share their experiences of sexual and reproductive health. A set of storytelling cards with text and graphics was developed with five categories to prompt women's lived experience (see Appendix 1). Four categories cover the full spectrum of sexual and reproductive health topics- reproductive system, sexual health and wellbeing, reproductive choices and fertility, pregnancy and birth. The fifth category is a set of feelings cards which enable women to speak to and match their feelings with their experience of sexual and reproductive health to retell their own story.

Stories and experiences were collected using these visual storytelling cards in a one-on-one conversation with a project worker, in a group workshop or through an online submission (outlined in Appendix 2). Women were also able to write their own story without the use of the visual storytelling cards through answering a series of reflective questions that were developed as a storytelling guide alongside the visual storytelling tool (see Storytelling Guide document below). Written submissions could also occur in a one-on-one conversation with a project worker, in a group workshop or through an online submission. The Storylines: Her Voice Matters website https://www.hervoicematters.org/ was also created to promote the project and allowed women to engage with the project through submitting their story online. The website allowed women to read other women's stories that had already been submitted, where women gave permission to share.

- Her Voice Matters - Storylines Flyer
- Storylines Card
- Facilitation Guide
- Her Voice Matters Card Outline
- Storytelling Guide
- Storylines Poster (A3 or A4)

2.2 Implementation of 'Her Voice Matters'

Engagement and Recruitment

Participants were engaged and recruited in a variety of ways.
Both WHLM and WHGNE engaged with partner organisations and established women's groups to discuss the project and potential interest in undertaking a Storylines: Her Voice Matters group workshop. Particular groups of women were targeted according to the analysis of demographic data across the regions and the intersectional approach of the project which considered access barriers to engagement and sharing online, such as lack of technology, poor internet and mobile services, cultural, language and capacity barriers.

Recruitment

Participants were recruited through the following methods:

- Media: media releases, interviews and Facebook posts were utilised by WHLM and WHGNE throughout July and August to engage and recruit women across the regions (see Appendix 3 for example post).

- Posters and flyers- posters and flyers were sent to partner organisations, community groups and networks across the LM and GNE regions to promote the project and website (see flyer and poster PDFs on previous page).

- WHLM's Well Women's Clinic- WHLM had flyers in the waiting area and reception desk. The WHLM Women's Health Nurse was also able to support women to retell their story through their chosen method- written or one-on-one conversation.

- Partner organisations and contacts- women's groups and partner organisations were engaged through existing contacts and relationships with WHLM and WHGNE.

- Website- the website engaged women by providing women with the opportunity to read other women's stories that had already been submitted where permission was granted. Women were also able to access the storytelling guide online to submit their story (anonymously and confidentially) through the website.

Method

The project utilised a variety of methods so that diverse women could become involved in the project in a way that met them where they are at in terms of ability, location and self-efficacy.

Story collection methods:

- Online story submissions- through the 'Her Voice Matters' website, women submitted their stories using the online storytelling guide that uses both a written story process and the Her Voice Matters Cards.

- Written submissions- women downloaded the storytelling guide form from the website or received a hard copy from a project worker or women's health nurse. The story was then written and returned or emailed to WHLM or WHGNE.

- One- on- one phone calls or meetings in person also took place; women were guided through the storytelling process with one of the project workers or women's health nurse. Stories were voice recorded and transcribed.

- Group workshop- project workers visited an existing women's group and ran a workshop to understand their sexual and reproductive health stories and experiences. After discussion with group contacts and informed consent from participants, stories were voice recorded with permission and transcribed, or women were supported to write their stories during planned sessions.

With informed consent, information for participant age, postcode, country of birth and Aboriginal or Torres Strait Islander identity was also collected. This was to ensure that diverse groups of women were represented from across the MPHN catchment. No other demographic or identifying data was recorded to ensure anonymity and confidentiality of all women and their stories (Appendix 4- ethical considerations). Women were also given the option to choose if they would like their story shared on the Her Voice Matters website. Stories with permission to be shared online have also had any identifying features such as town names or service names removed to protect participants' privacy.

Stories were analysed and thematically coded, with any voice recorded stories being transcribed before thematic coding. All stories were analysed to identify key topics, key impacts, key feelings and the sexual and reproductive topics (see Appendix 5). Thematic coding was used with the key topics related to sexual and reproductive health experiences, which were then clustered into five key themes (see Appendix 6).

Results

Throughout the story collection period, sixty- two (62) women living in rural and regional communities across the Murray PHN catchment shared their story utilising the various story collection methods. A diverse range of sexual and reproductive health topics were featured in the stories, with menstruation, contraception options and endometriosis the most prominent topics.

Participants

Participants were varied in age and location, although there was not story representation from all priority groups of women or every LGA across the catchment. Eight women were born outside of Australia.

Participant demographics:

Age Range (Years)	16-20	20-29	30-39	40-49	50-59	60-69	70+
Number of Participants	2	9	19	11	5	13	3

Themes

Analysis of stories shared by 62 women living in Loddon, Mallee, Goulburn and North East Victoria regions identified multiple and intersecting issues impacting lived experience of sexual and reproductive health. During analysis, key topics related to sexual and reproductive health experiences were identified. Thematic coding was then used on the key topics, resulting in five key themes: workforce knowledge and skills, impacts of sexual and reproductive ill health on women, availability and access, sexual and reproductive health literacy and systems and environments. Issues that were collectively raised are explored in a narrative, with deidentified quotes from women's stories to show how these issues and their intersections impact women's health and wellbeing. To enable women's voices through their lived experience, stories have not been edited, except where women gave permission for editing by project workers to protect a woman's privacy or the privacy of others, or to show additional story content added by a woman sharing her story in a project facilitated group discussion (See Appendices 7-11 for story examples from the project).

1. Workforce Knowledge and Skills

A recurring issue for women was their collective experience of not being listened to by health practitioners. Women frequently described the absence of active listening and inclusive communication in their initial appointment with General Practitioners, accompanied by a lack of information, choices and options to support their sexual and reproductive health.

"This has not been due to lack of trying but more due to lack of knowledge of symptoms I was describing to doctors/specialist I visited in those years. Unless a General Practitioner knows of endometriosis as such and has dealt with patients it can very easily go misdiagnosed."

"We don't all fit into the same boxes. Services should not only give us a bigger voice, they should actually listen."

"When my GP wouldn't listen to me, I felt frustrated and angry. I knew something wasn't right and that this wasn't normal."

Stories from young women seeking contraception information, women living with disabilities and culturally and linguistically diverse women demonstrate the impact of poor practitioner communication skills on their sexual and reproductive choices, autonomy and health.

"Just after I turned 18, I went to the GP for contraception. The only thing I was offered was the pill. No discussion around other options or referral to a women's health clinic to discuss."

"My biggest problem was that nobody listened and nobody heard what I was actually saying. I had had so many doctors who were trying to treat things as a wheel chair issue rather than a women's issue. We're not getting past first base because they only see the wheelchair. I am still a woman. I still function as a woman. So I don't go to the doctors to be told what to do as a paraplegic; I go because there's something wrong with my body… Eventually I was booked in for emergency surgery."

"Before I had the baby, I'm telling [the midwife] the baby is coming. And she's still standing next to me, ignoring what I'm saying. She thinks the baby's far away and I had to push the baby and the baby came out. She said 'Oh…you were right; you had baby quicker'. And why [doesn't] she check? And because no one was helping me [with the birth] I was cut really, really bad and it had to be stitched up. And she was standing next to me and I'm telling her [but] she doesn't listen to me. I'm still worried that something's bad there."

Women's lived experience of sexual and reproductive ill health highlights the need for increased workforce knowledge, skills and resources to support timely diagnosis and effective treatment. Common to many of these women's stories was the debilitating pain and prolonged ill health over many decades caused by the lack of practitioner knowledge and understanding of menstruation, Endometriosis and Polycystic Ovarian Syndrome (PCOS).

"I remember the first time I got my first periods at 13… once that year and about three times the following year. My mother dragged me to lots of doctors all of which could not give her an answer. In all of this I still got terrible pains to the point I was passing out at school. Heavy bleeding once my periods became regular if you can count regular as not knowing when your next period was coming. This was by age 15. I am now 51 years old and only recently have I been told that the problem with all the pain and abnormal amount of bleeding, [with] bouts of anaemia is due to having Endometriosis."

"As I aged my periods became heavier, more irregular and the pain was so intense, I could be bed ridden for days. At age 40, I asked my gynaecologist if I could have a hysterectomy and was refused. He insisted I was too young and that the Mirena IUD would be the answer to my problems. I left his office so angry… At age 46, [my new doctor] took one look at me and [booked me into surgery]. The operation found that I had not only been suffering with Endometriosis, but that I also had Adenomyosis and fibroids the size of oranges."

Stories from women living with disability, especially those with paraplegia, mobility, cognitive and intellectual disabilities show how a lack of knowledge about disability and women's sexual and reproductive health contribute to practitioner assumptions, poor communication and ineffective health care.

"[Lack of disability] knowledge is an issue in this area. As a paraplegic, there's a lot of doctors that don't know a lot. I've had everything from 'What you can drive?'"

"I went to the Doctors a couple of days ago and asked to get a test. They sent me home with the test and I had to do it myself and because of my disability I [didn't] understand. [The Doctor] didn't explain what to do with this test so I went back and I had to get the nurse to do it for me. I couldn't see what to do or how to do it."

Women who are refugees, have a migrant background or are culturally and linguistically diverse (CALD) shared stories showing the importance of cultural awareness to women's experience, particularly for those with a trauma background.

"Another time I had a big baby and the baby was late. And the doctor was coming to put the hand inside and I screamed because it hurt. I said 'Stop!' And the baby started kicking. It wasn't coming and I know. I'm not [a] new [mother] so I knew what was happening; I have four kids between Africa and here. No problems, I knew the baby wasn't coming yet. [They didn't] understand me or listen to me."

"[I don't see the doctors about my sexual health] because I know when I'm going, nothing will change. That's because I have a lump here, and when I go to doctor to tell doctor, nothing changes. When you don't understand good English, someone can [make it look like] you [are] the problem."

As a support worker for multicultural women in a regional centre explains, women's experience of primary health care in their community frequently determines whether they will continue to seek sexual and reproductive health care and services or not.

"For some women who approach a service and have a negative experience, they're unlikely to go back and then they're not addressing the initial reasons why they accessed that support in the first place."

Drilling further into women's experiences exposed the harms of practitioner responses to women based on individual assumptions, unconscious bias, discrimination and conscientious objection. Some women's stories demonstrate how medical bias and discrimination can become institutionalised, creating additional barriers to sexual and reproductive health care and support.

"There's only one pharmacy in town and [the pharmacist] won't provide emergency contraception. You can get it at the hospital but there's no privacy. The closest pharmacy is over 70 kms away."

"I felt disappointed obviously but more so I felt angry that the decision was being I felt made for me by someone who really didn't know me that well and who was make broad assumptions about me."

"A local community leader who's since left publicly announced views on same sex and transgendered people. I'm a member of the LGBTQI community and felt that I would not receive good health care if I was to go to the local health service with my partner where this leader was associated."

"I had my baby, then [the midwife] took the baby. My husband took the baby and when my husband was returning baby back to me… the midwife said, 'Let go of the baby!' When my husband let go, the baby nearly fell; I had to catch the baby. And [the midwife] didn't say 'I'm sorry'. She just stopped there and I felt really, really bad. I said to myself, 'Did she do that on purpose?' I think she did… because something just out of the blue, you should be sorry for that… [My husband] was [mad] about it too, but you cannot talk because you don't make people uncomfortable; you just do whatever they describe."

"I'm obese so I can't receive local fertility health care. The doctors here rule automatically on BMI. My friend, who is very athletic and strong, had to go to a regional city to receive health care despite living over 60 kms away. She was treated poorly there and made to feel bad about her weight. There is lots of research that proves medical bias toward obese people. Ruling on BMI alone is one indicator that these prejudices are systemised. I fear having a baby here for this reason."

2. Impacts of sexual and reproductive ill health on women

Women's stories powerfully show how delayed diagnosis and ineffective treatment for sexual and reproductive ill health contribute to poor health and wellbeing outcomes for all measures: physical, mental, emotional, psychological, sexual and reproductive.

"I got my first period when I was 14 years old…I was terrified, there was so much blood… My first period lasted 2 weeks. From then on my periods were excruciating, no one ever told me this wasn't normal. When I was 18, I saw a doctor and mentioned my periods…[and] he put me on the pill and suggested an IUD… It seemed to get worse, we ended up trying three different forms of oral contraception, obviously giving each one time to do what it was meant to, help ease pain and bleeding. It just kept making things worse, [my periods] got heavier and more painful, I felt so sick."

"My gynaecologist told me I was just one of these unfortunate women where there was no cause or cure for my problems. So I endured years of painful periods, regularly changing and trying new contraceptive treatments."

Increased and prolonged periods of debilitating pain arising from undiagnosed and/or ineffective treatment for one or multiple gynaecological conditions such as Endometriosis and Polycystic Ovarian Syndrome can affect a woman's capacity for and enjoyment of intimate relationships and social interaction, her relationships with family members, friends and colleagues, and her participation in the workplace and community. These cumulative impacts on a woman's health and wellbeing were common to most women's stories.

"And what I had is not uncommon and it's not major, but I ended up…in theatre twice and the second time was major surgery and was completely unnecessary. Besides the fact that it was nearly two years of my life that I had to manage [the ill health] with a young child while studying."

"It hurt constantly and affected a whole lot of other areas of my health. And where I really 'spat it' was where I couldn't pick my child up from school. I rang a friend and said '[the cyst's burst] and that's major."

"I spend a lot of time lying in bed, taking pain meds in high doses just so I can sleep through the pain. I have missed days at work, my fitness is at an all time low due to my pain. My next option is to have a hysterectomy which won't guarantee that the endometriosis will cease. I feel frustrated and angry at this invisible disease and the impact it has on my life and my family's life."

"The lack of investigation into what was causing my symptoms has led to years of infertility and many, many hours and days of medical intervention, not to mention the financial costs. I feel let down by the medical system which does not seem to take 'women's issues' seriously."

"When I ask about what we can do to help reduce the pain, my next step is a hysterectomy. Which I am not ready for. My relationship with my husband, my body, my sensuality is hanging on by a thread because all the hormones are changing me, I have no libido, they affect my ability to remember things, they change my moods. They just suck."

"I was sad (devastated) that my relationship was falling apart because our sex life suffered so much. I felt angry/confused/sad that my body had betrayed me."

3. Availability and Access

Women living in rural and regional areas already experience additional barriers to sexual and reproductive health care and services compared to women living in urban and metropolitan areas. A survey undertaken by the Victorian rural women's health services found these barriers include distance and travel times from services, lack of availability of General Practitioners and specialists, particularly in small towns, and reduced privacy in rural communities (WHAV 2012).

The lack of availability of General Practitioners (GPs), and specialists in rural and regional areas was often raised by many women as the precursor to untimely health care and ineffective treatment. Women described being asked when they phoned their local health clinic, in both towns and regional centres, if their health condition was 'life threatening or not.' Access to the same GP or to a female practitioner were also raised as barriers for women accessing sexual and reproductive health including contraception information and advice, vaginal examinations and cervical screening.

"My doctor finished up at the clinic after eleven years and they can't replace him. It's really hard for women to see a female Doctor in this town; you have to book weeks in advance for PAP tests or issues that you'd prefer to see a woman GP about."

"You can't even get into doctors. Like we've lost two good doctors and I'd been seeing this one doctor for years and now I don't have a doctor. And then the ones there; I've got nothing against the ones that come from another country but if you can't understand the information they're trying to provide and they don't understand what you're trying to tell them… you're left empty handed."

"The problem is that when you have a [health] problem that's a big issue, a specialist comes from Melbourne once a month…it's not enough. You have to wait on the list because [there's only one specialist] otherwise you've got to see the doctor. [Even] when I was in hospital for 2 weeks I had to wait for two doctors to come from Melbourne."

"I had to make multiple phone calls to find a provider who was able to insert it [Implanon] in Bendigo. There was no quick and easy resource to point me in the right direction."

Lack of linked up accessible transport in rural areas is another barrier to health care and services, particularly for women already experiencing financial and other forms of disadvantage. The need to travel considerable distances for specialist sexual and reproductive health services, including medical and surgical abortions also creates additional costs and time for women who may also be grappling with caring roles, intimate partner violence and lack of privacy.

"Trying to get to specialist appointments and getting home at a reasonable hour, that needs to change. I had to go to [regional city] for a specialist appointment [the day before the appointment] as the trains don't coincide with the specialist appointment on that day. So I had to go the day earlier…but I had to pay for a motel room with the specialist on top which was very expensive."

"Women living in Alexandra need to travel to Mansfield to have their babies, a 140km return trip. This makes visiting by partners and family difficult, especially in Winter or when you don't have your own transport."

"Falling pregnant when new to a small town, not a lot of options of where to have the baby, small country hospital 45 minutes away or back to the city where I'd come from. Opted for a city obstetrician my sister had been too (2 hours away)."

4. Sexual and Reproductive Health Literacy

Through their stories, women explained the importance of knowing about their sexual and reproductive health to know what to discuss with their health practitioner. Women felt more confident to describe symptoms and ask the right questions when they had the appropriate health language or sexual and reproductive health literacy. For some women, this confidence or understanding came only after their own personal research, personal conversations with friends, or education through lived experience. Clear two-way communication between health practitioners and their patients helped build women's confidence and sense of control of their health and wellbeing. Open and respectful communication between health practitioners and women also contributed to more timely health care and effective treatment.

"Unless you actually ask questions, you don't get information. You could ask to see the nurse and say 'Look that wasn't satisfactory; I haven't got the answers I need'. I don't know how they'd react."

"[Services] can be as flexible and we can know where to go and how to do that but I really don't think that [health] knowledge is out there."

"Control's important because that gives you your confidence, gives you your reassurance that you are safe and not being coerced or bullied in any way. That's what makes me feel like I can maintain my health."

"One of the hardest things is not knowing what to ask when you go to the doctors. And not having people to share your story with that understand. I found that once I was diagnosed and they had done all they could medically, the specialists failed to point me in the direction of support, for the emotional component of Endo."

Women's stories also often highlighted a lack of resources, information and support to make informed decisions about their sexual and reproductive health and care.

"I experienced an induction of labour due to the suspicion that my baby was large. I asked for information about what it involved and was told all women are different and that there was no handout or factsheet to give me."

"I would like to see gps have open discussions about the different contraception options and not just push their personal preference."

5. Systems and Environments

Women's lived experience highlighted the negative impacts of unwelcoming health systems and environments to health and wellbeing outcomes. Fragmented or siloed services also contributed to delayed diagnosis and effective treatment for sexual and reproductive ill health and can add additional costs for travel and services in regional areas.

"When you do try to discuss some of these [health] issues with people, you're often told 'Well that was someone else's responsibility to have informed you of that'. Maybe I was told but maybe I wasn't in a place to hear that at the time. Maybe I needed to take something away with me and think about it later on."

"I found some lumps in my breast and went to the hospital and had an ultrasound. They said there were a couple of cysts in fibrous tissue. Then they sent me onto Breastscreen [who] knocked me back [because there was something there]. Then I had to go to another part of Breastscreen for another ultrasound and they couldn't find anything. So here I am with two doctors' reports completely different. I went back to the Registrar and he said everything was okay. I said I'd rather have it tested for my own confidence so now I've got to wait and book in to have the biopsy done. Why have I got two different reports? They said it's not on Medicare [but] I still want to go ahead… It'll cost $125 and I've got to ring them… and have it done."

Women also raised concerns about the lack of accountability of health services delivering sexual and reproductive health care and treatment and the potential for harm and abuse from practitioners where women feel unsure or unable to follow up inappropriate behaviours and responses from health professionals.

"I don't know if I feel confident to contact the clinic and make a complaint if I've had a really terrible experience. Like who is available who can advocate or you can talk to that is a bit of a middle person. It might not be a big issue but you just want someone to know. You're often in that room with that person [health professional] by yourself. There's no one supervising or monitoring them if whatever happens. No one's ever asking them any questions or how that went. Or you could be leaving in tears and people see that and think 'she's having a bad day.'"

Many women described the value of supportive relationships from female health practitioners, family members and women in local community networks when navigating health systems for sexual and reproductive health issues. Their stories demonstrate the difference these relationships, advocacy and support made to their health and wellbeing outcomes.

"I told my doctor… again she brushed me off. By this stage, it had been going on for more than a year. It was by chance that I was chatting to a friend and she mentioned her brilliant GP that she was seeing for infertility issues. That afternoon I called this clinic and made an appointment… This doctor was amazing, she listened to me and sent me to an obstetrician/gynaecologist."

"[A friend who's a nurse] she worked with me for the entire 12 months and even after surgery she came to my house. And she's a wound care nurse. I had great back up all the way."

"…when my doctor came [back to work]… I saw her in the first week… I did not leave that clinic until I had an appointment with the surgeon. I was there for two hours. But it was only when she came in and I cried and told her what was going on, and she told me it was a [gynaecological] cyst and needed to be addressed as a cyst. It was a cyst in a gland after childbirth and it was quite apparent [to my Doctor] what needed to happen. It wasn't going to go away by itself, it wasn't a skin problem and it wasn't a sitting down issue. None of those things were going to change. But each time [I saw previous Doctors and specialists], it was seen by them as a pressure issue, 'From sitting down too much. Part of your muscle issues'. It was a cyst and finally I was booked in for emergency surgery."

"That terribly important, to have that network of people you can call on, people you can rely on. I've got one or two friends…so we have a pact and it's having those people you know you can call up and you know they'll be there. It can be your family or your friends."

Cross sector partnerships between health care, community and education services were seen to provide valuable models for planning and delivering integrated health and other services that were welcoming and responsive to women's needs. Women who identify with a disability and those who are refugees or culturally and linguistically diverse emphasised the importance of health care and other professionals building trust and respect to 'hear' what women's needs and priorities are. They described how holistic support from local workers that benefited their children and families helped them to feel safe and confident to seek health care and services for themselves through trusted advocates in local service networks.

"All the organisations need to get to know the women and work together with them to meet their needs and priorities".

"There might be an advocate or a separate entity outside the clinic like here [community centre] that you could tap into."

"[I'd like] some people who can support people like [women support worker], because she's been the main helper to us. Someone who can support her to help us more."

"One of the local agencies here said for a family violence case 'We'll get X'. X happened to be a male and didn't speak the language. Because he came from one of part of the same country, there was no curiosity, no understanding, no education that that person didn't speak the language. And it was entirely inappropriate getting a male who was a leader in the community and from the community."

Discussion

In analysing the sexual and reproductive health stories and experiences of women across the MPHN catchment, this project has identified several key issues and themes. The key themes highlight the multiple and intersecting issues collectively raised by women who shared their experiences. These issues offer insight into the local sexual and reproductive health context, including the service system and supports, and the impacts on women's health and wellbeing. They also identify strengths within the current context and opportunities for improvements.

Whilst a diverse range of sexual and reproductive health topics were featured in the stories, the most prominent topics aligned with the state-wide Women's sexual and reproductive health key priorities 2017-2020, including Endometriosis, reproductive choices/contraception options and access to respectful and safe sexual health services. Endometriosis was most regularly discussed in the stories and highlighted the long-term and often debilitating impacts of the condition. With the newly released National Endometriosis Action Plan and the prioritisation of Endometriosis in the Women's sexual and reproductive health key priorities 2017-2020, this offers further opportunity and action to improve treatment, understanding and awareness of Endometriosis across the region.

A recurring theme for women was not being listened to by health practitioners, a lack of inclusive communication by health practitioners and a lack of information, choices and options to support their sexual and reproductive health. These intersecting issues often cumulated into ineffective treatment, prolonged pain, delayed diagnosis and further impacts on a woman's physical, social and emotional health and wellbeing, particularly intimate relationships. These issues highlight the need for increased workforce knowledge, skills and resources to support timely diagnosis and effective treatment for sexual and reproductive ill health.

The need for improved access to and availability of sexual and reproductive health services was also consistently highlighted in women's stories. The lack of availability of GPs, and more specifically female GPs, as well as the lack of specialist services was common to many stories, and created barriers for women accessing sexual and reproductive health services. This highlights the need to investigate and resource innovative models of care, such as nurse-led models, to both improve access to sexual health services in regional settings and access to female practitioners. The additional barriers of travel time to reach services, lack of linked up and accessible transport and the cost of specialist services were also consistently highlighted. Potential means of overcoming these barriers will require a systems thinking approach to the way sexual and reproductive health services are delivered across the region, looking closely at the interactions between access and availability for regional and rural living women.

Women's lived experience highlighted the negative impacts of unwelcoming health systems and environments on health and wellbeing outcomes. A fragmented service system was also highlighted as contributing to delayed diagnosis, ineffective treatment and some feelings of distrust in services and practitioners. This points to the need for enabling environments and systems for women to improve their sexual and reproductive health, particularly referral pathways. The nurse-led Well Women's Clinic model can provide welcoming and safe environments for women to discuss their sexual and reproductive health through longer appointment times. They also offer local service system knowledge and referral pathways. Cross sector partnerships between health care, community and education services were seen to provide valuable models for planning and delivering integrated health and other services that were welcoming and responsive to women's needs. Gateway Health's nurse-led delivery of MTOP services is a great example of these partnerships, providing holistic sexual and reproductive health services and support within the primary care setting.

Conclusions and Recommendations

1. Workforce development led by MPHN targeting GPs, primary health, Child and Maternal Health nurses, midwives and sexual and reproductive health specialists

Targeted sexual and reproductive health education and training that is rights based and responsive to the multiple and intersecting forms of disadvantage and inequity experienced by women living in Loddon, Mallee, Goulburn and North East Victorian regions.

Priority areas:

- Menstruation
- Endometriosis
- Polycystic Ovarian Syndrome (PCOS)
- Contraception Options
- Pregnancy choices counselling and referral, including medical and surgical abortion services.
- Women, disability and sexual and reproductive health
- Women from refugee and culturally linguistically diverse backgrounds: sexual and reproductive health and cultural awareness.
- Young Women

2. Deliver rights based women's sexual and reproductive health education and training in MPHN communities.

Targeted education and training for priority populations to build knowledge, understanding and awareness of sexual and reproductive health and services availability, including women with disabilities, women from refugee and culturally linguistically diverse backgrounds and young women.

3. Work in strategic partnerships to address sexual and reproductive health service gaps and priorities for women living in Loddon Mallee, Goulburn and North East Victoria regions, including increasing women's access to timely and affordable medical and surgical abortion services based on best practice models.

- Understanding of referral pathways, both locally and in neighbouring areas to provide women with choice and anonymity.

4. Increase knowledge of and access to practice nurses and evidence based nurse led models of sexual and reproductive health care and services.

- Resource accessible, innovative and flexible nurse led models of care.
- Increase knowledge about primary health care nurses and referral pathways in health care and community settings.

5. Create sexual and reproductive health information and support resources that are accessible for all women.

- Resources should provide rights-based information in Easy English, in a range of accessible formats appropriate for girls and women of all abilities and diversities.
- Resources should promote services that support women's safety, privacy and choice.
- Resource priorities: Menstruation, Endometriosis, PCOS, Contraception options and Pregnancy choices and options including abortion.

6. Build and support cross sector partnerships between government, health, education and community services to plan and deliver place based collective action aimed at improving access to timely, safe, affordable and inclusive sexual and reproductive health care, services and treatment, in the communities where women live.

2.3 "Her Voice Matters' Implementation Guide

Storylines: Her Voice Matters involved the development of multiple resources and tools for engagement and recruitment, as well as an online platform for the sharing of stories and experiences. The process of the implementation of the project is detailed below, as well as the facilitation guide for the use of the visual storytelling tools.

Background

"I raise up my voice, not so I can shout,
but so that those without a voice can be heard." - **Malala Yousafzai**

Malala Yousafzai, is a young woman from Pakistan famous for standing up for girls and women and their right to an education in her country. She was shot by Taliban soldiers for refusing to accept the ban on girls attending school in her region. She miraculously recovered and has emerged as a world leading activist for girls and women's rights and is the youngest Nobel Peace laureate in history.

In regional Victoria, women face different challenges to Malala but can be encouraged by her example to raise their voices and share their experiences of sexual and reproductive health. Each story will be used to create a picture of where things are working well and where things are not working well. We will gather experiences from women across our region and discover what women really need in order to have the best possible sexual and reproductive health.

Over 158,088 women live in the Loddon Mallee Regions which spans across 59,000 square kilometres of Victoria. Over 142,000 women live in the Goulburn North, Goulburn Valley and Ovens Murray Regions, which spans across 40,380 square kilometres of Victoria. Combined these regions make up approximately half of Victoria's land mass.

Women living in these regions are supported by two women's health organisations, Women's Health Loddon Mallee and Women's Health Goulburn North East. Sexual and reproductive health is a priority for both these organisations and is an important issue for all women. Sexual and reproductive health influences how women develop and maintain meaningful relationships, appreciate their bodies, interact with others, express affection, love an intimacy and by choice, bear children (WHV, 2016). A woman's sexual and reproductive health is influenced by her access to affordable and timely information and services where her choices are enabled and supported.

Intent

Storylines: Her Voice Matters, is a joint initiative of Women's Health Loddon Mallee (WHLM), Women's Health Goulburn North East (WHGNE), and the Murray Primary Health Network (MPHN) that aims to give voice to women's sexual health and reproductive needs and experiences across the MPHN catchment. It is a collaborative, enquiry-based approach using co-design methodology to accurately represent the lived experience of all women in our region regardless of age, stage of life, financial status, ability/disability, country of origin and sexual orientation.

The Storylines: Her Voice Matters Project informs the development of WHLM and WHGNE sexual and reproductive health strategies.

For the best possible sexual and reproductive health, all women need access to accurate information and welcoming, effective services in the following health and wellness areas:

- sex education,
- periods,
- sexually transmitted infections (STIs),
- contraception,
- Polycystic Ovarian Syndrome (PCOS),
- Endometriosis,
- libido
- fertility support,
- all-options pregnancy support,
- termination of pregnancy,
- childbirth,
- prenatal and postnatal support,
- cancer screening (breast and cervical),
- menopause and peri-menopause, and
- any other health issues that affect a woman's health.

Participants

This project has a focus on intersectionality (WHV, 2016) so that the starting point is at diversity instead of commonality. The project aims to bring a range of women's voices to the centre of analysis, rather than positioning them at the margins to be defined by their 'difference from' the centre.

Storylines: Her Voice Matters has a focus on reaching diverse women who have 'lived experience' and valuing their contribution. The project values the engagement of women's groups who are already meeting to share and learn from one another. These groups offer a safe and respectful environment for story gathering and telling. Some of these groups include women who identify as:

- LGBTQI,
- Aboriginal or Torres Strait Islander,
- newly arrived women/refugees,
- culturally and linguistically diverse women,
- rurally isolated women,
- young women,
- women with disabilities,
- women who are financially disadvantaged,
- women who are incarcerated,
- women who work in the sex industry,
- women who have lived experience of family and intimate partner violence, and
- older women

Participation is also self-selected through the Her Voice Matter's website, social media and direct contact with the women's health organisations. www.hervoicematters.org

Phases

1. **Jan – April 2018 PLAN**
   - Development and testing of 'Her Voice Matters' story gathering card set.
   - Development of Easy English versions of story gathering process
   - Develop 'Her Voice Matters' website
   - Create methodology

2. **May– July GATHER**
   - Interviews (one-with-one conversations)
   - Group Workshop (one-with-many conversations)
   - Online submission (one-to-web conversations or email)

3. **July – August – ANALYSIS**
   - Stories are entered in to a coding matrix.
   - Qualitative data becomes quantitative.
   - Trends, geographic information analysis and challenges identified.

4. **August – REPORTING**
   - Summaries of the Storylines Project demonstrate the lived experience of women in our region and inform WHLM and WHGNE sexual and reproductive health strategies and resulting action plans.

5. **August – Forward: FUTURE STORY GATHERING.**
   - Using www.hervoicematters.org as a communication tool for women in the region to continue to share their experiences.
   - Data can be collated, collected and analysed for future monitoring of progress and need.

Participant Engagement & Recruitment

Communication strategy

There are a number of options for women to become involved in the project. A focus is on methodology that meets each woman where they are in terms of ability, location and self-efficacy.

A woman can be involved in her own time, from home (if she has access to a computer or smartphone) by visiting www.hervoicematters.org and submitting her experience, voice and story using a form that uses both a written story process and the Her Voice Matters Cards. She can also submit a voice recording if she prefers this to typing.

A woman can also email her story using the Her Voice Matters Cards as visual prompts and story process, that assist her in storytelling. These can be downloaded from the website. A woman can also contact either organisation and arrange a time for a one on one phone call or meeting in a relaxed and friendly setting to be guided through the process with one of the project workers.

For larger groups of women, project workers can visit an existing group or create small place based groups of women. A woman's circle/workshop can be conducted that builds storytelling skills and connection using the Her Voice Matters Cards and the Storytelling Guide. There are also Easy English versions of the Storytelling Guide for women who are culturally and linguistically diverse or where women may require adjustments suitable for all abilities.

Ethical Considerations & Risk assessment

This project encourages women to share their highly personal experiences of issues that are often stigmatised and carry high levels of shame, guilt and repression. Therefore, it is of upmost importance that ethical considerations are noted and that there are systems in place to ensure confidentiality, risk management and the safety of all women involved in the project. An ethical guideline is attached at Appendix 4. Some of the basic principles of the ethics of Story Gathering are listed below:

1. **OBTAIN INFORMED CONSENT –** Consent must be given for participation in any aspect of the Storylines: Her Voice Matters Project, specifically to utilise imagery, stories and personal experiences. Consent must be given for imagery taken in the storytelling process to be used for promotional purposes, to take pictures of people and/or private homes or businesses, and for consent of people identified in photographs. At all times we need to ask ourselves:
    - How can we protect a woman's privacy?
    - How can we ensure women of all abilities can provide informed consent: for participation in the project AND permission for sharing of their story, words, image, voice or video with partners and in the public domain?
    - How can we ensure each woman who is interested in sharing her story is enabled to do so?
    - How can we ensure each woman's safety through her involvement?

2. PROTECT the PARTICIPANT – Safe access and participation for women of all abilities. Think not only about danger in terms of physical harm, but also in emotional harm, harm to individual reputation, or potential financial harm, among others. Will it harm me or others? Is it dangerous? Is sharing this image potentially placing a woman in harm?

3. PROTECT the COMMUNITY – It is important to protect others by abstaining sharing stories that may harm the reputation, safety, or individual liberty of another. Will it put a person's employment, status in the community, etc. in jeopardy? Stories of gross misconduct and medical negligence do require careful analysis and de-identification before publishing.

4. FALSE LIGHT – It is necessary to make sure that situations in the community are reflected accurately. Necessary steps must be taken to accurately portray the community and to avoid placing stories, images or multimedia out of context. Is it truthful? Does it accurately represent the situation?

5. PRIVACY- To protect participants' privacy, ensure participant anonymity and deidentification of any information that could reveal the identity of the participant or harm the reputation, safety, liberty, employment of status of the participant or anyone else. Ensure that participants have consented to the use of pseudonyms if names are to be used with their shared content. Ensure that all participants are provided with informed choice to share images where they may be identified or their safety at risk.

Where women have granted permission to share on line, website stories are deidentified and used as examples or common lived experiences of women in our region.

Limitations

- Timeline (effectively less than eight weeks to gather data post planning phase)
- Staffing and EFT
- Budget
- Website – limited capacity to have interactive website functions due to cost and time to develop.
- Appropriate Australian diversity women imagery and reliance on stock photography.
- Developing a data analysis method based on feminist framed qualitative research (women's voices are our focus but how do we identify themes and gaps etc)
- Geographic distance (a geographic distance equal to half of the state of Victoria is involved in this project with a very small number of project workers)
- Constant evaluation and adjustment of the Storylines process through co-design.
- Acknowledging the women's lived experience and contribution limited by budget constraints to certificate/catering
- Compensating women for their time and travel is non-existent due to budget constraints (large distances up to hundreds of kms)
- Limited access to appropriate (female) translation services budget constraints and availability.
- Video recording capability – to create multimedia output is limited due to budget constraints.
- Photography to record process
- Funding for travel to support participants' community accessibility.

Resources required

- Storylines Cards - Pre made card set printed in house, laminated and cut out.
- Storylines: Her Voice Matters Story Telling Guide 'How to use the card set one on one and in a workshop setting'.
- Mp3 player/recorders with dragon dictation function to record stories and transcribe.
- Butchers paper
- Coloured markers
- Informed consent information and resources suitable for women of all abilities and backgrounds.

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1. Kate Lawrence – StoryWise Storytelling Education http://www.storywise.com.au/about-kate-lawrence-story-wise/

2. Photo Voice Program – Guidelines and Ethics for visual imagery

3. Women's Health Goulburn North East Work & Women with Disabilities Victoria 2017, Enabling Women Evaluation Report 2017: Available at https://www.whealth.com.au/documents/work/enabling-women/EnablingWomenEvaluationReport.pdf

Items

Consent Forms:

1. Expression of interest form Print and Digital
2. Consent Form Single Print and Digital
3. Consent Form Group Print in range of formats suitable for women of all abilities.

Engagement and Communication Strategy Storylines: Her Voice Matters:

- Kumu: Placed Based Planning GIS.
- Expression of interest Print and Digital
- A5 Flyer Digital/Print
- A4 Flyer Digital
- Social Media Posts FB/Instagram
- Posters
- Website
  http://www.hervoicematters.org/

Methodology Storylines: Her Voice Matters:

- Ethical considerations and risk assessment.
- Co-design methodology and resources.
- Story gathering framework and resources.
- Storylines: Her Voice Matters Visual Storytelling Card Set print and digital.
- Storytelling guide print and digital.
- Storytelling guide print and digital (CALD)
- Storytelling guide print (Disabilities)
- Thank you letter and certificate print

The facilitation guide below provides an outline on how to use the visual storytelling tools/ card set and how to facilitate a group workshop.

- Facilitation Guide

Key Area 3: Evaluate to Enable

To evaluate the effectiveness of this project, particularly the Storylines: Her Voice Matters phase, project worker reflections have been used to identify limitations, enablers and key learnings. Further evaluation of the project will be provided by Melbourne University's external evaluation.

Project Officer Reflections

The project offered a great opportunity to deepen women's health services and primary health network understanding of the sexual and reproductive health needs of women across our regions. Listening to the lived experience of women provided further evidence to support and narrate quantitative data from both the Loddon Mallee and Goulburn North East regions. The project and concurrent development of respective sexual and reproductive health strategies for each women's health service, also provided opportunity for stakeholder engagement. A wide range of organisations, settings and sectors including community health, social services and education, showed support for these initiatives and for future work partnerships in this space.

Limitations

Through project worker reflection, several limitations were identified for this project. These limitations offer the opportunity to see what could have been done better but also how the project can be improved for future progress.

Timeline

The timeline for the project became challenging due to the time needed to:

- Establish project partnership, roles and responsibilities across the respective regions and together, as well as establish evaluation needs for the project report and external evaluation.
- Create the branding, website and visual tools for the story gathering phase of the project.
- Create a comprehensive range of new information tools and resources that required dedicated skills to (a) promote the project and (b) engage with diverse women of all abilities aged 16-75+ living across the vast catchment (LM & GNE).
- Develop consistent messaging and appropriate language for information and engagement resources about women's sexual and reproductive health, rights and equity that are accurate but accessible for all. This was particularly challenging when trying to break down the project purpose and 'pitch' to engage GNE regional media, partners and community in media releases, Facebook posts, emails and phone calls, to explain why we were involved, why women should get on board and what the project would achieve.

- Make sure women already experiencing barriers to access and greatest disadvantage could share their stories. This was a priority but engaging with key contacts for women's voices gathering and workshops took months of engagement, follow up and planning.

- To effectively analyse and collate data, as many of the women's group workshops took place very late in the timeline due to the time it took to engage, follow up and plan with these groups.

Staff and EFT

The hiring of a project worker was essential in being able to develop the Storylines: Her Voice Matters component of the project. However, WHLM and WHGNE both had staff leave their organisations who were working on this project. This was challenging in terms of having the capacity to engage with a diverse range of women's groups for workshop delivery and further engagement.

Enablers

Through project worker reflection, many enablers were identified for this project, particularly the value of working collaboratively to design and implement the project.

- Two rural women's health services working together to design and implement the project. Enabling environment due to shared values, guiding principles and goal to improve rural and regional women's access and equity for optimal sexual and reproductive health.
- The broad staff experience, skills and strengths from having two women's health services and teams work together. This allowed different aspects of the project to be supported by different people with those specialist skills– including graphics and website design, information and resources development, evaluation, consultation and qualitative research, quantitative and qualitative data collection and analysis, writing and reporting.
- The shared lived and professional experience in rural and regional environments – understanding of some of the existing barriers and enablers for women through personal and professional experience to support engagement.
- Existing WHGNE and WHLM partnerships and contacts with community groups and organisations which enabled easier engagement with some target groups and promotion of the project.

Key Learnings

- Talking about women's sexual and reproductive health and promoting the importance of sexual and reproductive health (SRH) to women's overall health and well- being through a gendered lens is a challenging topic with all groups (clinicians, allied health, cross sector professionals/ existing partners, rural communities and women.

- Creating a language to discuss SRH in relation to the multiple and intersecting issues that influence a woman's overall health and wellbeing in the short and long term is also challenging, as there is limited qualitative research of women's SRH in Australian rural and regional communities.

- Diverse women's place based experiences and reflections about sexual and reproductive health are powerful in demonstrating strong links between a woman's access to timely, affordable and effective SRH health care, services and treatment and a woman's overall health and wellbeing and equity (relationships, workforce and community participation, access and inclusion).

- Providing a range of strength based information, resources and strategies (online,face to face, phone, email, small group) supports engagement with diverse women in different rural settings (small towns, regional centres, more remote areas), with existing relationships/partnerships with female professionals and community members crucial in supporting engagement with marginalised and disadvantaged groups of women.

- The project demonstrates the importance of women's lived experience as rich qualitative data to use with quantitative data to guide collective action and system reform that is sensitive to the needs and priorities of diverse women living in rural and regional communities.

- The project demonstrates the value of partnerships between PHNs and Women's Health services to engage diverse women in consultation, research and collective action where their lived experience is valued and respected.

- The project demonstrates the importance of engaging women in projects and supporting women to share their experiences to better understand their intersecting needs in regional settings. Qualitative projects are extremely valuable in providing powerful stories and data to build understanding about intersections between sexuality, gender, race, dis/ability, culture, poverty, faith and rural issues such as distance, travel, availability, privacy and judgement, and a woman's overall health and wellbeing, including her sexual and reproductive health.

Recommendations

Key Area 1:

- Ensure sexual and reproductive health services and health promotion programs meet the demographic needs of women in the Murray PHN region. Targeted interventions should focus on particular ages and stages, such as menopause information and education, as most local government areas (LGAs) in the catchment show the highest population female age group is between 45 and 64 years.

- Ensure sexual and reproductive health services are financially accessible as almost 50% of women in the MPHN catchment earn below the weekly minimum wage.

- Promote service coordination between the family violence and sexual and reproductive health service systems, due to the high rates of family violence in the MPHN catchment and the link between controlling behaviours and adverse effects on sexual and reproductive health.

- Promote the importance of cervical screening and where cervical screening

  is provided to increase the uptake of cervical screening across the MPHN catchment, with a focus in LGAs with comparatively low uptake.

- Progress the 'Welcoming Doors for Women' project in the Loddon Mallee region, and in areas of Goulburn North East Victoria that are poorly serviced.

- Gain understanding of what sexual and reproductive health services are delivered by GPs across the MPHN catchment, particularly the availability of long acting reversible contraception (LARC) insertion and removal, and medical termination of pregnancy services (MTOPs).

- Increase provision of surgical termination of pregnancy services (STOPs) across the MPHN catchment to improve access,
  (in line with the Victorian women's sexual and reproductive health key priorities 2017-2020, page 17)
  and develop appropriate and accessible referral pathways for women.

- Investigate and resource innovative and flexible models of care for the delivery of sexual and reproductive health services in regional areas.

Recommendations

Key Area 2:

1. **Workforce development led by MPHN targeting GPs, primary health, Child and Maternal Health nurses, midwives and sexual and reproductive health specialists**

Targeted sexual and reproductive health education and training that is rights based and responsive to the multiple and intersecting forms of disadvantage and inequity experienced by women living in Loddon, Mallee, Goulburn and North East Victorian regions.

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- Endometriosis
- Polycystic Ovarian Syndrome (PCOS)
- Contraception Options
- Pregnancy choices counselling and referral, including medical and surgical abortion services.
- Women, disability and sexual and reproductive health
- Women from refugee and culturally and linguistically diverse (CALD) backgrounds: sexual and reproductive health and cultural awareness.
- Young Women

2. **Deliver rights based women's sexual and reproductive health education and training in MPHN communities.**

Targeted education and training for priority populations to build knowledge, understanding and awareness of sexual and reproductive health and services availability, including women with disabilities, women from refugee and CALD backgrounds and young women.

3. **Work in strategic partnerships to address sexual and reproductive health service gaps and priorities for women living in Loddon Mallee, Goulburn and North East Victoria regions, including increasing women's access to timely and affordable medical and surgical abortion services based on best practice models.**

    - Understanding of referral pathways, both locally and in neighbouring areas to provide women with choice and anonymity.

4. **Increase knowledge of and access to practice nurses and evidence based nurse led models of sexual and reproductive health care and services.**

    - Resource accessible, innovative and flexible nurse led models of care.
    - Increase knowledge about primary health care nurses and referral pathways in health care and community settings.

5. **Create sexual and reproductive health information and support resources that are accessible for all women.**

    - Resources that provide rights-based information in Easy English, in a range of accessible formats appropriate for girls and women of all abilities and diversities.
    - Resources that promote services that support women's safety, privacy and choice.
    - Resource priorities: menstruation, Endometriosis, PCOS, menopause, contraception options, and pregnancy choices and options including abortion.

6. **Build and support cross sector partnerships between government, health, education and community services to plan and deliver place based collective action aimed at improving access to timely, safe, affordable and inclusive sexual and reproductive health care, services and treatment, in the communities where women live.**

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Appendices

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Appendix 1- Storylines: Her Voice Matters Card Outline

Visual Story Telling - Storylines: Her Voice Matters Card Set

This storytelling card set includes 5 different sets of cards designed to assist a woman to share her experience through telling her story of Sexual and Reproductive Health. The card sets are listed below:

FEELINGS: This set of 48 cards display a range of feelings, which we all experience. These feelings cards add emotion, feeling and texture to each story and prompt a woman to explain the card in relation to her experience. Feelings show range from hopelessness, stress, racism, stigma, guilt, shame, despair to freedom, growth, relief, support, compassion and other feelings of resolution like transformation and understanding.

1. Can't see
2. Out of my control
3. Shut down
4. Desperate
5. Disability
6. Frustration
7. Alone/Lonely
8. Isolation
9. Help me
10. Stress
11. Choices
12. Locked out
13. No access
14. Trapped
15. Depressed
16. Drowning
17. Lifeless
18. Shame/ Judgement
19. Don't understand
20. Fear
21. Labelling/Stigma
22. Sad/Grief
23. Financial Stress
24. Gossip
25. Behind Closed Doors
26. Body Shame
27. Lying
28. Racism
29. Freedom
30. Choice
31. Loving My Body
32. Relaxed
33. Strong/Powerful
34. Happy Family
35. Friendship
36. Growth/New Life
37. Support
38. Joy
39. Gratitude
40. Compassion/Understanding
41. Peacefulness
42. Wisdom
43. Relief/Let it Go
44. Transformation
45. Self-Acceptance
46. Excitement
47. Women's Business
48. Girl's Business

FERTILTY, PREGNANCY & BIRTH: This set of 26 cards look at situations that are common from just thinking about having children, getting pregnant or not, pregnancy and childbirth. Some themes displayed are midwife managed pregnancy, IVF, difficulty breastfeeding, morning sickness, charting your cycle, caesarean, same sex conception, termination choice and medical intervention.

1. Hospital vs Homebirth
2. New beginnings
3. My Body, My Choice
4. Medical Termination of Pregnancy (MTOP)
5. New Beginnings Same Sex
6. Grief/Loss
7. Morning Sickness
8. Pregnancy Test
9. Breastfeeding/Early Days
10. Cycle monitoring
11. Caesarean
12. IVF
13. Post Natal Depression
14. Post Natal Complications
15. Couple despair
16. Couple same sex joyful
17. Older mother
18. Mothering support/friendship
19. Thinking about fertility/having a baby
20. Hospital bed/ Surgical Termination of pregnancy
21. Positive birth experience
22. Breastfeeding a newborn
23. Trouble breastfeeding
24. Crying baby
25. Midwife Managed Pregnancy
26. Baby Wearing

SEXUAL HEALTH & WELLBEING: This set of 24 cards deal with topics such as intimacy, pleasure, unwanted pregnancy, endometriosis, incontinence, abuse, disability, sexuality, STI's, menopause and other issues relevant to a woman's sexual health and wellbeing.

1. Reproductive pain
2. STI screening and education
3. LGBTIQ
4. Coming out
5. CALD
6. Disability and sexuality
7. Libido
8. Pleasure
9. Orgasm
10. Sexual assault/violence
11. Stigma
12. Pregnancy
13. Young pregnancy
14. Reproductive problems
15. Pain
16. Peri-Menopause
17. Menopause
18. Breast Cancer screening
19. Cervical Cancer screening
20. PCOS
21. Endometriosis
22. Incontinence
23. Hospital visit
24. Sex positive lifestyle

REPRODUCTIVE CHOICES: This set of 16 cards are all about options for contraception that a woman can choose from. The cards look at the available options in Australia at this current time such as barrier methods, hormonal methods and natural family planning methods. These cards may need a quick explanation so that women understand the images.

1. Withdrawal
2. Fertility Awareness Methods
3. Breastfeeding
4. Male Condom
5. Female Condom
6. Female Sterilisation
7. Intra Uterine Device – Copper
8. Intra Uterine Device – Hormonal
9. Vaginal Ring
10. Emergency Contraceptive Pill
11. Abstinence/other type of intimacy
12. Oral Contraceptive Pill
13. Contraceptive Implant
14. Contraceptive Patch
15. Sterilisation
16. Contraceptive Injection
17. Diaphragm or Cervical Cap

REPRODUCTIVE SYSTEM HEALTH AND CARE: This set of 12 cards deal with menstrual and reproductive health. The cards look at issues such as heavy bleeding, menopause, tampons, menstrual cups, period proof underwear, cloth pads and the first period (menarche).

1. Menarche/first period
2. Tampon
3. Applicator Tampon
4. Menstrual Cups
5. Cloth Pads
6. Disposable Pads
7. Improvisation menstrual products
8. Period Proof Underwear
9. Hygiene – TSS or odour from pads
10. Heavy Bleeding
11. Peri-menopause
12. Menopause

Appendix 2 - Facilitation Guide

Introduction to the project

Welcome to Storylines: Her Voice Matters a visual storytelling tool designed to assist women to share their experiences of Sexual and Reproductive Health.
Each story becomes part of a bigger story that will help build a picture of how we can improve the quality, access, and type of health support for women.

Sexual and reproductive health is an important issue for all women, affecting them at every life stage, and influences how women develop and maintain meaningful relationships, appreciate their bodies, interact with others, express affection, love, and intimacy and by choice, bear children (WHV, 2016).

Background - Story Wisdom

Story is the universal tool that enables humans to express, understand and connect. It enables us to process and express emotion and make meaning from our experiences. Visual storytelling adds the element of visual imagery that assists us to find the words to tell of our experience. Story crafting is a reflective process that enables us to make sense of our experiences and deepen our connection to who we are and what we stand for and is accessible for all women.

The Storylines: Her Story Matters approach uses story as a tool in 3 key areas:

- Self-Awareness: self-discovery, inner reflection, personal history, emotional processing and intelligence
- Meaning Making: persuasion, messaging, making sense, re-storying, vision & values, metaphor, illustration.
- Trust: vulnerability, openness, authenticity, trust, connection, emotion.

Story Gathering

Story gathering provides insights into culture, emotions and attitudes, while simultaneously allowing people to speak and listen, which deepens connection, belonging and understanding. Story gathering also allows the creation of a shared story, for celebrating, preserving and learning group experiences. The project also has the deeper purpose of gathering individual women's stories to tell a much larger story, the story of women's experience of sexual and reproductive health across the region.

Storylines: Her Story Matters

This is a series of carefully designed gatherings, for an individual, a small group of women or existing women's groups during which powerful questions and visual imagery create a space for expression, reflection and honouring.

The simple but skilled art of holding space and listening, can be implemented to provide an intentional outcome to collate and then transform deep, rich personal stories into quality data that can inform strategy and planning for the sexual and reproductive health services across our region. The process will also inevitably work in a multi layered way to reveal the complexity of human nature, gaps in our current service, successes and areas for focused analysis.

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Potential Outcomes:

- The experiences participants share gives us an opportunity to understand and gather information from a women's lived experience.
- The material gathered will be collated into a documented story about the collective experience of the women who participate. This story will we retold in a safe, feminist, empowered model via the website. Stories will be analysed, coded and data used to inform the sexual and reproductive health strategy.
- Difficult events can be processed, participants feel heard by each other as well as by 'the system'.

Storylines: Her Story Matters Card Structure

In alignment with the Loddon Mallee sexual and reproductive health strategy, the cards reflect the four strategic priorities and the core set of 'feelings' cards. This ensures that the full spectrum of women's health issues are identified as prompts for women to speak to and match with feelings and create their own story.

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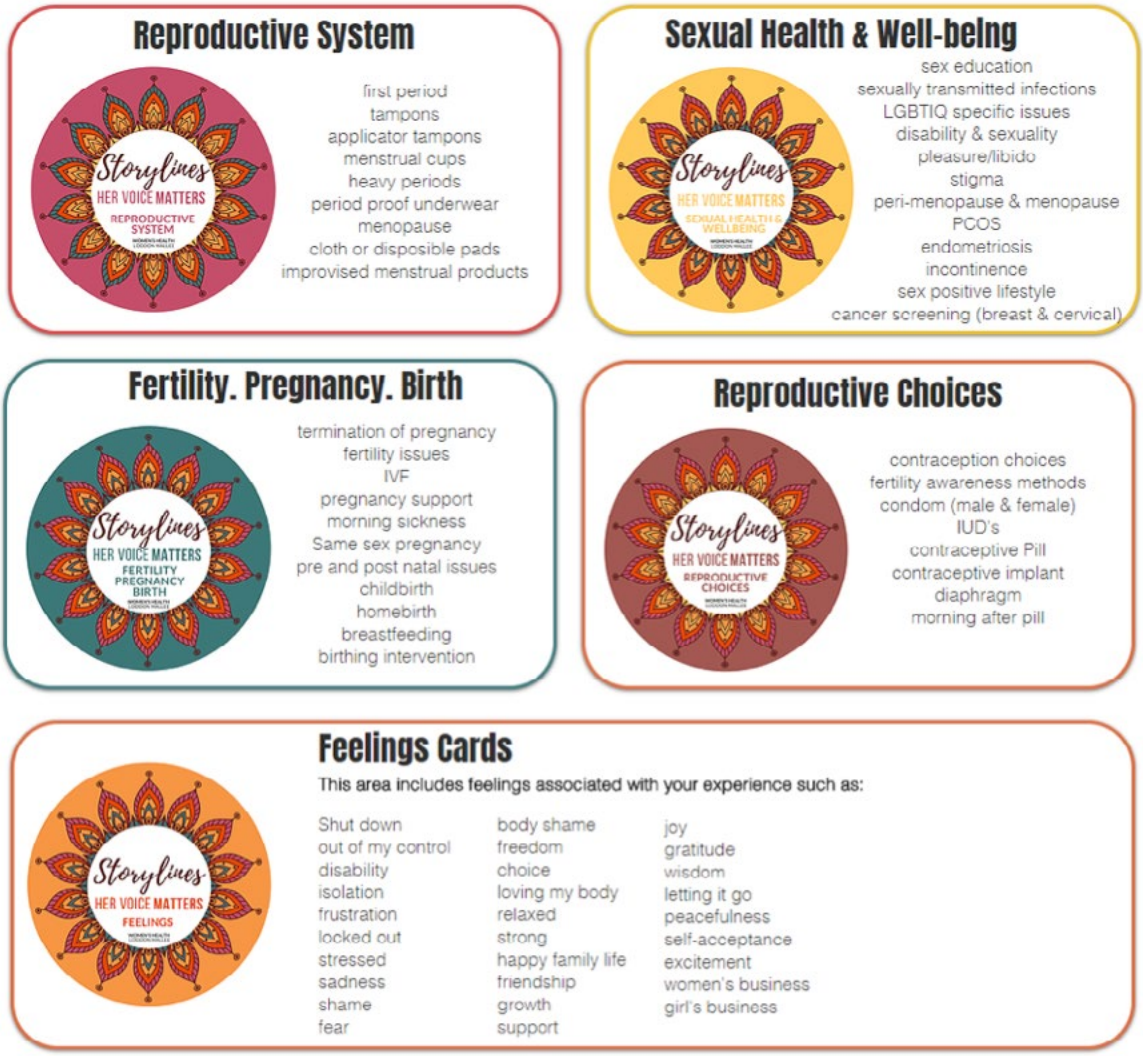

OVERALL GUIDELINES FOR CONDUCTING THE STORYTELLING CIRCLE

Creating a safe and welcoming space for storytelling

The purpose of the workshop is for participants to share a story or experience from some of the most vulnerable times in their lives. The most important factor for a successful small group discussion is that the environment and group feel safe, respectful and welcoming. Ensure the space is accessible for women with disabilities with accessible facilities including toilets. Sitting in a circle without tables is encouraged as this opens up the group to connecting and everyone can be seen and heard. Alternatively, tables can be useful where groups decide to share lunch and for providing space for informed consent, permission forms and workshop materials.

Accessibility and inclusion issues are important to discuss with key group contacts and leaders prior to the workshop to enable all women in the group to participate.

The process is a way for women to reframe their experience, feel as though their voice matters and through sharing come to understand that they are not alone. As this is not a therapeutic process, the aim is not to deliver counselling or get stuck in a 'victim/blaming/problem solving' process with anyone's story.

Acknowledge that, given the topic, there might be times when participants feel uncomfortable and that it will be useful for the group to agree to some guidelines for any discussions. Talk the group through the guidelines for safe and welcoming discussions.

1. Briefly explain each of the guidelines, then ask the group for their thoughts.
2. Ask if people have ideas for any guidelines that should be added to the document.
3. Ask if anyone disagrees with any of the guidelines, or sees them as not applicable to the group. The group then discusses any points that come up.
4. Finish by having each person commit to following the agreed-upon guidelines. You can do this by simply saying 'Are we all ok with the guidelines we've just discussed?'
5. Setting the tone for having a respectful conversation is critical- without it, people are less likely to speak up.

Suggested Guidelines

- Maintain confidentiality and privacy; that what is shared in this group stays here.
- Speak for yourself only.
- Listen with respect to other women's experiences accepting that their perception is true for them.
- Be curious and willing to learn.
- Listen without interrupting with your own story, checking your phone or chatting on the side.
- Avoid making judgements about others, be positive and caring.
- Support other people's attempts to talk about uncomfortable subjects.
- Try not to 'rescue' anyone or touch anyone even if they feel upset, allow them to work through it for themselves.
- If you feel like you don't know what to do let the facilitator know. Say it here. Say it now.

During the Discussion

Once the group has committed to the guidelines, you can dive into the workshop. As the discussion progresses, keep these tips in mind.

- Make sure you follow the agreed upon discussion guidelines yourself, by modelling openness to others' perspectives. If you don't engage in these behaviours, it reduces the chances that others will.
- Hold the group accountable to the guidelines. For example, if someone is interrupting or speaking for someone else, redirect her.
- Get comfortable with silences. At times, people may need a chance to process the nformation or get their thoughts together before they speak. If you jump in too quickly when the group is silent, you run the risk of cutting off potentially productive discussion.
- Solicit the opinions of those who are quiet. If there are people in the group who are not speaking up, ask their opinions. This can help keep people engaged and creates an opening for some of the introverts, who might be having difficulty getting a word in edgewise.

Hints for Challenging Situations

- Encourage all contributions no matter how small.

- Be flexible: there might be times when you need to re-state something, help a small group who are struggling with the process, work in groups of 3 etc.

- Stay calm: if a woman becomes upset or emotional allow her to process without rushing to rescue her, however, if this begins to affect the group, give her the chance to get a glass of water or move to another room.

- Distractions: Ignore any behavioural distractions, some people may laugh or become over the top when talking about difficult or taboo topics. Be ok with this but check in with groups that might need your guidance to answer a question or regain focus. If anyone is seriously disengaged, speak with them away from the group to determine how you can help and what level of involvement they are comfortable with.

- Early finishers: some groups will take longer than others to go through the process, have another activity set up for early finishers.

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Handling Disclosures

It is possible that at times, participants may self-disclose or raise concerns that you don't feel equipped to answer.

When working with established groups, it is important to talk with a group leader or support person about the procedures for disclosures of sexual assault, family violence etc. Ask that person to be responsible for handling these disclosures.

If a woman approaches you with a disclosure, engage the nominated group leaders and suggest that they discuss with them is issue and follow the procedures for this type of disclosure.

For each workshop women will receive a pack with the following support information:

- 1800RESPECT Card
- 1800 MYOPTIONS Card
- Murray PHN Voices Postcard
- Murray PHN Magnet
- Women's Heath Loddon Mallee Well Women's Clinic and
- Women's Heath Loddon Mallee Options Clinic Postcards
- 1800 RESEPCT Pens
- Easy English flyer about Women's Health Goulburn North East (WHGNE)
- Violence support services card for LGAs in Goulburn North East
- WHGNE No Interest Loans (NILS) brochure –
  General NILS and Domestic Violence NILS
- WHGNE financial abuse postcard with support services Copies here

Be Yourself

Bring your own unique style, experience and stories into the project. Providing your own safe, appropriate examples particularly during discussions, will encourage participants to contribute, and this is where the real learning takes place. The workshop will be enhanced if you add your own creativity, knowledge and skills to bring it to life!

Informed Consent

As part of the ethical considerations for this project Informed consent needs to be gained from each participant. It is important to briefly talk through what this means and the form you ask women to sign so that they feel completely comfortable with what they are signing and their rights.

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Appendix 3 - Example of Facebook Post

Posted by Women's Health Loddon Mallee and Women's Health Goulburn North East

We need to hear rural and regional women's voices about sexual and reproductive health. This will help us improve services, treatment and care.

Menstruation…contraception…pregnancy choices… childbirth… menopause...endometriosis and more. Your voice matters!

Share your story to help us improve services for ALL women.
https://www.hervoicematters.org/storytelling-guide

Appendix 4 - Ethical Considerations Document

ETHICAL CONSIDERATIONS AND RISK ASSESSMENT

1. **Aim of the project:** To give voice to women's sexual and reproductive health needs and experience across the Loddon Mallee and Goulbourn North East regions. The initiative is to gather the voices of women to express the rich lived experiences of women of all ages and stages and their experience of sexual and reproductive health, as well as the system that supports it.

2. **Type of research:** The project is action research underpinned by gathering women's experiences as stories. These stories are then analysed and form data as a coding matrix.

3. **Vulnerable Participants:** It has been identified that there are several potentially vulnerable participant groups in this project, these are:
   - Women who are pregnant,
   - Young women aged 16-20 years old,
   - Women with and impaired capacity for communication,
   - Women with intellectual disability or mental impairment,
   - Female prisoners or people on parole,
   - Women in relationships that have an unequal balance of power and control,
   - Women who have experienced intimate partner violence, family violence or sexual assault,
   - Women who identify as Aboriginal and / or Torres Strait Islander, and
   - Women from culturally and linguistically diverse backgrounds.

4. **Proposed Participants:** Proposed participants (groups) involved in this project:
   - LGBTQI,
   - Women who identify as Aboriginal or Torres Strait Islander,
   - Newly arrived women/refugees,
   - Culturally and linguistically diverse women,
   - Rurally isolated women,
   - Young women,
   - Women with disabilities,
   - Women who are financially disadvantaged,
   - Women who are incarcerated,
   - Women who work in the sex industry,
   - Women who have lived experience of family and intimate partner violence,
   - Older women, and
   - Any other woman who chooses to participate.

5. **Participation time and incentives:** Women can be involved in their own time through the www.hervoicematters.org website and contribute their time voluntarily. Women who are members of established groups will spend approx. 1-2hrs participating in a workshop called 'Storylines: Her Voice Matters' using a visual storytelling approach, verbal storytelling approach or written storytelling approach. Other women may spend 15 – 45 minutes one-on-one with a project worker sharing their story. All group session will provide women with a certificate of appreciation, thank you letter with details about the project results and catering for each event.

6. **Recruitment:** Participants will be invited to be part of the project though a letter, email and social media. Initial contact with groups will be via an invitational letter.
   - Participants can be involved in their own time from home by visiting the website and sharing their story.
   - Participants can also download the Storylines question activity and Her Voice Matters Card Set from the website and email their story directly to a project officer. They may also email a voice recording.
   - Participants can book in a time to talk on the phone or meet with a project worker in person in a relaxed and friendly setting.
   - Groups and organisations can arrange for a project worker to visit their existing group or create a small focus croup to conduct a workshop that builds storytelling skills and connection. Stories will be gathered in these workshops in written, visual or audio formats.

7. **Procedures for explanation and gaining informed consent:** All participants are given a clear outline of their rights and informed consent to participate in the project in print and verbal formats accessible for all abilities:
   - they have ownership of their story,
   - they have the right to withdraw their story at any time,
   - they have a choice for their story to be published on line or not,
   - they have a choice how their story will be shared and who with,
   - all stories are de-identified to protect their identify, safety and privacy, and
   - no demographic data will be linked to their story.

8. **Collection of data and procedures and collection of personal information procedures:**
   - Data is collected in written, audio or imagery formats.
     Data will be stored in locked folders within each organisation's internal data storage system.

9. **Disclosure procedures and post participant support:** Support pathways are made available for all participants in the form of a pack of information for relevant services at the beginning of each session. A support person is also identified from their region or group that can be approached to assist with relevant information. If a participant discloses any form of sexual assault, family violence, intimate partner violence or any identified assault they will be provided with

Appendix 5 - Coding Matrix

Analysis and Coding Methodology

Participants

Non representative sample. Intended to sample the diversity of the community.

- Convenience sample:
  People with links to WHLM/WHGNE willing to participate at the time
- Self -selected:
- Via social media campaigning and online story submission
- Snowball effect/WOM
- Targeted when gaps in representation to be filled through group workshops
  and one on one sessions.

Data Analysis:

Storylines: Her Voice Matters uses a framework approach to thematic analysis. The framework approach was chosen due to its suitability for analysing cross-sectional descriptive data. The process involves scanning the data set to identify patterns in responses and working together to create codes (themes) and categories (sub-themes), repeating the process as understanding of the data increases. The initial matrix has been developed through codesign and reflects the card set categories.

Step 1: Scan data set. We will scan and analyse the data set.

Step 2: Identify initial codes. Each member of the team will review the responses and assign a 'code' or 'theme' that encapsulates the meaning of the response.
Code: A descriptive label that is assigned to excerpts of raw data- in this case, a community conversation response (Gale et al, 2013, 2)

Step 3: Populate initial categories. The Code, or Initial Theme, is then grouped with other similar themes to begin developing an overarching category.
Categories: During the analysis process codes are grouped into clusters around similar and interrelated ideas or concepts (Gale et al, 2013; 1)

Step 4: Refine categories. Based on the refined understanding from the additional data scan, thecategories are condensed into broader statements that encapsulate a wider range of codes.

Step 5: Refine themes. Based on the refined categories, more accurate ways of interpreting the responses emerge and a new refined theme is assigned to the response.
The team works together summarising and synthesising the range of entries by refining initial themes and categories until the "whole picture" emerges (Gale et al, 2013; 56).

Step 7: Summarise into an overarching 'Core Concept'. At the conclusion of the coding and categorising, related themes will be organised under overarching 'core concepts'.
The resulting core concepts will inform the overarching vision and priority areas.

Thematic Analysis Matrix- For Visual Storytelling Tool (card sets)

	Category	Theme	Response Examples
FERTILITY, PREGANANCY AND BIRTH	Hospital/Homebirth		
	New beginnings		
	My Body, My Choice		
	MTOP		
	New beginnings same sex		
	Grief and loss		
	Morning Sickness		
	Pregnancy Test		
	Breastfeeding early days		
	Cycle Monitoring		
	Caesarean		
	IVF		
	Post Natal Depression		
	Post Natal Complications		
	Couple Despair		
	Couple same sex joyful		
	Older Mothering		
	Mothering support and friendship		
	Thinking about fertility or having a baby		
	Hospital Bed/ Surgical termination of pregnancy		
	Positive birth experience		
	Breastfeeding a newborn		
	Trouble breastfeeding		
	Crying baby		
	Midwife managed pregnancy		
	Baby wearing		

	Category	Theme	Response Examples
REPRODUCTIVE CHOICES	Withdrawal (contraception)		
	Fertility Awareness Method		
	Breastfeeding (contraception)		
	Male Condom		
	Female sterilisation		
	Intra Uterine Device Copper		
	Intra Uterine Device Hormonal		
	Vaginal Ring		
	Emergency Contraceptive Pill		
	Abstinence or another type of intimacy		
	Oral contraceptive pill		
	Contraceptive Implant		
	Sterilisation		
	Contraceptive injection		
	Diaphragm or cervical cap		

REPRODUCTIVE SYSTEM, HEALTH AND CARE	Category	Theme	Response Examples
	Menarche/ first period		
	Tampon		
	Applicator tampon		
	Menstrual cups		
	Cloth Pads		
	Disposable pads		
	Improvisation menstrual products		
	Period proof underwear		
	Hygiene		
	Heavy bleeding		
	Peri-menopause		
	Menopause		

SEXUAL HEALTH AND WELLBEING	Category	Theme	Response Examples
	Reproductive system pain		
	STI screening and education		
	LGBTIQ		
	Coming out		
	CALD		
	Disability and sexuality		
	Libido		
	Pleasure		
	Orgasm		
	Sexual assault and family violence		
	Stigma		
	Pregnancy		
	Young pregnancy		
	Reproductive problems		
	Pain		
	Peri-menopause		
	Menopause		
	Breast Cancer screening		
	Cervical Cancer screening		
	PCOS		
	Endometriosis		
	Incontinence		
	Hospital visit		
	Sex positive lifestyle		

FEELINGS	Category	Theme	Response Examples
	Can't see the way ahead		
	Out of my control		
	Shut down		
	Desperate		
	Disability		
	Frustration		
	Alone/Lonely		
	Isolation		
	Help me		
	Stress		
	Choices		
	Locked out		
	No Access		
	Trapped		
	Depressed		
	Drowning		
	Lifeless		
	Shame/Judgement		
	Don't understand		
	Fear		
	Labelling and Stigma		
	Sadness and grief		
	Financial stress		
	Gossip		
	Behind closed doors		
	Body shame		
	Lying		
	Racism		
	Freedom		
	Choice		
	Loving my body		
	Relaxed		
	Strong and powerful		
	Happy Family		
	Friendship		
	Growth/New life		
	Support		
	Joy		
	Gratitude		
	Compassion/Understanding		
	Peacefulness		
	Wisdom		
	Relief/Let it go		
	Transformation		
	Self-Acceptance		
	Excitement		
	Women's business		
	Girls' business		

Appendix 6 - Thematic Coding and Clustering

KEY ISSUES	KEY THEME
• Lack of comprehensive knowledge about paraplegia and different disabilities amongst rural and regional GPs and health practitioners. • GPs' & specialists' attitudes to and assumptions about women. • Health practitioners not listening to women. • Lack of appropriate information to women regarding follow up testing and treatment • Rural GPs and health practitioners are too busy to listen to women and give them choices • Race based discrimination in hospital • Lack of trust/ confidence in doctors / health system following negative experience • Lack of practitioner SRH knowledge • Lack of choice/age discrimination • Age discrimination/assumptions of health professionals • Lack of communication between health practitioners and patient • Lack of support/understanding from health practitioners • Lack of appropriate information and options given to women for informed decision making/ Lack of health practitioner SRH knowledge • Health practitioners not listening to women/GP assumptions and attitudes to women	**Workforce Knowledge & Skills**
• Disconnect with own body because of SRH ill health • Responsibility of contraception/Impacts on women • Negative impacts on intimate relationships due to SRH ill health • Negative impacts on employment due to SRH ill health • Strain on family life and relationships • Stigma/Shame/Embarrassment of SRH ill health/condition • Disconnect with body because of SRH ill health, lack of support • The journey of SRH ill health (length of time) • Access to hospitals/obs- distance to travel to give birth	**Impacts of Sexual and Reproductive Ill Health on Women**
• Availability of specialist services in rural areas • Lack of availability of GPs and specialists in rural areas. • Ignorance of women's social and economic circumstances as barriers to access and inclusion • Delayed diagnosis and treatment due to wait times for specialists • Access to integrated health and wellbeing information and services for women of all abilities is important for health and wellbeing • Lack of linked up accessible transport in rural areas is another barrier to access • Additional access costs due to travel and accommodation • Benefit of visiting specialists to rural towns • Cost of multiple appointments for IUD insertion • Anonymity and accessing services in rural towns • Cost of services	**Availability and Access**

KEY ISSUES	KEY THEME
• Knowledge about health and wellbeing or health literacy is important for women to be empowered about their sexual and reproductive health • Public testing and screening programs like bowel cancer screening can be complicated and difficult to follow. • Lack of information, support and resources to support informed decision making • Access to integrated health and wellbeing information and services for women of all abilities is important for health and wellbeing • Lack of appropriate SRH information and education • Lack of appropriate information given to women	**Sexual and Reproductive Health Literacy**
• Health care system can be unwelcoming and services fragmented or siloed • Clear two-way communication between health practitioners and patients builds women's confidence and a sense control of their health and wellbeing • Unwelcoming/unsupportive health care system • Connections to supportive health practitioners, family and community networks enable women's health and wellbeing. • Rural GPs and health practitioners are too busy to listen to women and give them choices • Lack of accountability of health services • Strong female community leaders and inclusive women's groups can give voice to shared concerns and issues in CALD communities. • The value of an independent health advocate or support person • The value of information and support from local women & Child Maternal Health Nurses appropriate to the needs of the woman and her child/ren. • Lack of trust/ confidence in doctors/ health system following negative experience as CALD woman with children. • Education and training for regional doctors and nurses: active listening to support person/ woman centred care. • Female interpreters for different language groups in regional areas to support face to face SRH information provision and services • Women want holistic support that enables and empowers then, their families and communities. • Importance of building respectful relationships with women in CALD communities to hear what their needs and priorities are. • Fertility support, BMI & sexuality discrimination • Feeling comfortable with health practitioner to discuss sexual health • Lack of support/value of providing support to women • Lack of appropriate information given to women	**Systems and Environments**

Appendix 7 - Story One

I remember the first time I got my first periods at 13. I said to my mother ok, “So I get them once a year in Winter time!” She looked at me puzzled. Even though my mother had explained to my sister and myself at 9years all about our periods and the whole process. Yes, she had got her periods at 9 years of age and did not want her daughters to go through what she went through at boarding school.

My journey starts here I only got my periods once that year and about 3 times the following year. My mother dragged me to lots of doctors all of which could not give her an answer. In all of this I still got terrible pains to the point I was passing out at school. Heavy bleeding once my periods became regular if you can count regular as not knowing when your next period was coming. This was by age 15.

I am now 51 years old and only recently have I been told that the problem with all the pain and abnormal amount of bleeding, yes I do also suffer from bouts of anaemia. Is due to having endometriosis. When a specialist tells you that you have been lucky to have two kids and that your pain threshold must be very high. The feeling not only of relief & that you are not crazy and that all the pain that you are regularly in, is not in your head and that you are making it all up. One cannot explain the joy that someone finally understands and is listening to you.

It has taken me 37 years for someone to say no that is not normal for you to be feeling this way. This has not been due to lack of trying but more due to lack of knowledge of symptoms I was describing to doctors/specialist I visited in those years. Unless a General Practioner knows of endometriosis as such and has dealt with patients it can very easily go misdiagnosed. I consider myself lucky as I had the health insurance and funds to pay for tests and specialists visits. I wonder about not only the 13-year-olds who families cannot afford to pay but also the 51-year-olds that cannot pay $200 to visit a specialist. How can we help these young women?

Appendix 8 - Story Two

My doctor went away and had kids and came back after eight years and when she came back I thought 'Thank God you're back…' I had so many doctors trying to treat things as a wheel chair issue rather than a woman's issue.

That's something that I struggled with quite a few times. I went back to the Austin [Hospital] and said 'It's too hard to sort this out. They don't get it. It's got nothing what so ever to do with being in a wheelchair. But we're not getting past first base and they only see the wheelchair and [General Practitioners and specialists I've seen] think that must be where it's at'.

I am still a woman, and I still function as a woman and have the same issues that every woman has, and [these issues] still have just as big an impact on me… And when my doctor came back, I didn't have to explain anything to her. I'd say 'This is what the issue is', and she'd look at the issue. I don't know whether that's a country or a city thing or an ignorance thing. Just a general lack of knowledge I suspect.

And I think for everyone with a disability who's not quite the 'normal' format is going to have those issues of getting actually to the point [with their Doctor] rather than them seeing the disability each time. I know how to function as a paraplegic, it's not new. So I don't go to the Doctor's to be told how to function as a paraplegic, I go because there's something wrong with my body.

I had one year where I should have had surgery and I was told at the beginning of the year [by a nurse friend] that I needed surgery, but [this happened] in December that year. I'd seen four different specialists over three different regions where I kept saying 'It's nothing to do with the wheelchair'. I was treated for all kinds of things but I'd been told right at the beginning what the problem was by a nurse, who is also a friend, and she'd said, 'This is what it is. This is what needs to happen. How are you going to get that through to them? Stay in touch'.

And it was when my doctor came [back to work], and I saw her in the first week… I did not leave that clinic until I had an appointment with the surgeon. I was there for two hours. But it was only when she came in and I cried and told her what was going on, and she told me it was a [gynaecological] cyst and needed to be addressed as a cyst. It was a cyst in a gland after childbirth and it was quite apparent [to my Doctor] what needed to happen. It wasn't going to go away by itself, it wasn't a skin problem and it wasn't a sitting down issue. None of those things were going to change. But each time [I saw previous Doctors and specialists], it was seen by them as a pressure issue, 'From sitting down too much. Part of your muscle issues'. It was a cyst and finally I was booked in for emergency surgery.

I don't know how much more clear I could have been [when describing symptoms to health practitioners]. After her return, my Doctor told me what would need to happen [with surgery] and that's exactly what I was told should happen by my nurse friend at the beginning of the year. But the damage that had been done in that twelve months was huge and following surgery, I ended up being six months on antibiotics. I had major surgery the second time around to fix the damage that had been done.

Even the Austin Hospital had asked me when I was sent down before the surgery why I was there. I told them that I knew what it was and [The Austin staff] knew it wasn't a spinal issue but I told them I just couldn't get through to [regional] Doctors and specialists that it wasn't related to my spine and wheelchair.

I was not able to get past the fact that I was a paraplegic with Doctors and specialists that I'd seen until my own Doctor who knew me well, returned. My biggest problem with this was that nobody listened, and nobody actually heard what I was saying. I know Doctors see a lot of people and I don't expect that they'll have the answers all the time, but I do expect that if they don't know the answer, that they'll say that and [refer] me to see someone else.

And what I had is not uncommon and it's not major, but I ended up…in theatre twice and the second time was major surgery and was completely unnecessary. Besides the fact that it was nearly two years of my life that I had to manage [the ill health] with a young child while studying. It hurt constantly and affected a whole lot of other areas of my health. And where I really 'spat it' was where I couldn't pick my child up from school. I rang a friend and said '[the cyst's burst] and that's major. What helped during this time was the support from my friends and family and the confidence to speak up knowing something wasn't right. That could have become a life and death issue if you couldn't speak up and keep going back again and again and again. My friend who's a nurse worked with me the entire twelve months and even after surgery, she came to my house… and she's a wound care nurse. After the second lot of surgery my mum and dad dropped everything and came up and stayed at my house for twelve days and took my child to school.

Appendix 9 - Story Three

My partner and I had been going through a bit of a rut and decided to have a night out together. We had our two children babysat and we went out for dinner. We reconnected and it was a really positive outcome for us. That night we had unprotected sex and decided the next day that we weren't ready for a baby so we would take the morning after pill to eliminate the risk. We are two educated adults and usually practise safe sex. Unfortunately the morning after pill failed, resulting in an unplanned pregnancy. We were torn. We were not yet ready for a third child. Our youngest had just turned one and our eldest was not yet three. Physically, my body was not ready to be pregnant again. Mentally, I was not ready to be pregnant again. Our lives felt settled. We were both working, the children were enjoying their routine of daycare and time with their grandparents. We weren't ready to rock the little boat we were sailing in. After a week or so of thought, we decided that the time wasn't right and made the decision as adults with the right to choice to terminate. It was hard. Mentally I was a mess. But we made a decision not to tell anybody for fear of judgement. At work, I snapped at colleagues and cried in the toilets. My extremely intuitive manager noticed I was a bit 'off' and asked if I was ok. Trigger tears! It was so great to speak to someone about it who was not directly involved.

Appendix 10 - Story Four

I got my first period when I was 14 years old. I had been told all about getting my period, I had had sex ed classes in grade 6 and year 7, my mum and sister talked to me about it, I was ready for it! I wanted to grow up, I wanted to wear a bra, I wanted my period! But then I got my period. We were on holiday with my gran and late grandad. I started getting pain in my tummy, I thought it was an upset stomach so I went into the toilet. Sex ed told me there would only be a table spoon of blood, I remember them saying it and showing it in a cartoon, there was only meant to be a table spoon. I was terrified, there was so much blood. I didn't even know it was my period, I was in the bathroom for over half an hour, I could hear my gran getting annoyed because she and my sister needed a shower. Finally I called my mum to the door, cue her and my sister rushing around trying to find a pad for me, I used a lot of toilet paper and 2 pads because I was so scared I would leak blood everywhere, I had read enough "Dolly; embarrassing period moments". My first period lasted 2 weeks. From then on my periods were excruciating, no one ever told me this wasn't normal.

When I was 18 I saw a doctor and mentioned my periods were quite heavy and painful and could I do anything to help with it, he put me on the pill and suggested an iud, after research into an iud I decided it wasn't for me, it seemed a bit daunting and at this point I was very shy in regards to my reprodictive health so I stayed on the pill. It seemed to get worse, we ended up trying 3 different forms of oral contraception, obviously giving each one time to do what it was meant to, help ease pain and bleeding. It just kept making things worse, it got heavier and more painful, I felt so sick. I stopped taking the pill, the doctor then suggested an implanon, I gave it a shot for a few months but again it made me feel awful. I gave my body a rest for 12 months, for the first 6 months my period never showed up, I knew I wasn't pregnant, I'd never had sex or any type of sexual relationship, this was just my stupid reproductive system acting up like it had since I was 14. Then my period came. It didn't go away for roughly 6 months. It wasn't heavy all the time, more so just cramping and spotting heavily. My period then stayed irregular, 2 months on 3 months off, 1 month on, 5 months off. The first week when my period would come it was excruciating, but I'd keep living, everyone kept saying it was normal.

My gp suggested the Depo needle to try and regulate everything, because hormones had worked well in the past right? I trusted my doctor and got the needle. I had the exact same reaction as before, it made everything worse. It was then a family member told me about Polycystic Ovarian Syndrome which can be diagnosed through certain bloodtests and internal ultrasounds and Endometriosis which can only be diagnosed through a laproscopic procedure, she had suffered from Adenomyosis which is the "sister" to Endometriosis but can only be diagnosed through a hysterectomy. This began a new search for me, I then got a referral to see my local womens health hospital, this took 12 months to get into but I knew it would be worth the wait, I'd finally get some help. My appointment came around and the doctor was the opposite of helpful. They did an internal exam, the pain made me cry. They then said "we can't find anything what do you want us to do?" I didn't go back for a follow up. I thought I was being weak.

One morning I woke up and was in so much pain, surely this wasn't normal, I messaged a nurse friend, they told me to go to ED. I didn't want to go to my local hospital again. I ended up catching a train to The Royal Womens in Melbourne. Someone finally listened to me. The ED doctor said she believed I could be suffering endo or PCOS or possibly both. She reffered me to get an ultra sound and be seen by their endocrine/metobolic clinic. Within a month I was booked in for an ultrasound and was diagnosed with PCO, this is different from Polycystic Ovarian Syndrome, it just meant that my ovaries were prone to "cysts", these cysts aren't what we normally think of when it comes to that word, we think of infection and in some cases pus. This is more our eggs don't develop fully and become "cystic". I then began seeing the endocrine/metobolic clinic. They believed strongly that I had endo as well, but as surgery was the only way to prove this they were hesitant, they suggested oral contraception, the depo shot, the implanon and the iud as treatment, I strongly declined saying they made me worse. A lot of Doctors I saw didn't seem to believe this, I was told pregnancy or contraception would treat my endo. Pregnancy is a common misconception, yes it does help some women, but I've heard it has caused so many more issues for others.

I then found the love of my life (soppy I know, but if you knew this guy you would get it) he was the most understanding and supportive relationship I'd ever had. He comes to every RWH appointment I have. I began pushing for surgery, and finally I was referred to the surgical clinic, I was told by the doctor that I was too young for endo and it was not likely at all that's what I suffered from, she left the room to discuss with the surgical team should I have the surgery, they decided that I should. We were on the train home when I got a call from the admissions nurse saying they could book me in in two months. They convinced me that the iud would be great to put in while I was under as it doesn't have the same amount of hormones as the other contraception I'd been on had. I agreed. They were the proffessionals, I trusted them. The day arrived. I was told I was under for 3 hours because of the mass amounts of endo that they had to remove. The recovery was hard- There are two ways to remove endo, cutting or burning, cutting I've been told is a lot more effective which is what they did. Imagine the pain of having mass amounts of your insides cut out. I know a lot of people with female reproductive systems and even their partners, friends, family can relate to this pain.

I ended up in my local ED a week later due to an infection, which is normal, surgery can get messy. The ED doctor told me he suspected my endo was coming back, it wasn't an infection and that I should get pregnant ASAP. This baffled me, endo can not grow back in a week. I saw my gp the next day and she did some bloods and saw that their was an internal infection somewhere so put me on some strong antibiotics. The iud was a bad idea, I was just as sick and sore. I had it removed 3 months after the surgery, within 24 hours I felt like a new woman, I could move, I didn't get fatigue every second day where I couldn't physically get out of bed, I felt good!

Fast forward 2 years, my partner and I decided we wanted to start a family. We tried for 12 months with no luck, I decided to see a specialist in my home town, he had been in town for decades. He cared. I started going down hill again, sleeping all day because I physically couldn't get up, my periods were as bad as ever. We ended up having another surgery at Royal Womens, they found my right oviary adhered to my pelvic wall and had to cut it away. We are now in the process of trying to concieve again, which I am now needing fertility treatment for. This treatment makes me sick, my boobs are constantly hurting to the point if I graze them I have to grit my teeth. This will all be so worth it if my silly little ovaries do what they were designed to do and give us our little miracle. Some days I give up hope completley, some days I wonder if I shouldn't be a mum and that's why mother nature won't let me naturally be one, but my partner snaps me out of those moods, we will be amazing parents. I hope my story helps some people going through this. You are not alone. You need to fight to be heard. Endometriosis does not have an age, a race, and for some a "gender". Endometriosis is a bitch, and it will hit whoever it wants, whenever it wants. My story is my own, I've heard of contraception being a miracle worker for some, it just didn't agree with *me*. But that works the other way too, if contraction does not agree with you, don't be afraid to put your foot down, it is your body and your choices. Fight to be heard.

Appendix 11 - Story Five

Just after I turned 18 I went to the GP for contraception. The only thing I was offered was the pill. No discussion around other options or referral to a women's health clinic to discuss. I was on the pill for nearly 18months. During this time I experienced changes in my motivation and enjoyment of normal activities. Even at reviews to get a new script I was never asked if I was experiencing anything different. At the time I didn't recognise it until I went off the pill. After that I had 3 years with the Implanon implant as I had a friend in sexual health who was able to advise me. I had to make multiple phone calls to find a provider who was able to insert it in Bendigo. There was no quick and easy resource to point me in the right direction. Implanon made the world of difference to my health and allowed me to control my reporoductive future. I wish my GP had have spoken to me about it earlier.