LONG STORY SHORT

Reshaping the Narrative

of Women's Sexual and Reproductive Health

2022-2024

Women's Health LODDON MALLEE

WOMEN'S HEALTH Goulburn North East

Last updated August 2024

Acknowledgement of Country

Women's Health Loddon Mallee (WHLM) and Women's Health Goulburn North East (WHGNE) acknowledge the Traditional Custodians of the lands on which we live, work and play.

We celebrate and respect the unique cultural and spiritual relationship that Aboriginal and Torres Strait Islander peoples share with the lands, sky and waters and the ongoing contribution their cultures make to the life of the region.

As we pay our respects to Elders past, present and future, we pledge our organisational commitment towards reconciliation and justice.

We recognise the strength and resilience of all Aboriginal and Torres Strait Islander peoples and are dedicated to a future in which they feel connected, empowered and safe within the communities of the Loddon Mallee (LM) and Goulburn North East (GNE) regions.

Acknowledgement

WHLM and WHGNE would like to acknowledge the many women and gender diverse people, Community Advisory Group (CAG) members, health care professionals, and other stakeholders who contributed to the Long Story Short - Reshaping the Narrative of Women's Sexual and Reproductive Health project.

We thank them for generously sharing their expertise, sexual and reproductive health (SRH) experiences, and aspirations for the region, and entrusting us to honour their voices in advocating for systemic and practical change.

WHLM and WHGNE acknowledge the contribution of Bendigo Community Health Service to the project through the collection and analysis of regional demographic and SRH data.

This project was funded by the Victorian Department of Health through the Victorian Women's Health Program.

Women – Key Terminology

The term "women" is used within this report to recognise the diverse range of individuals who identify as women. This definition encompasses cisgender women, transgender women, and those who are nonbinary or gender diverse and align themselves with the female experience.

A comprehensive glossary of terms used in this report is provided in the appendix for reference.

Key Abbreviations

Key abbreviations used within this report are listed below.

CAG	Community Advisory Group
HPCW	Health Professionals Consultation Workshop
GNE	Goulburn North East
IRSD	Index of Relative Socio-Economic Disadvantage
LGA	Local Government Area
LGBTIQA+	Lesbian, gay, transgender, intersex, queer/questioning, asexual
LM	Loddon Mallee
LSS	Long Story Short
NDIS	National Disability Insurance Scheme
PWG	Project Working Group
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
WHLM	Women's Health Loddon Mallee
WHGNE	Women's Health Goulburn North East

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Introduction

This project report and recommendations has been co-authored by two regional Victorian women's health services - Women's Health Loddon Mallee (WHLM) and Women's Health Goulburn North East (WHGNE), who both work within an intersectional feminist framework to promote gender equality and to enhance the health and wellbeing of rural and regional women across the Loddon Mallee (LM) and Goulburn North East (GNE) regions through advocacy and primary prevention activities.

WHLM and WHGNE recognise that Victorian women will continue to be disadvantaged and have poorer health outcomes if sexual and reproductive health (SRH) across the continuum of care, from primary prevention to service provision continues to be inadequately funded. In addition, the quality and appropriateness of care women receive, particularly those from marginalised backgrounds,will continue to be affected if service provision continues to fail to address implicit and explicit gender bias, issues of inclusion and access, and the compounding accessibility barriers that regional and rural women face. Complex and inadequate systems, structures and policies continue to prevent women having their voices and needs heard and actioned.

Guided by principles/frameworks that consider gender, human rights and intersectional influences, this report and recommendations aim to address health disparities and improve the SRH of women living in the LM and GNE regions. It is crucial to adopt an intersectional approach that acknowledges the unique barriers faced by women, and in particular Aboriginal and Torres Strait Islander women, multicultural women, LGBTQIA+ individuals, women with disabilities, and women from other marginalised communities. By addressing these intersecting factors, we can ensure that the diverse needs of all women are met, promoting equitable access to SRH services and ultimately improving health outcomes for everyone.

Local SRH data, lived and living experiences of women, gender diverse people and health professionals are at the centre of this project, and have guided the development of the project recommendations. The recommendations act as a call to action, encouraging WHLM and WHGNE in partnership with multiple stakeholders, high-level decision makers and leaders to inform, advocate, implement and support SRH primary prevention efforts, policy and system reform to create supportive environments, grow the evidence base, and build healthy public policy to enhance SRH outcomes for LM and GNE women.

Executive Summary

Report purpose:

'Long Story Short: Reshaping the Narrative of Women's Sexual and Reproductive Health' (LSS) was a multi-stage partnership project between Women's Health Loddon Mallee (WHLM) and Women's Health Goulburn North East (WHGNE) undertaken between 2022 and 2024. The project was adapted and built upon a previous partnership project known as 'Storylines: Her Voice Matters'.

Guided by women's voices and key learnings identified throughout the project's implementation, this document forms the final project report and recommendations. It calls for action from WHLM, WHGNE and other relevant stakeholders, including leaders and decision-makers, to implement, support and/or inform SRH primary prevention activities, research, policy and system reform to address health disparities and improve the SRH of rural and regional women.

Strategic guidance:

The Australian and Victorian healthcare system includes a focus on SRH, but often does not recognise the unique accessibility barriers for rural and regional women. Leveraging off the positive momentum from Victorian-wide SRH investment, policies and strategies that prioritise the SRH of women and gender diverse people, the LSS project aimed to address this inequity, empowering women to confidently manage their SRH free from stigma and discrimination through increased information and service access within the LM and GNE regions. Based on regional need and lived and living experience, the project has a strong focus on SRH workforce capacity and development, leadership, enhancing research and evaluation practices, knowledge sharing, and increasing affordable SRH options.

Project principles:

Women's lived and living experiences and stories are at the centre of the Long Story Short project, ensuring that the project recommendations represent the specific and unique SRH needs of LM and GNE women. The project adopted a lens that centred feminist practice, gender, human rights and the social determinants of health, including rurality, and other broader intersectional influences to ensure the consideration of experiences, needs, and aspirations of women marginalised due to structural and systemic barriers.

Objectives:

- Increase organisational understanding of women's SRH issues within the target regions through data analysis and service mapping activities.
- Provide opportunities for women to have a voice in SRH service design and delivery.
- Advocate for systems-level change to develop a safe SRH system that is person-centred, culturally appropriate, rights-based, and that meets the timely SRH needs of women.

Governance:

A project working group (PWG) consisting of WHLM and WHGNE staff was responsible for the project's implementation. A community advisory group (CAG) was established, ensuring the opinions, perspectives and SRH experiences of LM and GNE women and gender diverse people guided the project's development and implementation.

Approaches:

A mixed methods approach was adopted using both quantitative and qualitative methods. The combination of both research approaches facilitated a comprehensive collection of data to build a localised evidence base, creating a rich and detailed picture of the SRH landscape for women residing in the LM and GNE regions.

Data collection:

A regional data profile and literature scan were undertaken, alongside a number of community engagement activities including workshops, focus groups, surveys and questionnaires to collect and analyse local demographic and SRH data, map services and service delivery, explore inequities, and capture the lived and living SRH experiences and stories of local women, gender diverse people, and healthcare professionals.

Key findings:

Regional data profile: Bendigo Community Health Services (BCHS) were engaged to develop a regional data profile to ensure this project was based on local evidence. Approximately half of those living within the LM and GNE regions identify as female, some of whom are from Aboriginal and Torres Strait Islander backgrounds and from multicultural communities. A large proportion of LM and GNE local government areas (LGAs) have greater than state-average level of National Disability Insurance Scheme (NDIS) participants, mothers with low educational attainment, sole-parent households, low-income households, and households receiving rent assistance. This contributes towards the large degree of socioeconomic disadvantage entrenched within both regions, with 16 of the 22 LGAs across the regions ranking in the bottom half of Victoria's Index of Relative Socio-Economic Disadvantage (IRSD). There is a noticeable socioeconomic divide between LGAs within each of the catchments. The more affluent LGAs enjoying greater access to health services including GPs and exhibit higher standards of living and lower rates of disability, and the more disadvantaged LGAs face significant challenges, such as low incomes, limited access to public transport, internet connectivity, and fewer public health services. Across all indicators, LM appears to experience a higher level of entrenched collective disadvantage in comparison to GNE, however both LM and GNE have pockets of significant disadvantage and barriers to SRH access. Data reveals that STIs are prevalent across both regions with Chlamydia and Gonorrhea being the most common, and gender-based violence is a serious public health concern that needs to be addressed.

Barriers and solutions: Consultation with local women, gender diverse people and healthcare professionals identified many barriers restricting SRH care and service provision within the LM and GNE regions, which creates service gaps and reduces quality of care. Such barriers relate to a lack of SRH service accessibility and availability, poor societal attitudes towards SRH and stigmatisation, reduced quality of care, and low levels of community SRH education and awareness. This coupled with poorer socioeconomic conditions (outlined above) restricts women's accessibility to SRH services, intensifying SRH conditions, and creates poorer SRH outcomes for LM and GNE women, particularly those from marginalised population groups.

Applying a strengths-based approach, drawing from available community resources and lived and living experiences, local women, gender diverse people and healthcare professionals put forward solutions to address the identified barriers to enhance SRH information and service provision within the LM and GNE regions. These solutions, alongside local demographic and SRH data, and literature have formed the project's future recommendations.

Recommendations:

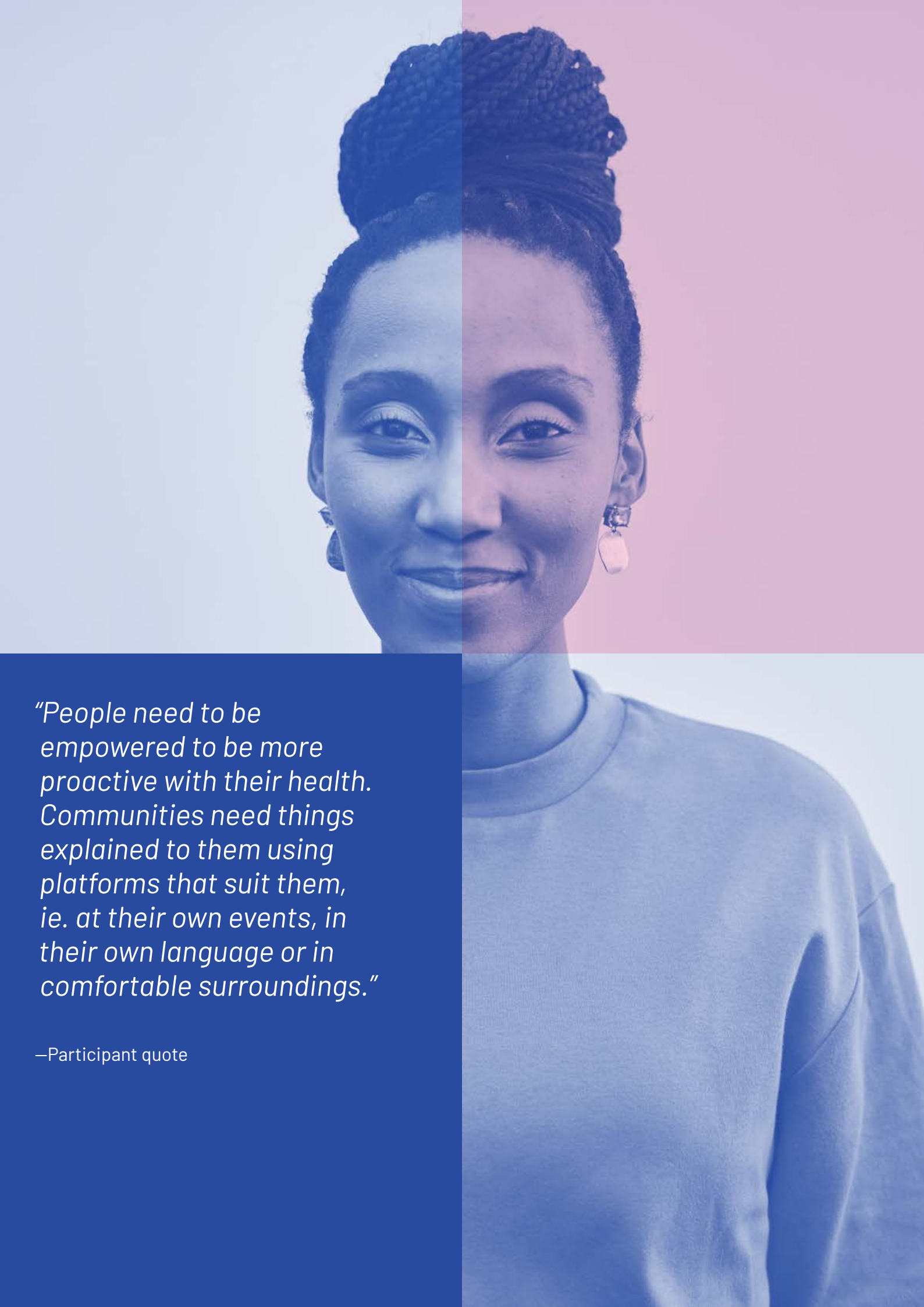
In support and alignment with state, regional and local level SRH and SRH related policies, acts and strategies, the recommendations presented in this report aim to guide future efforts within the three priority areas to improve the SRH of regional and rural women:

1. Creating Supportive Environments
2. Growing the Evidence Base
3. Building Healthy Public Policy

Concluding remarks:

This project has shown that since the original Storylines project women's SRH experiences across the LM and GNE regions have remained largely unchanged. Barriers remain, and women reflect on the challenges that inhibit their ability to secure the quality care they require, highlighting the complex systems, structures and policies that continue to prevent their voices and needs from being heard and actioned.

The project recommendations are community-driven, multi-level, and will guide WHLM, WHGNE, key stakeholders, leaders and decision-makers to make systems-level change whilst promoting SRH, empowering women, and addressing SRH inequities that exist within the LM and GNE regions.



"People need to be empowered to be more proactive with their health. Communities need things explained to them using platforms that suit them, ie. at their own events, in their own language or in comfortable surroundings."

—Participant quote

1. About Women's Health Loddon Mallee and Women's Health Goulburn North East

WHLM and WHGNE are not for profit (but for purpose), independent, specialist regional health promotion services run by women, for women.

Having each been in operation for over 30 years, the organisations are a part of the Victorian Women's Health Services Network, a collective of 12 state government-funded women's health services that centre their efforts around gendered health promotion, primary prevention and gender equity.

WHLM and WHGNE engage with women and gender diverse people, communities, local governments, health services, education providers and other organisations to promote and enhance the health and wellbeing of women across the LM and GNE regions.

Both organisations are committed to using a rights-based approach in advocating for women, working within an intersectional feminist framework to achieve gender equality. A gendered lens approach is applied to their work, recognising the influence of sex and gender and the complex relationship between the physical, social, emotional, cultural, environmental and economic determinants of health, which often result in compounding and poorer health outcomes for women.

WHLM and WHGNE focus on improving health through primary prevention initiatives that address health and wellbeing issues at the population level before they occur.

To undertake meaningful, lasting, and impactful primary prevention work, local women's voices, experiences, and expertise are central to everything that WHLM and WHGNE do, informing strategies, policies, projects, and advocacy. Their work is tailored and delivered with and for communities in the places people live, work, socialise, and play.

WHLM and WHGNE have a shared strategic focus on gender equity, primary prevention of violence against women, mental health and wellbeing, the impacts/role of women in today's changing society, and sexual and reproductive health (SRH).

2. Sexual and Reproductive Health – A Shared Strategic Priority

Within the SRH priority area, both WHLM and WHGNE have committed to the SRH priority within their respective Strategic Plans:

- Ensuring communities have access to informed and appropriate SRH services that are provided free of judgement and discrimination. Individuals should be empowered to have safe, respectful, and pleasurable relationships and have a positive approach to sexuality and its expression (WHLM, 2021).
- Supporting women's SRH rights to be upheld by the law and not to be constrained by rigid gender stereotypes. Women make their own choices and can access the information and services needed to support those choices (WHGNE, 2021).

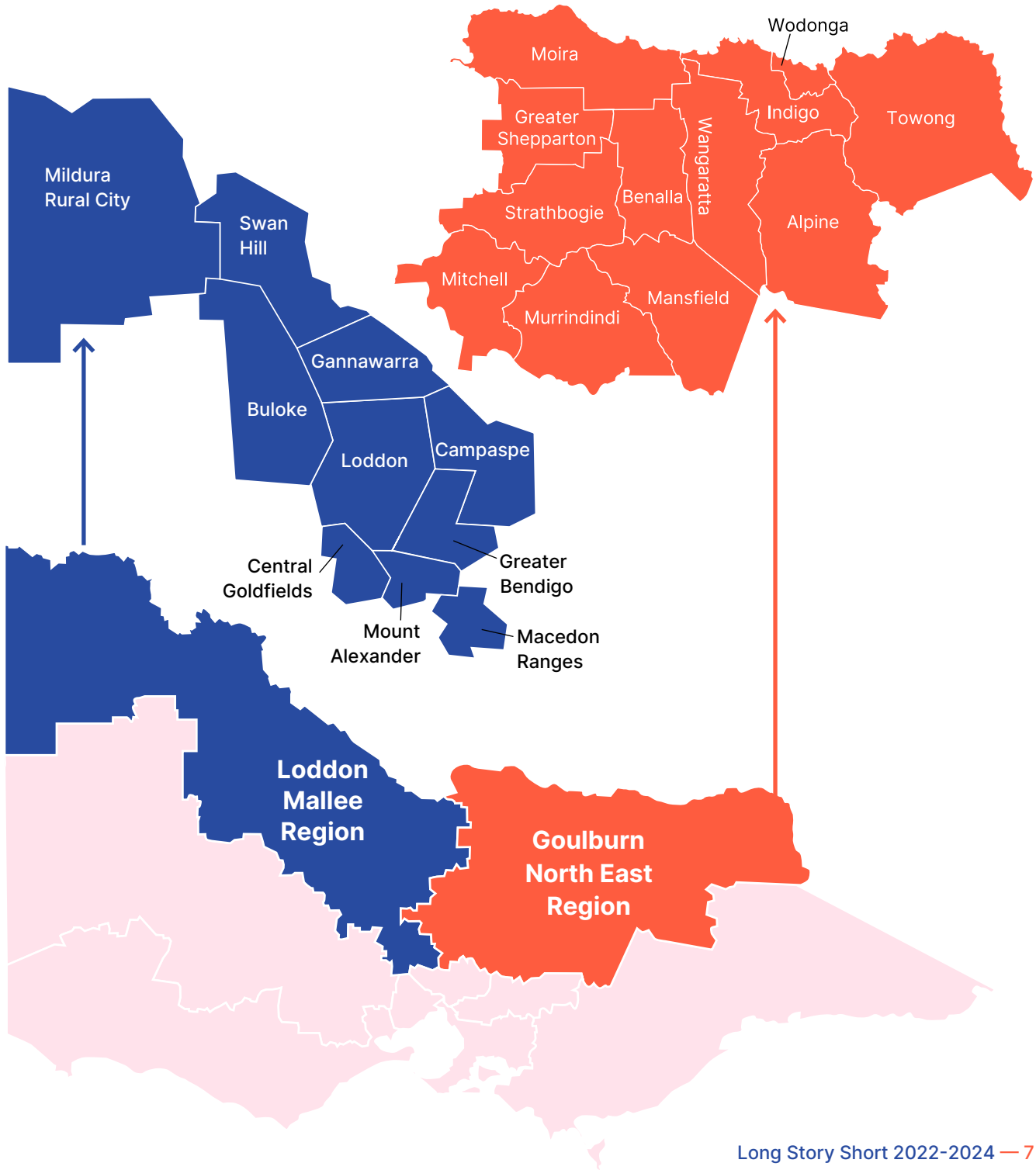
Using a shared and collaborative strategic approach between the two organisations, the development and implementation of the Long Story Short project dedicated resources and efforts to achieve these SRH priorities during 2022-2024.

3. Catchment Areas

WHLM covers 10 local government areas (LGAs) across the Loddon Mallee (LM) region and WHGNE covers 12 LGAs in the Goulburn North East (GNE) region (refer to map below).

The LM region includes the LGAs of Buloke, Campaspe, Central Goldfields, Gannawarra, Greater Bendigo, Loddon, Macedon Ranges, Mildura, Mount Alexander and Swan Hill. The Traditional Owners include the Wiradjuri, Yorta Yorta, Dja Dja Wurrung, Barappa Barappa, Wemba Wemba, Barkindji, Latji Latji, Taungurung and Wurundjeri peoples.

The GNE region includes the LGAs of Moira, Greater Sheparton, Strathbogie, Mitchell, Murrindindi, Mansfield, Benalla, Wangaratta, Alpine, Indigo, Towong and Wodonga. The Traditional Owners include the Yorta Yorta, Taungurung, Bpangerang, Minjambuta, Duduroa and Jaitmathang peoples.



4. Project Background

The 'Long Story Short – Reshaping the Narrative of Women's Sexual and Reproductive Health' project – shortened to 'Long Story Short' and abbreviated as LSS, was adapted from a previous project known as 'Storylines: Her Voice Matters'.

Storylines was a collaborative partnership project carried out from 2017-2018. In addition to a regional quantitative data profile and needs assessment, the project invited women to share their SRH experiences. This resulted in a comprehensive understanding of the quality, access, and types of health supports available to women in the LM and GNE regions, highlighting areas for improvement.

In 2020 WHLM and WHGNE produced a report 'Women's Sexual and Reproductive Health Needs in the Murray Region' in partnership with Murray Primary Health Network (PHN) (2020), providing WHLM and WHGNE with recommendations on applying key learnings from activities undertaken throughout the Storylines project.

The report recommendations included:

- Workforce development with targeted SRH education and training that is rights-based and responsive to the multiple and intersecting forms of disadvantage and inequity experienced by women.
- The delivery of rights-based women's SRH education and training, including targeted education and training for priority populations to build knowledge, understanding and awareness of SRH and access to services.
- Strategic partnerships to address SRH service gaps, including increasing women's access to timely and affordable medical and surgical abortion services that are based on best practice models.
- Building understanding and knowledge of local and neighbouring area SRH referral pathways that provide women with the choice of anonymity.
- Building knowledge of and access to practice nurses and evidence-based nurse led models of SRH care and services across the sector.

In addition, key achievements and outcomes of the Storylines project included:

- Building on the progress of activities undertaken by WHGNE and WHLM, significant achievements from the 2018 Storylines project centered on workforce development and expanding access to SRH services.
- Key initiatives included targeted education and training for GPs, primary health workers, Child and Maternal Health nurses, midwives, and sexual and reproductive health specialists.
- A notable collaboration with Melbourne University and Sexual Health Victoria led to the establishment of a preceptorship program within WHLM's nurse led Well Women's Clinic.
- Bendigo Community Health Services (BCHS) became Victoria's first regional women's SRH hub, significantly increasing service access for women by increasing its workforce and offering expanded services at multiple locations with an emphasis on comprehensive and confidential care.
- WHGNE and WHLM delivered extensive rights-based education and training, particularly to marginalised population groups. This included the development of straightforward guides on various health topics and the delivery of menopause and reproductive health workshops to diverse groups, including women from migrant and refugee backgrounds and Deaf and Hard of Hearing communities.
- Strategic partnerships with organisations including 1800 My Options and local health services were established to enhance access to timely and affordable medical and surgical abortion services.
- WHLM's Well Women's Clinic adopted a collaborative network model, increasing the availability of essential services.

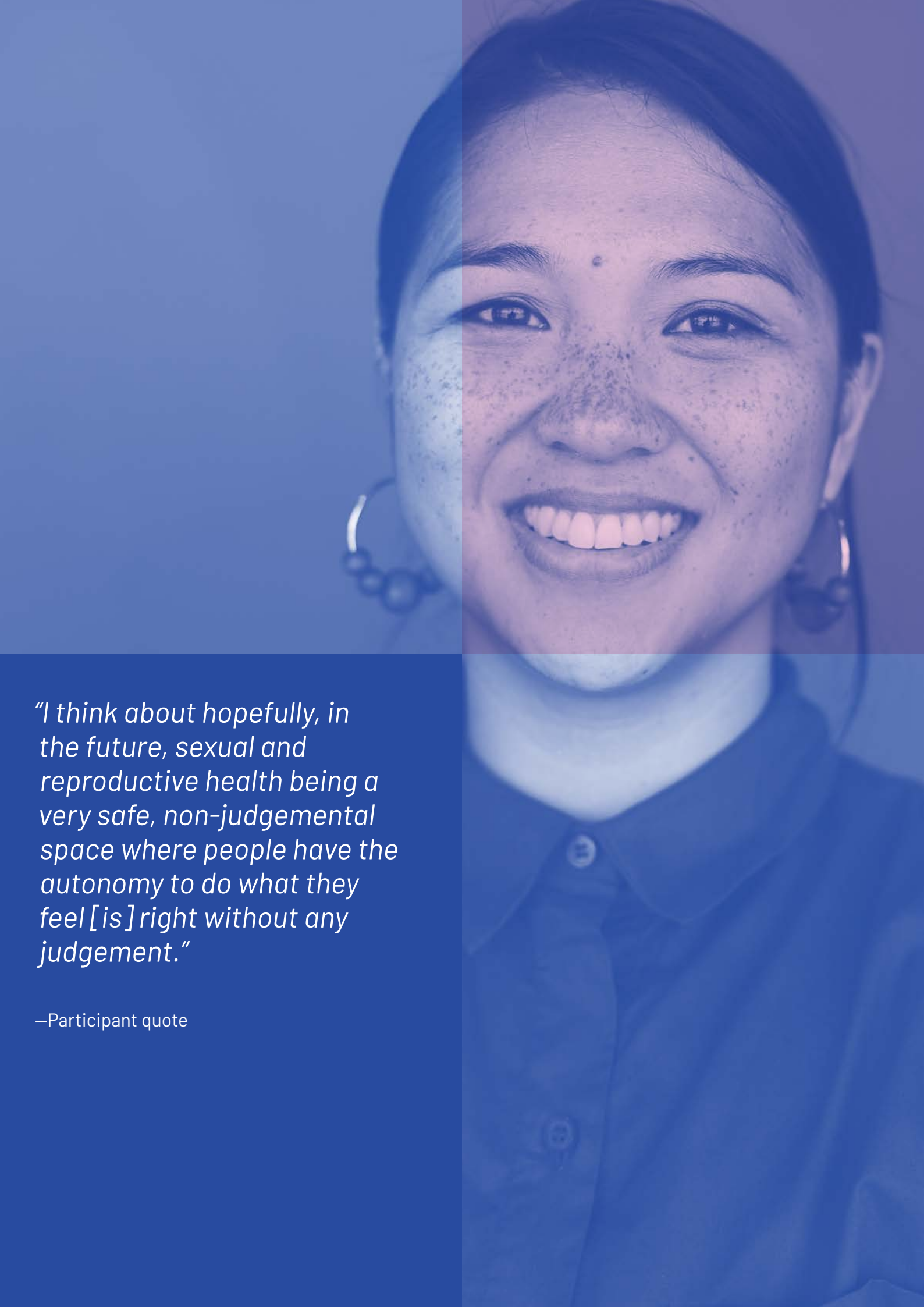
- WHLM and WHGNE focused on building knowledge of referral pathways and evidence-based nurse-led models of care, conducting research to better understand barriers to accessing SRH services among young regional and rural women.

The 2020 report highlighted the importance of accessing the most up-to-date local data and capturing lived and living experience to provide a clear overview of the current SRH landscape within the LM and GNE regions. These insights are crucial for building community capacity to navigate the health system, increasing knowledge of SRH issues, and improving confidence of individuals to self-advocate. This data, also allowed WHLM and WHGNE to advocate for an expansion of rights-based SRH services and information that is provided to women in a way that is non-judgmental, easily understood, culturally sensitive, non-discriminatory, affordable, geographically accessible, and sex positive.

In response to these recommendations, the Storylines project was reignited, redesigned, and renamed to the 'Long Story Short – Reshaping the Narrative of Women's Sexual and Reproductive Health' project, which commenced implementation in 2022.

Elevation of Women's SRH experiences:

In February 2024, the Women's Health Service Network (WHSN) held a Gender Health and Wellbeing showcase to demonstrate the important work undertaken by the WHSN. To elevate women's voices and experiences WHGNE and WHLM created advocacy videos, inspired by the lived and living experience stories heard throughout the Storylines project. Like the LSS project, the videos highlight the strengths and solutions that can be drawn from lived and living experience.



"I think about hopefully, in the future, sexual and reproductive health being a very safe, non-judgemental space where people have the autonomy to do what they feel [is] right without any judgement."

—Participant quote

5. Strategic Guidance

The LSS project is guided by multiple frameworks, policies and strategies at the international, national, state, regional and local level.

Adopted in 1948, the International Bill of Human Rights highlights the universal right to health.

At the national level, the Australian Government commits to this human right with health and wellbeing the key focus within the current National Preventive Health Strategy 2021-2030. This strategy highlights the need for systems-level, preventative health promotion efforts like the LSS project that address the broader determinants of health to create sustainable long-term health improvements across the lifespan. Health promotion efforts are guided by the Ottawa Charter for Health Promotion Framework which outlines five key actions to improve population level health outcomes including creating supportive environments, strengthening community action, developing personal skills, reorienting health services, and building healthy public policy.

Since the 2018 Storylines project, considerable investment and policy has been made in women's SRH at the state-level. For example, the Victorian Government has released the Victorian Department of Health and Wellbeing Plan 2023- 2027 with improving SRH being listed as a key priority, and the Victorian Aboriginal Sexual Health and Reproductive Health Plan 2022-30 and Victorian Women's Sexual and Reproductive Health Plan 2022-30 highlighting the importance of Women's Health Services like WHLM and WHGNE in leading and influencing structural SRH change within communities, addressing the greater inequalities some women, girls and gender diverse people face when accessing SRH information and services.

The Women's Health Services Network SRH Community of Practice supports the commitment to enhancing SRH outcomes at the state-level, including the development of A Theory of Change in Sexual and Reproductive Health for Victorian Women (ToC) document to guide the collective and individual work of women's health services to track progress towards the vision for the rights for all Victorian women to optimal SRH and wellbeing. The ToC has used an intersectional approach to ensure the impacts on the SRH of women from marginalised backgrounds are always considered.

WHLM (2021-2025) and WHGNE (2021-2025) have committed to the enhancement of women's health and wellbeing, with consideration of gender, human rights, and intersectionality to create systems-level change within their strategic plans. There is a specific focus on improving access to SRH information and services, growing community capacity and knowledge, building connections, developing evidence informed solutions and actions, and amplifying women's voices.

Aligning with the Her Health Matters – a Regional Approach to Women's Sexual and Reproductive Health 2023-2026 strategy developed by WHLM, women's lived and living experiences and stories are at the centre of the LSS project, ensuring that solutions-based recommendations represent the specific and unique SRH needs of local women.

At the regional level, the LSS project draws strategic connections to the Centre of Excellence in Rural Sexual Health (CERSH) and the Sexual Wellness Action Plans being collectively developed in specific local government areas, where there is a focus on rural workforce capacity and development, leadership, enhancing research and evaluation practices, knowledge sharing, and increasing affordable SRH options.

6. Project Principles

In alignment with the strategic principles of WHLM and WHGNE, the project considers and embraces comprehensive definitions of health, emphasising wellness, well-being, and recognition of broader determinants that influence individual health outcomes.

Despite access to SRH care being a fundamental human right, often social norms, historical powers and hierarchical inequalities can intersect and create complex SRH barriers for women (Lokot & Avakyan, 2020; Starrs et al., 2018; World Health Organization [WHO], 2019). In response to this, and in alignment with the broader strategies and policies that have guided the development of the LSS project, multiple lenses have been adopted to understand the barriers to SRH information and service provision, with specific consideration to gender, human rights and intersectional influences.

The rurality of the LM and GNE landscapes is an important project consideration, as living in regional, rural and remote areas often restricts access to SRH information and services (Cashman, Downing & Russell, 2021; Doran & Hornibrook, 2016; Malatzky & Hulme, 2022). As rurality may intersect with other influences such as, but not limited to, gender, culture, sexual orientation, age, socioeconomic status, and ability, an intersectional lens was embedded into the project to understand and respond to inequalities that can further marginalise, discriminate, and oppress women from diverse population groups. These groups may include women who are Aboriginal and Torres Strait Islander, lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual (LGBTIQA+), young and older in age, those living with a disability, those from multicultural communities and people from low socio-economic backgrounds/households (Dawkins et al., 2020; Del Tufo et al., 2023; Grant, Nash & Hansen, 2020; Nyugen, 2020; Victorian Government, 2023).

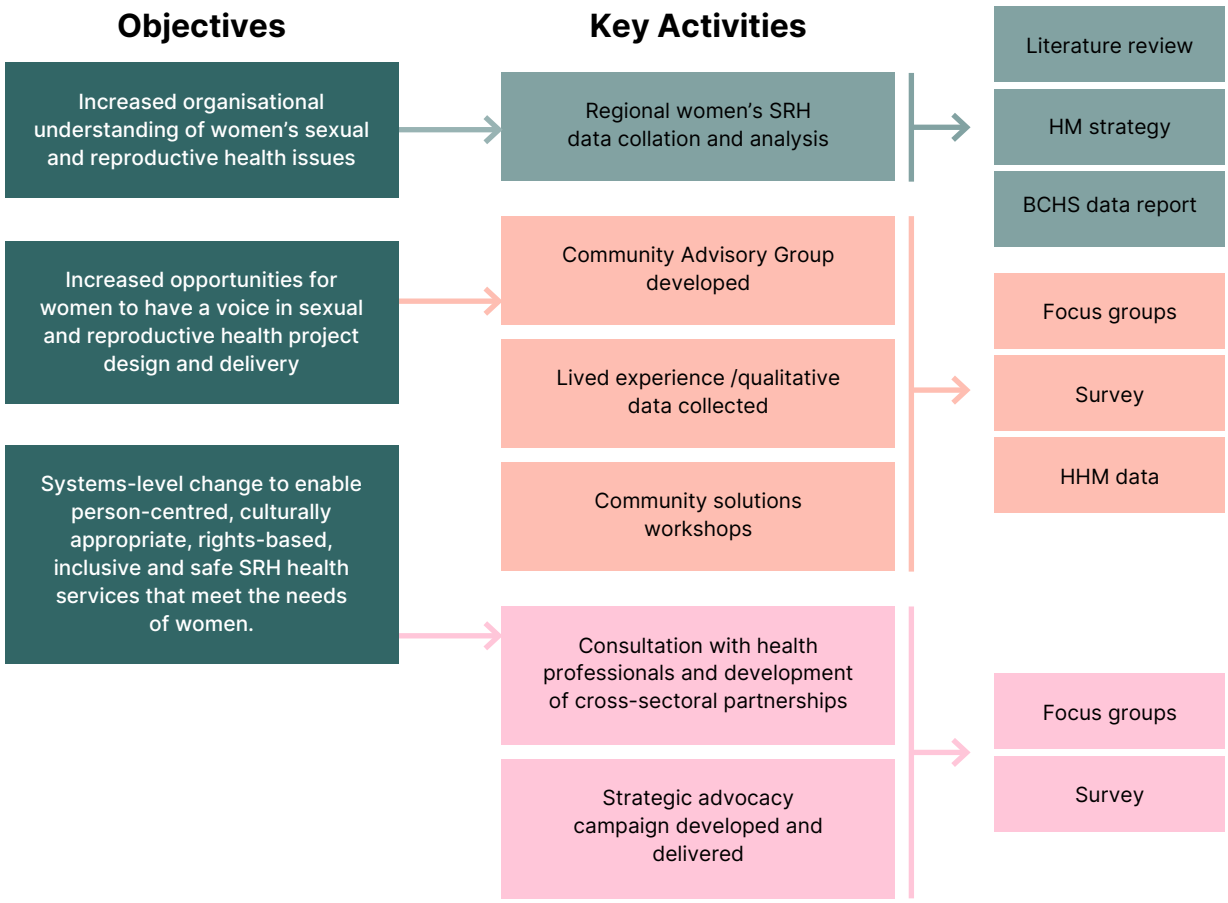
The project considers the socioecological model of health, examining barriers and enablers at multiple ecological levels, including intrapersonal, interpersonal, organisational, community, and societal/policy, and how this influences SRH information and service provision within the LM and GNE regions (World Health Organization, 2022). Considering this model, and the influence of the interacting layers throughout the project, provides SRH context specific to the LM and GNE regions, and recognises the power, control, and community resources/assets required to create systems-level change (Reye et al., 2023).

Gaining insight into women's lived and living experience is essential to ensure that the needs of LM and GNE marginalised populations are met. This was achieved through the adoption of an ethical health promotion approach which considered equity, social justice, autonomy and choice when collecting lived and living experiences.

WHLM and WHGNE utilised a strengths-based solutions-focused approach so that the stories and perspectives of local women and healthcare professionals generated positive, future orientated solutions. The strengths-based, solutions-focused approach asserts that all experiences, even negative ones, present opportunities for growth, place emphasis on removing barriers, aim to identify and use available community resources, and empower individuals and communities to make positive change (Australian Health Promotion Association, 2024; Chapin, Nelson-Becker & MacMillan, 2006).

7. Project Overview

Project aim: Through the LSS project (2022-2024) women in LM and GNE regions will have the information they need to manage their SRH confidently and access safe and appropriate health services that are delivered free from stigma and discrimination.



Short Term Outcomes

Quantitative evidence informs Long Story Short project objectives and activities.

Women with lived experience provide advice and guidance to the Long Story Short project

Qualitative evidence informs Long Story Short project activities

SRH service providers provide advice and guidance to the Long Story Short project

Medium Term Outcomes

Local evidence informs service and program design and delivery

Service providers and other key stakeholders have an increased knowledge of women's sexual and reproductive health needs in the target regions.

Women, including priority groups, have access to information about sexual and reproductive health and how to access support

Long Term Outcomes

Women have access to evidence-based information about sexual and reproductive health

Women are empowered to make informed decisions about their own sexual and reproductive health

Women have access to safe and appropriate sexual and reproductive health services that are free from stigma and discrimination

Women know where and how to access safe + appropriate sexual and reproductive health services in their area that enable them to exercise their rights

8. Approaches

The project's aims and objectives were achieved through a mixed methods approach that adopted both quantitative and qualitative methods.

The combination of both research methods facilitated a comprehensive approach to capturing and building a localised evidence base. The quantitative approach allowed for local demographic and SRH data to be collected and analysed and service mapping to be completed. The qualitative approach captured the SRH viewpoints, opinions, and experiences of LM and GNE women specific to their time and place (Miles & Huberman, 2014; Patton, 2015).

The combination of these methods painted a rich and detailed picture of the SRH landscape for women residing in the LM and GNE regions, allowing for community and data informed strength-based recommendations, that aim to enhance SRH service provision and information accessibility for LM and GNE women (Crotty, 1998; Patton, 2015).

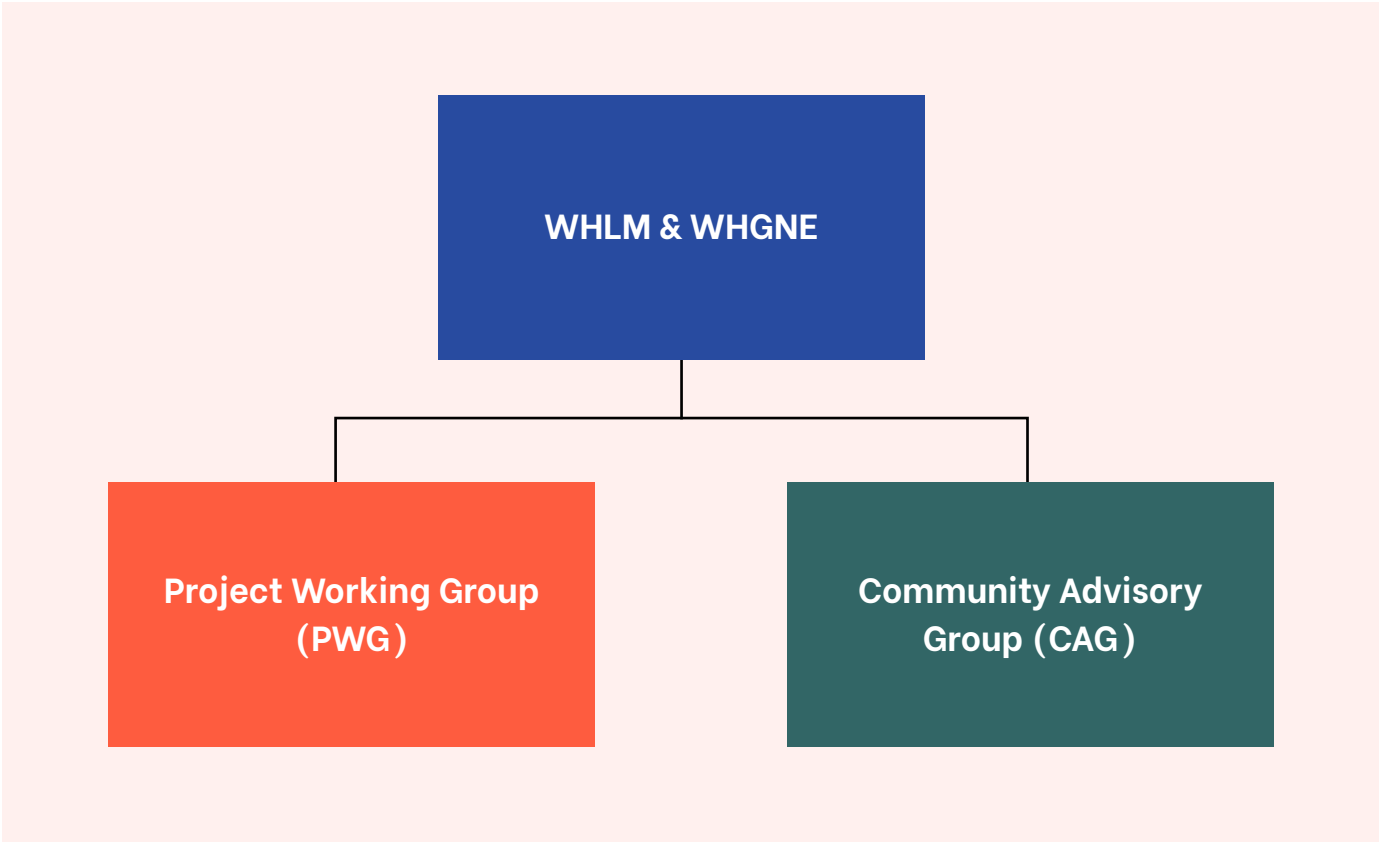
Methods that were adopted to enhance the trustworthiness and credibility of the findings included:

- Establishment of the Community Advisory Group (CAG), utilisng SRH lived and living experiences and stories to guide the project's development and implementation. This minimised the risk of Project Working Group (PWG) biases affecting the design and delivery of the project.
- Adoption of an ethical health promotion approach, with the PWG aligning their work to the National Statement on Ethical Conduct in Human Research.
- Ongoing, collaborative data analysis between the Project Working Group (PWG) to formulate themes, enhancing methodological rigor and accuracy of findings.
- A reflexive research approach reminding the PWG to be attentive and conscious of their own perceptions and past experiences when collecting and analysing data.
- Peer debriefing during research process/ analysis stages to ensure agreement on key learnings and prevent the influence of biases from the PWG.
- The position of key members of the PWG and their demonstrated experience in mixed method research studies with the public health sector.

9. Project Governance

With a history of working together from the previous Storylines project, the LSS project was again delivered in partnership by WHLM and WHGNE and required a shared governance structure.

Diagram 1. LSS Project Governance Structure



9.1 Project Working Group

WHLM and WHGNE formed a PWG in July 2022, consisting of up to 3 staff from each organisation, with additional support available from senior staff as required.

As the project was implemented over a two-year period, there was a degree of staff turnover amongst the PWG members. However detailed minutes were taken and filed appropriately to ensure the project's progress was fully documented, and a shared Microsoft Teams channel was established for the housing and sharing of information, and project related resources. This ensured the project's sustainability as new PWG members could be provided with the most up-to-date information on the project's implementation and progress.

9.2 Community Advisory Group

A CAG was formed in the early stages of the project implementation (February 2023), consisting of 20 (10 from the LM and 10 from GNE) women and gender diverse people aged 19 to 67 years, living in LM and GNE regions.

Key objectives of the CAG included to:

- Contribute to the design of community conversations, including who will be spoken to, what will be spoken about, and how to consider the needs of the most marginalised community groups.
- Lead the identification of key priorities for LM and GNE regions.

- Facilitate community conversations to hear women's experiences around SRH, with support from the LSS project team.
- Support the LSS project team to utilise lived and living experience to identify community-driven solutions that support ongoing advocacy and project work for rural and regional women.

The CAG model ensured women were acknowledged as experts in their own experiences. Women were able to provide data in a safe, supported way where they could direct the discussion. The use of open-ended questions allowed for rich, diverse perspectives and experiences to be shared while also creating opportunities for future networking.

An inclusive recruitment approach enabled engagement of participants with diverse experiences and provided comprehensive insights into the unique challenges and opportunities faced by women across the two regions. Reimbursement was provided to participants for their time and to value their expertise and lived and living experience. This was a project enabler that increased participation and could be adopted in future projects. However, this must be done with careful consideration so as not to be coercive and to align with agreed project budgets.

The process of establishing a CAG and the running of sessions was time and resource intensive, as each step, for example, recruitment, establishing Terms of Reference (ToR), reviewing applicants, delivering sessions, and processing payments, all required careful consideration and team input. However, these robust conversations and processes strengthened the approach and outcome.

The sessions were run online, and at times required prompting for members to contribute/answer questions. A face-to-face environment could enrich input in future projects. However, the format (online vs. face-to-face) and ensuring a balance between diversity aspects, location and availability needs to be weighed up when selecting the best delivery mode in future.

The PWG was unable to pursue more complex CAG engagements, such as further co-design sessions with members and having CAG members lead focus groups, due to time and resource constraints.

The CAG came up with many rich and innovative suggestions, however some were unable to be activated or utilised as they were not within the scope of the project. These ideas are not lost, with the opportunity to reference them in future SRH project design.

9.3 WHLM and WHGNE partnership

An internal mid-cycle partnership evaluation was conducted in January 2024, highlighting the strength of this partnership to work efficiently and effectively on shared projects and initiatives.

To undertake the evaluation, a partnership agreement scorecard was used. This tool aids in co-creating and reviewing partner agreements, supporting discussions, and guiding decision-making between partners. It allows partners to review, comment, score and compare various elements to decide whether good partnership principles have been embedded in the current agreement and how they might be improved. Both organisations independently completed the partnership agreement scorecard.

The scorecards revealed self-reported partnership scores of 91.5 out of 112 for WHLM and 92 out of 112 for WHGNE. According to Partnerships Resource Centre, scores between 60- 99 may indicate concern that some aspects leading to comprehensive agreements have not been properly addressed (Pfisterer, Payandeh & Reid, 2014). This might suggest the agreement is unbalanced towards a particular aspect of the partnership, potentially leading to a transactional relationship or remaining vague in terms of resource commitments, responsibilities and expectations.

This issue was partly attributed to the absence of a comprehensive partnership agreement at the project's inception. Instead, the partnership

relied on a TOR and Planning and Evaluation document that did not cover all partnership elements. To address this, an online partnership health check was conducted separately with each organisation, supplementing the scorecard with additional questions about the partnership. Comments were consolidated from both engagements, resulting in a report that provided combined feedback and recommendations.

These insights offered a comprehensive overview of the partnership, highlighting positive aspects and valuable lessons for future collaboration and project success.

"You should be made to feel like you're not just the next patient but rather you are a person who requires all the details and knowledge around your health."

—Participant quote

10.Data Collection

Data collection tasks were undertaken to identify SRH trends, issues and inequities within the LM, GNE and more broadly within regional, rural and remote communities, and to capture the lived and living SRH experiences and possible solutions to SRH challenges from the perspective of local women, gender diverse people and health professionals.

To do this, the following tasks were undertaken:

- Regional data profiling
- A desktop literature scan
- Community engagement strategies including Community Advisory Group (CAG), health professional consultation workshop (HPCW), health professionals survey, online questionnaire and focus groups.

Note: focus groups were only conducted in GNE as WHLM had already conducted focus groups to inform the development of their Her Health Matters: Sexual and Reproductive Health strategy.

A summary of the data collection strategies is provided below.

<table>
<tr><th></th><th>Feb - May 2023</th><th>Feb 2023</th><th>Mar 2023</th><th>May 2023</th><th>June 2023</th><th>Feb – June 2023</th><th>July 2023</th><th>Aug 2023</th><th>Sept 2023 - Mar 2024</th><th>Oct 2023</th><th>Nov 2023</th><th>Feb 2024</th></tr>
<tr><td rowspan="2">Task/ Strategy</td><td rowspan="2">Data report Collection and analysis of local demographic and SRH data, and regional service mapping.</td><td colspan="4">Community Advisory Group (CAG)</td><td rowspan="2">Literature scan</td><td>Health Professionals Consultation Workshop (HPCW)</td><td>Health Professional survey</td><td>Online Questionnaire</td><td colspan="3">GNE Focus Groups</td></tr>
<tr><td>CAG formed</td><td>Meeting 1 - Zoom</td><td>Meeting 2 - Zoom</td><td>Meeting 3 - Zoom</td><td>Zoom</td><td>Open online</td><td>Open online</td><td>1. Shepparton</td><td>2. Wodonga</td><td>3. Online/ Zoom</td></tr>
<tr><td>Objective/ Aim</td><td>Local demographic and SRH data were analysed to identify trends and issues that exist within the LM and GNE.</td><td colspan="4">Provided women and gender diverse people with the opportunity to contribute to the project's design, direction, implementation and branding, explore SRH data, share their own lived and living experiences and what could support better SRH outcomes, and opinions on how to promote SRH stories.</td><td>Undertaken with the intention of exploring the health inequities surrounding SRH faced by regional and rural Victorian women with key recommendations for future SRH practice provided.</td><td colspan="2">Provided clinicians and health professionals from across the LM and GNE regions to share their SRH perspectives.</td><td colspan="4">Provided women and gender diverse people from the GNE region with the opportunity to share their lived and living experience and draw from their perspectives to collaborate in developing place-based, lived/living experience solutions to the challenges of seeking SRH care in rural and regional communities.</td></tr>
</table>

*Please see the report Appendix for full details on each strategy.

11. Key Findings

This section of the report presents the key findings identified throughout the data collection process.

Findings are presented in relevance to specific data collection processes undertaken and the achievement of project objectives.

11.1 Regional Data Profile

Project objective:
Increase organisational understanding of women's SRH issues within the target regions through data analysis and service mapping activities.

Key findings from the Regional Data Profile are presented below, including information and data relating to demographic profiles, socioeconomic indexes, workforce capacity, preventative screening rates, access to supporting infrastructure, prevalence of sexually transmitted infections (STIs) and gender-based violence, and access to reproductive services. Correlations have been drawn between key findings and peer reviewed literature (identified within the literature scan) where appropriate.

In summary, approximately half of those living within the LM and GNE regions identify as female, some of whom are from Aboriginal and Torres Strait Islander backgrounds and multicultural communities. A large proportion of LM and GNE LGAs have greater than state-average level of National Disability Insurance Scheme (NDIS) participants, mothers with low educational attainment, sole-parent households, low-income households, and households receiving rent assistance. This contributes towards the large degree of socioeconomic disadvantage entrenched within both regions, with 16 of the 22 LGAs within the regions ranking in the bottom half of Victoria's Index of Relative Socio-Economic Disadvantage (IRDS).

There is a noticeable socioeconomic divide between LGAs within each of their catchments, with the more affluent LGAs enjoying greater access to health services, including GPs, and exhibit higher standards of living and lower rates of disability. In contrast, the more disadvantaged LGAs face significant challenges, including lower incomes, limited access to public transport, limited/poor internet connectivity, and few public health services. Across all indicators, LM appears to experience a higher level of entrenched collective disadvantage in comparison to GNE, however both LM and GNE have pockets of significant disadvantage and barriers to SRH access.

STIs are prevalent across the GNE and LM regions with Chlamydia and Gonorrhoea being the most common, and gender-based violence is a serious public health concern that needs to be addressed.

The following information outlines more detail relating to these findings.

11.1.1 Demographic profile

70,276 females aged 10 to 44 years living in the LM and 62,061 in the GNE (PHIDUa, 2023).

Rural, regional, and remote women make up one-third of Australia's women, however they have poorer SRH outcomes than women living in metropolitan areas (O'Reilly 2022). This finding is supported by WHLM's Her Health Matters strategy, which highlights the SRH health inequities that regional, rural and remote women face, particularly those from marginalised populations.

Australian SRH services are highly concentrated within metropolitan areas, with accessibility lacking within regional and rural communities. This coupled with poorer socioeconomic conditions contributes towards poorer SRH status of rural and remote women (AIHW, 2023; Cashman et al., 2021; Coombe et al., 2021; Malatzky & Hulme, 2022; Moulton et al., 2022; O'Reilly 2022).

2,643 females aged 14 to 49 living in the LM and 2,129 females living in GNE identify as Aboriginal and Torres Strait Islander (PHIDUa, 2023).

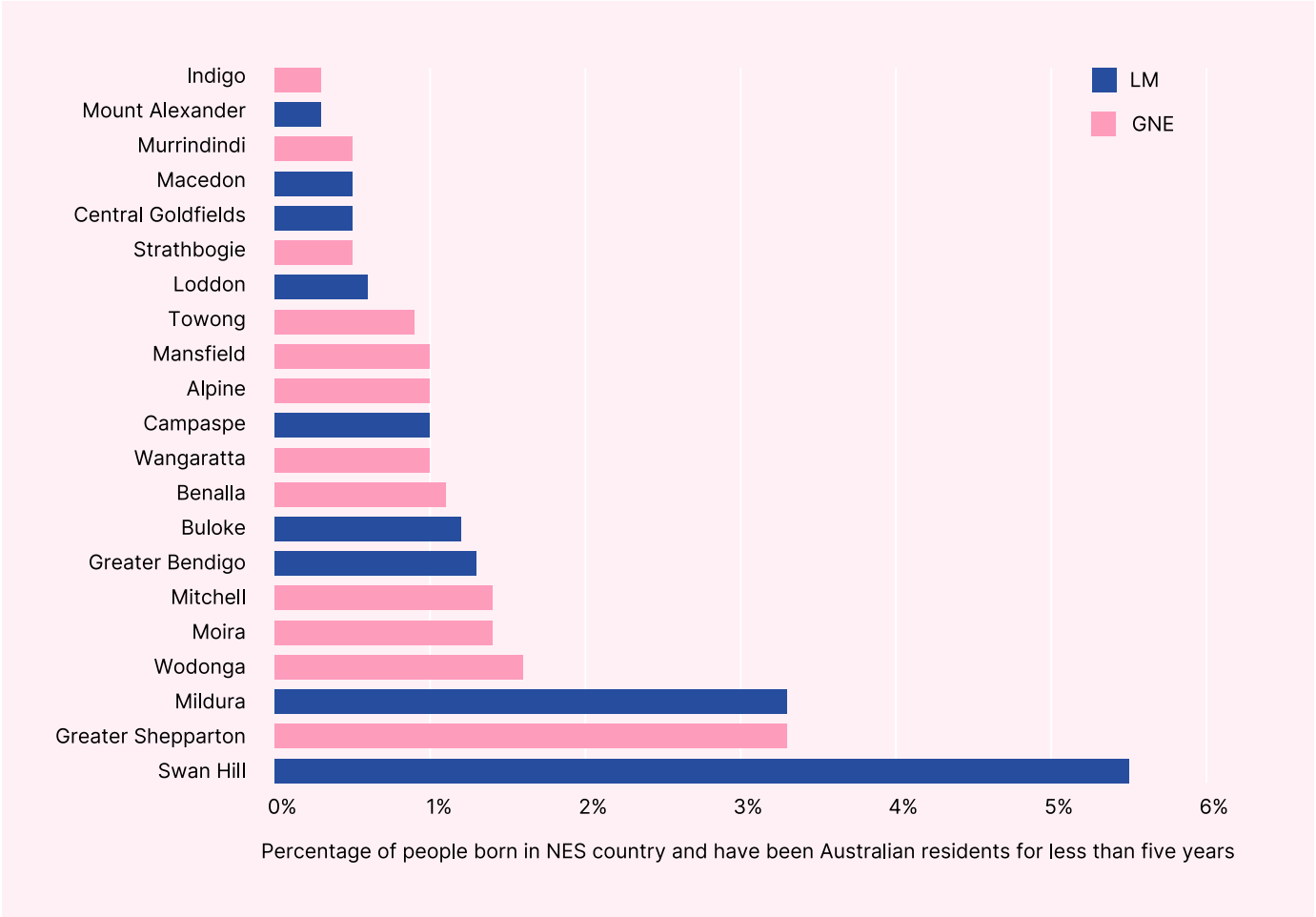
Aboriginal and Torres Strait Islander women face significant health inequities and are considered one of the most disadvantaged groups of people within Australia (Austin, 2023).

Due to the impacts of colonisation, intergenerational trauma, and historical oppressions, this population group has a much lower life expectancy, is more likely to be impacted by gender-based violence and face profound SRH inequities such as higher prevalence of STIs, maternal mortality and infant deaths (AIHWa, 2022; Austin, 2023; Duley et al., 2017; Ireland et al., 2015; Kerry, 2016).

"[Better looks like] clear communication and promotion of local services so people know what's available and there is an increase in services openly available that don't get backlash for supporting women's choice."

—Participant quote

Figure 1. Percentage of Australian residents who have been living in Australia for less than five years and were born in non-English speaking (NES) countries - LGA - 2021



Swan Hill (5.5%), Greater Shepparton (3.3%), and Mildura (3.3%) are the leading LGAs with residents (less than 5 years) who were born in non-English speaking countries (PHIDUa, 2023).

Greater Shepparton (1.8%), followed by Greater Bendigo and Wodonga (0.8%), and then Mildura and Swan Hill (0.7%) were the leading LGAs in 2016 with residents a part of the permanent humanitarian migrant program (PHIDUb, 2023).

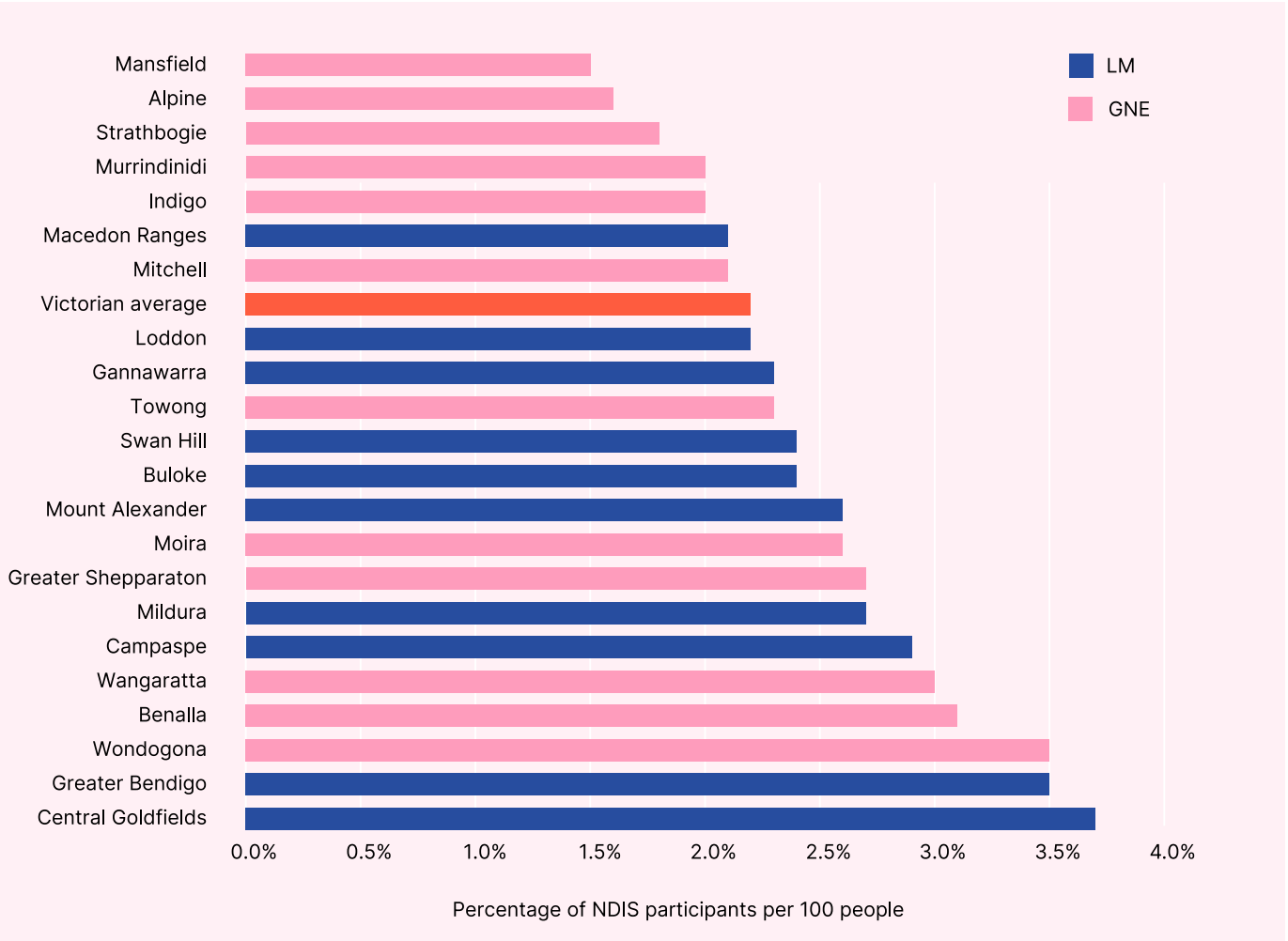
In Australia the population of multicultural communities are growing with a net gain of 170,900 people between the years 2021 and 2022 (ABS, 2022).

Efforts have been made to address and improve the healthcare experiences of multicultural communities; however, the experiences can be different based on past life events as well as cultural norms (Chen, 2017). For example, multicultural women can have adverse health outcomes related to their experiences of leaving a country/their home due to war, violence, conflict, or persecution (Hawkins et al., 2021).

Women from multicultural communities have lower health literacy rates and confront a wide range of material barriers to accessing SRH services such as language barriers, difficulties navigating complex healthcare systems, logistical and financial burdens (Hawkey et al., 2022; Mengesha et al, 2016).

Strategies suggested to enhance health literacy and the SRH of multicultural women identified in literature and the Her Health Matters strategy include the development and promotion of multilingual resources, onsite or readily available interpreters, and advocating for political will and interventions that address structural barriers to reduce social disparities (Khatri & Assefa, 2022).

Figure 2. Percentage of NDIS participants per 100 people - LGA - 2022



Out of the 22 LGAs, 15 have a greater than state average (2.2% per 100 people) of NDIS participants. Central Goldfields (3.7%), Greater Bendigo (3.5%) and Wodonga (3.5%) are the leading LGAs (PHIDUb, 2023).

The LM had a greater level of NDIS participants (per 100 people) than the GNE region, with nine of the 10 LGAs in the region having a percentage higher than state-level average (PHIDUb, 2023).

Often there are unfair and discriminatory attitudes held towards women with a disability, presuming that they are not sexually active, unfit for relationships, and incapable of having children. This can result in their autonomy to make informed SRH decisions being taken away from them by clinicians and/or family members (Nyugen, 2020; Ride & Newton, 2018).

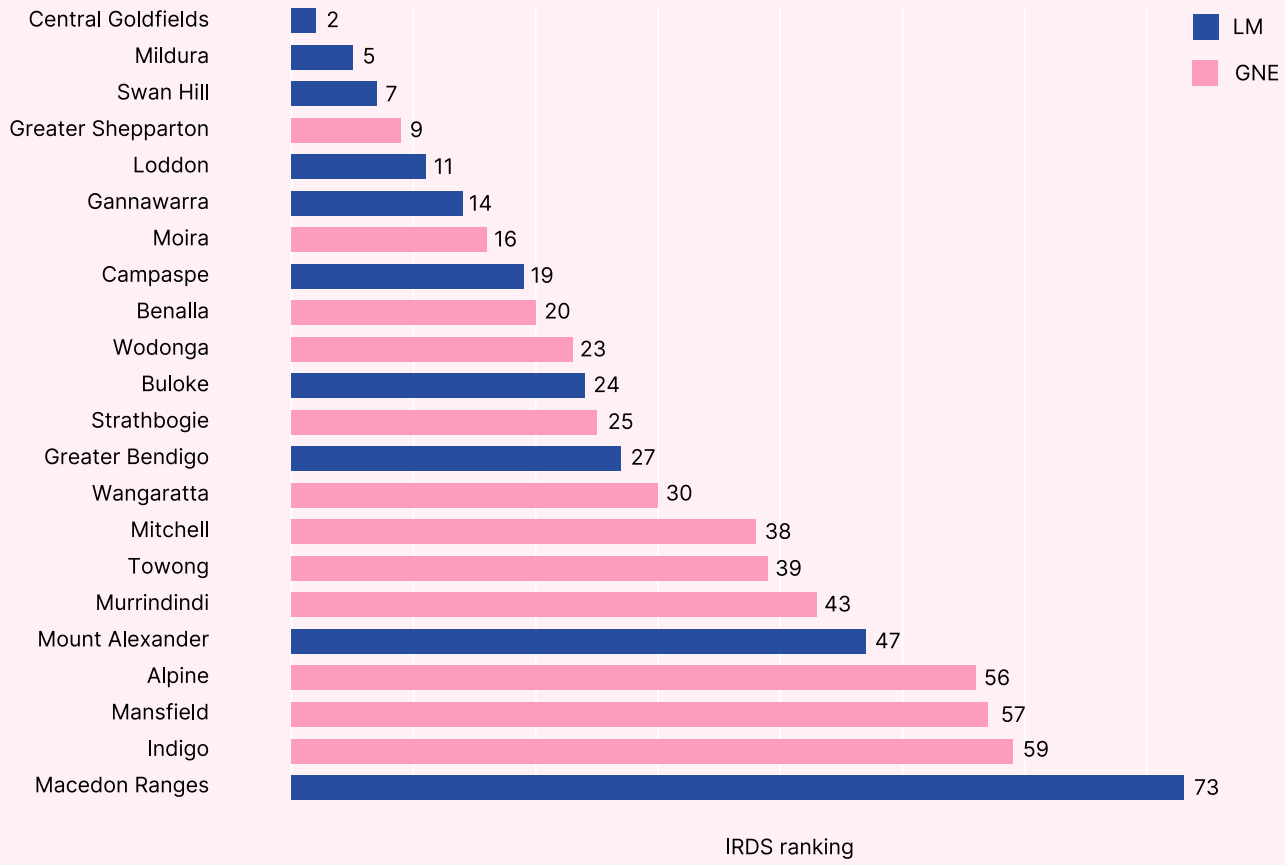
Those with a disability may also be unable to understand SRH information or communicate with healthcare professionals in an understandable way i.e. using sign language (Nyugen, 2020).

Physical impairment may impact the ability of those living with a disability to access healthcare buildings/infrastructure, or their use of reproductive technology i.e. a lack of finger dexterity to use a diaphragm (Nyugen, 2020).

11.1.2 Socioeconomic indexes

The Index of Relative Socio-economic Disadvantage (IRSD) summarises a range of information about the economic and social conditions of people and households. A low rank indicates greater disadvantage, a high rank indicates lower levels of disadvantage (ABS, 2023).

Figure 3. Index of Relative Socio-economic Disadvantage (IRSD) ranking - LGA - 2021

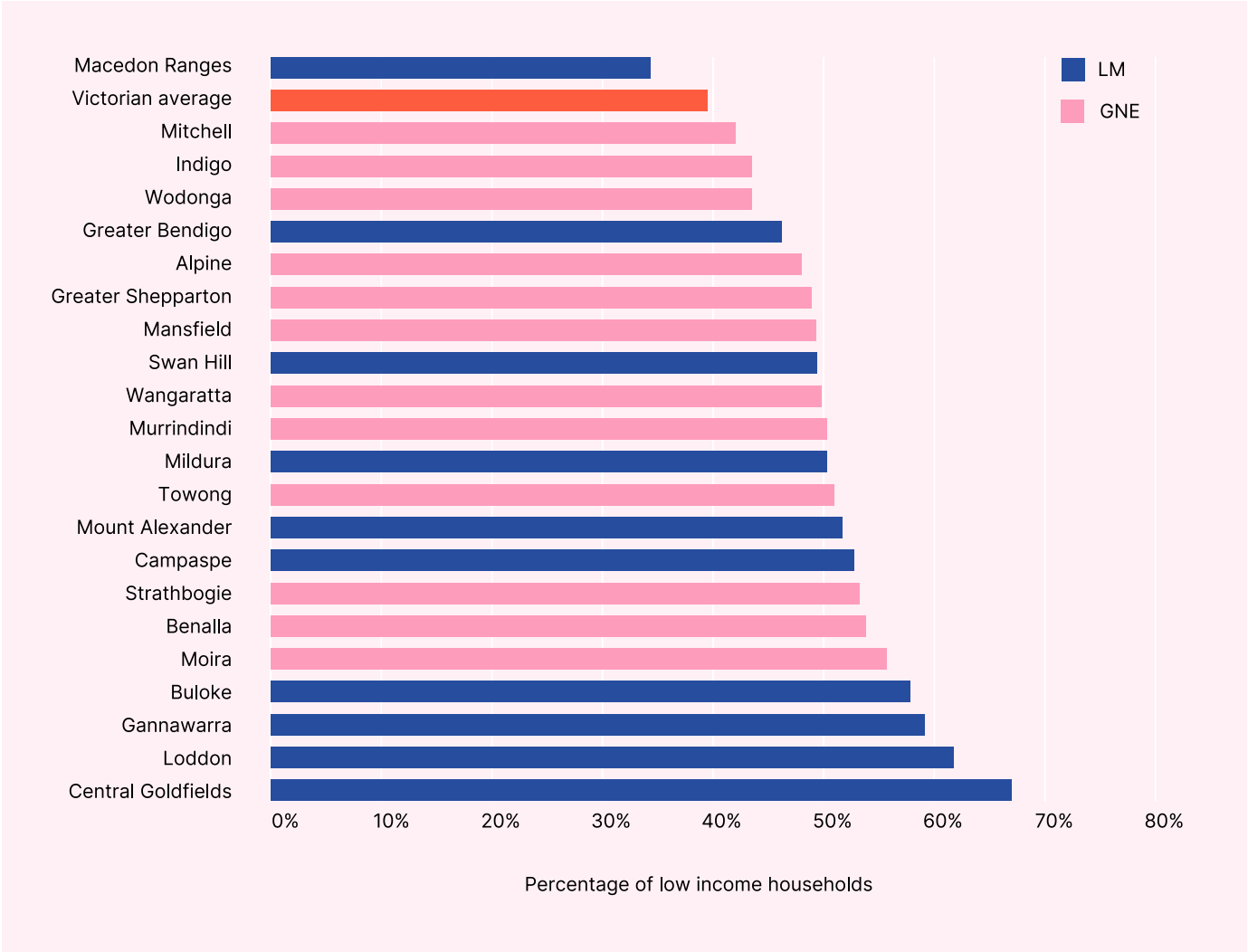


Out of the 22 LGAS, 16 rank in the bottom half (below 40 of a possible 79) of Victoria's IRDS rankings.

Four LGAs - Central Goldfields (2), Mildura (5), Swan Hill (7), and Greater Shepparton (9), are in the top 10 IRSD ranking and therefore the most disadvantaged LGAs within the state. Three of these LGAs are from the LM region (ABS, 2023).

The LM appears to experience a higher level of entrenched collective disadvantage in comparison to GNE. However, both LM and GNE have pockets of significant disadvantage and therefore barriers to SRH access.

Figure 4. Percentage of low-income households - LGA - 2021



All LGAs except for one (Macedon Ranges) recorded higher numbers of low-income households than the Victorian average (PHIDUa, 2023). The top three LGAs are all from the LM region being Central Goldfields (67%), Loddon (62%), and Gannawarra (59%).

Rent assistance is very common within both the LM and GNE regions, with eight LGAs being above the state average (18.1%) (PHIDUa, 2023). These LGAs included Mildura (24%), Greater Bendigo (24%), Central Goldfields (22%), Campaspe (19%) from the LM, and Greater Shepparton (27%), Wodonga (22%), Moira (20%), and Mitchell (19%) from the GNE.

There is a greater than state average of sole parent families and mothers with a low educational attainment within 19 of the 22 LGAs (PHIDUa, 2023). Mount Alexander, Macedon Ranges and Mansfield LGAs were the exception.

Education attainment is closely linked to health literacy, which is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health-related decisions" (AIHWb, 2022).

Using a 'settings-based approach' across the lifespan has been proven to enhance SRH literacy amongst population groups. Examples of this, many of which are identified as action areas within the Her Health Matters Strategy, include:

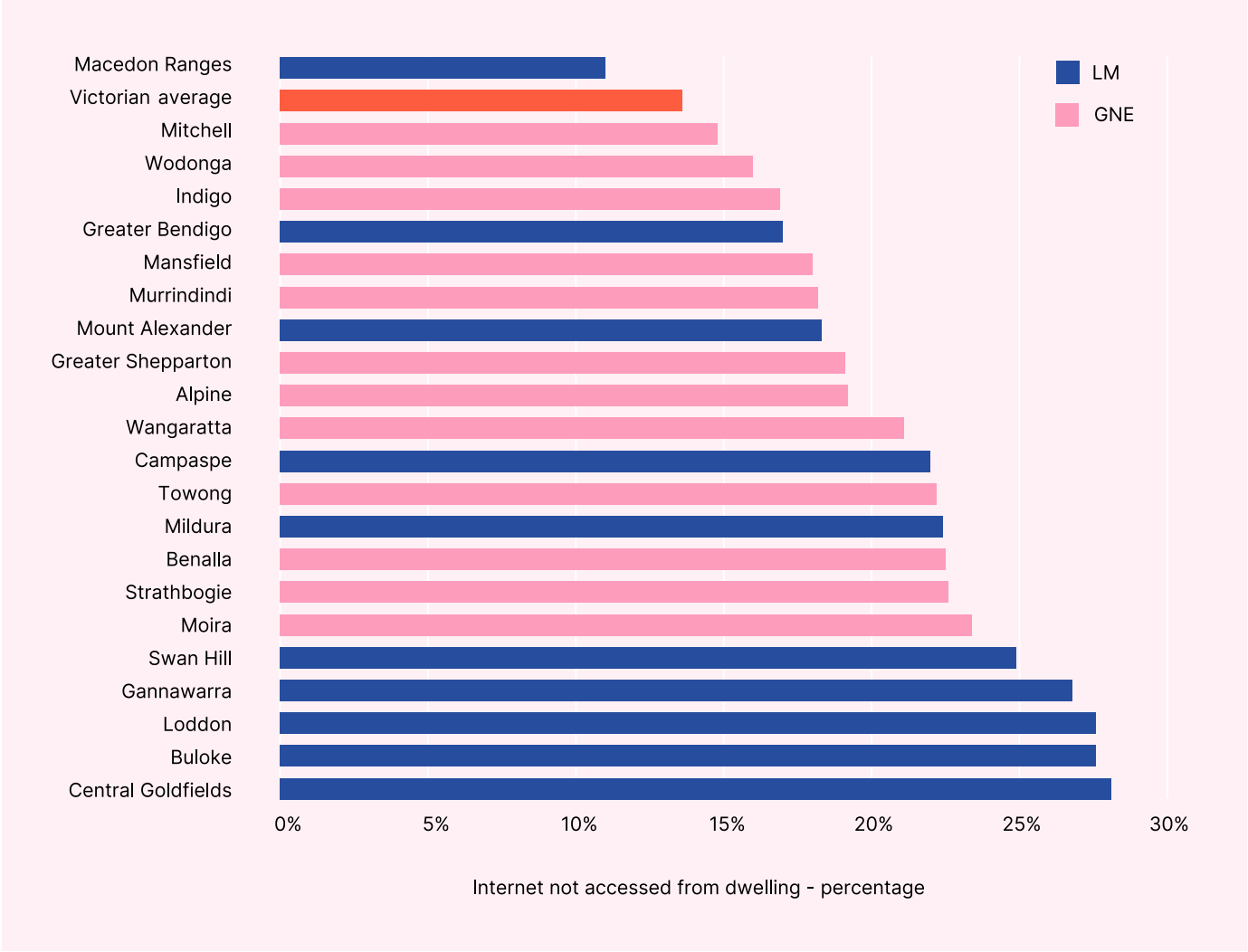
- Comprehensive Sexuality Education (CSE) sessions in schools and youth LGBTIQA+ groups/services.
- Policy changes and education in workplaces surrounding perimenopause and menopause, the symptoms and available supports for older women.
- Readily available information sessions and/or resources relating to SRH for aging populations.
- Culturally appropriate STI prevention programs targeting Aboriginal and Torres Strait Islander and multicultural communities.
- Freely available menstruation products in public places for lower income families.
- The establishment of informal peer networks to encourage SRH knowledge sharing amongst the LGBTIQA+ community (Austin, 2023; Byron & Hunt, 2017; Ericksen & Weed, 2019; Goldman, 2015; Hawkey et al., 2022; UNESCO, 2018).

11.1.3 Supporting Infrastructure

Digital technologies and online platforms allow service providers to deliver services at a time and place that suits consumers, reduces costs and travel, and encourages groups who are not accessing services to engage anonymously (Stevenson et al., 2023). For example, due to stigmatisation, fear of stigmatisation, or a lack of practitioner LGBTQIA+ health knowledge in their communities, online platforms are a popular platform amongst LGTBIQA+ communities (Matthews et al., 2018; Strauss et al., 2020).

However, in rural and remote communities, the lack of affordable internet connectivity often restricts the use of online platforms and Telehealth services (Cheng, Humphreys & Kane, 2022)

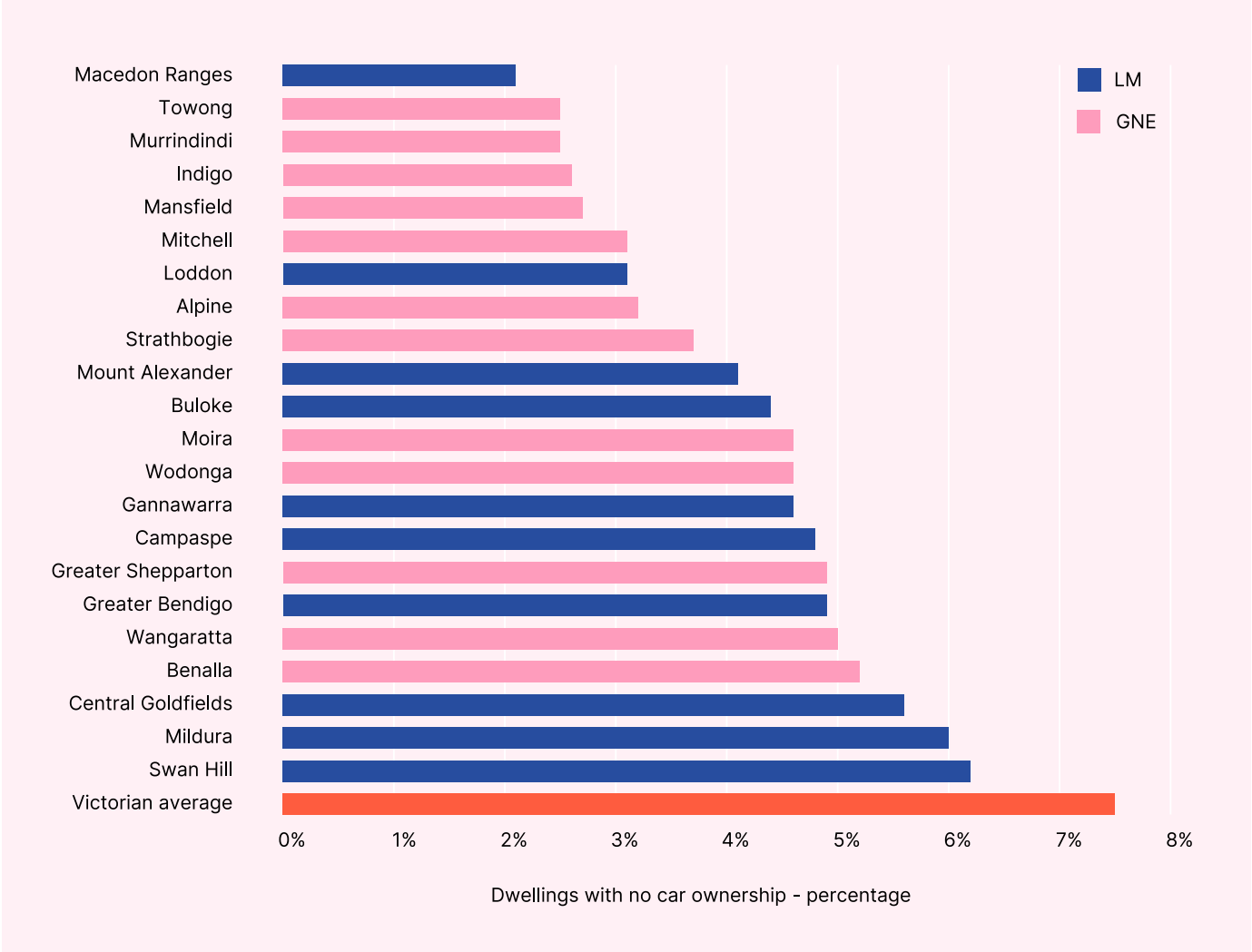
Figure 5. Internet not accessed from dwelling - LGA - 2016



Pockets of the LM and GNE regions lack affordable digital connectivity options, have inadequate mobile coverage, and deficient Wi-Fi networks (Infrastructure Victoria).

The above figure highlights that the majority of LM and GNE LGAs have more dwellings with no internet connectivity than the state average. The top five LGAs are all from the LM region, being Central Goldfields (28.1%), Buloke (27.6%), Loddon (27.6%), Gannawarra (26.8%), and Swan Hill (24.9%).

Figure 6. Dwellings with no motor vehicle ownership - LGA - 2021



Motor vehicle access is more common within the regions in comparison to the state average, with all LGAs having a greater than state average rating (7.5%) for dwellings with no car ownership (PHIDUa, 2023).

Macedon Ranges (2.1%) in the LM, and Towong, Murrindindi (2.5%), Indigo (2.6%), and Mansfield (2.7%) in the GNE are the LGAs with the lowest percentages of dwellings with no motor vehicle ownership.

Limitations in public transport from sub-regions of the LM and GNE to regional or metropolitan areas creates logistical barriers for women to access services and may be contributing to the need for car ownership in some of the LGAs (Infrastructure Australia, 2022).

Four of the five LGAs – Macedon Ranges, Murrindindi, Indigo and Mansfield, with low percentages of dwellings with no motor vehicle ownership highlighted in Figure 11 above, are ranked in the top half (above 40 of a possible 79 LGAs) of Victoria's IRDS rankings – the fifth LGA, Towong, falls just outside with a ranking of 39. This indicates that car ownership may be affordable for those living in these LGAs.

The LGAs with higher rates of no car ownership have lower IRDS rankings and therefore higher levels of disadvantage. For example, Swan Hill, Mildura and Central Goldfields have the top three percentages of dwellings with no car ownership within the regions and are ranked within the top 10 most disadvantaged LGAs within the state (based on IRDS ranking).

Families living in disadvantage with lower household incomes may lack monetary means to afford vehicle ownership and usage costs, limiting their ability to access required health services. This coupled with a lack of transportation compounds logistical barriers, particularly for young women, and women from marginalised population groups (Botfield, Newman & Zwi, 2017; Johnston et al., 2015; Ride & Newton, 2018).

11.1.4 Workforce capacity

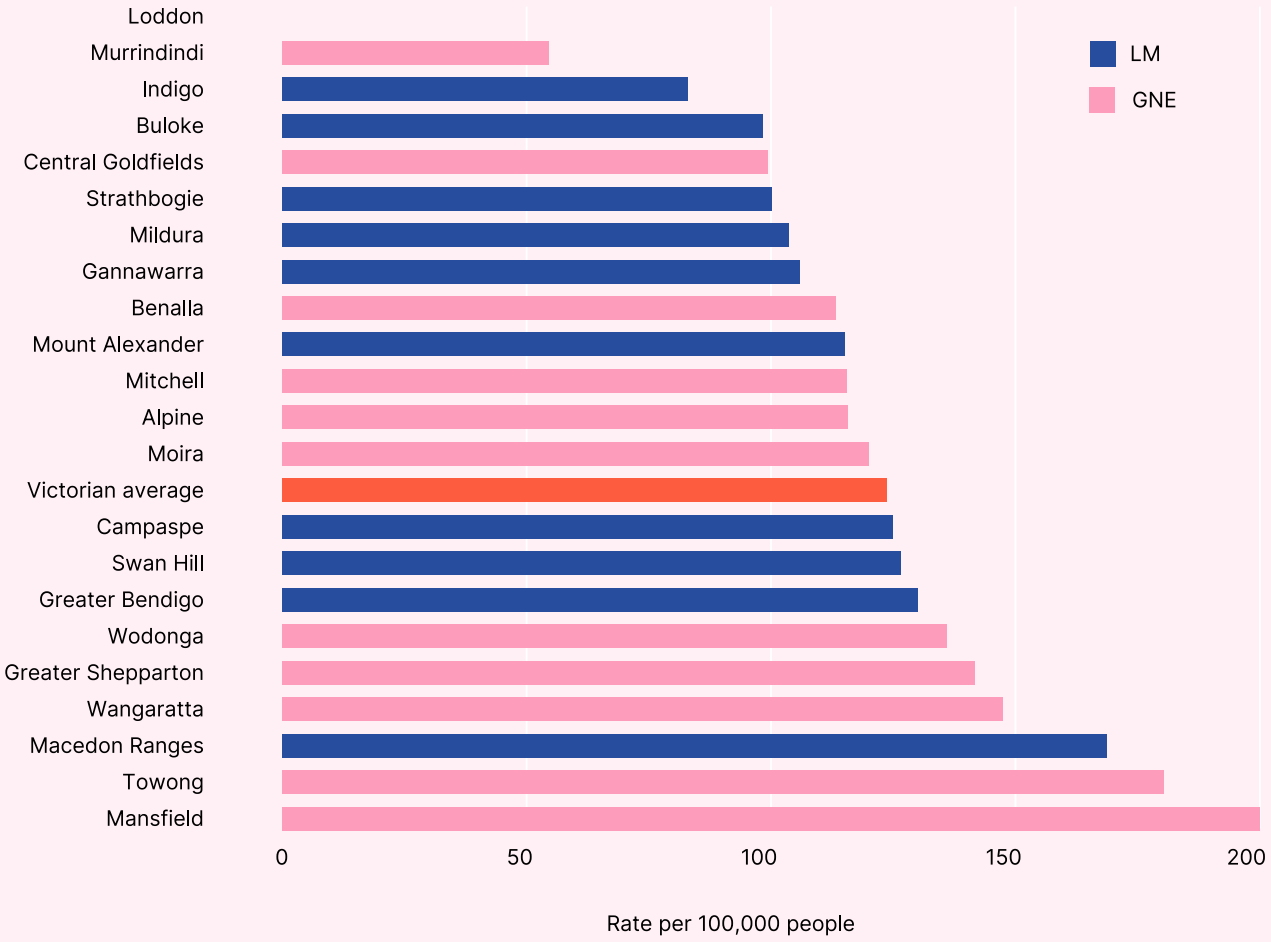
Please note - within this theme caution is needed in drawing conclusions of workforce/service capacity from alternative SRH care models as roles by equivalent full time are not included within data, and numbers can fluctuate with ever changing population movements and funding allocations.

General Practitioners (GPs) are often viewed as the 'backbone' of primary care services acting as a 'gateway' to other services, playing a critical role in delivering the social model of health and reducing overall health system costs (RACGP, 2021).

GPs remain the most common health professional attendance with over 83% of Australians attending a GP in 2020-2021 (Deloitte, 2022).

Women's health GPs have a broad scope of practice particularly in rural and remote areas. They are involved in aspects of screening, testing, treatment, care coordination and management of women's health conditions including, but not limited to cancer prevention, screening and care, LGBTIQA+ health, SRH, and support and care for people who have experienced different forms of violence (RACGP, 2022).

Figure 7. Medical practitioner rate per 100,000 people – LGA - 2020



In 2020, the rate of medical practitioners was lower than the state average (123.6 per 100,000 people) within 13 of the 22 LM and GNE LGAs (PHIDUb, 2023).

Macedon Ranges (169), Greater Bendigo (130), Swan Hill (127) and Campaspe (125) in the LM and Mansfield (201), Towong (180), Wangaratta (147), Greater Shepparton (142) and Wodonga (136) in GNE have above-state averages in relation to their population sizes.

Loddon is the only LGA that does not have any medical practitioners, indicating a gap in healthcare services in that LGA.

Nurses provide many crucial services across the health care system making up the largest registered qualification within health care.

Nurse-led models of care are cost effective models to enhance SRH service accessibility in rural and remote communities (Moulton et al., 2022).

Demand for nurses has continued to increase due to an aging workforce, burn out, and diversification of nurse roles.

Australia is fast approaching a severe nurse shortage, with estimates of a shortfall of over 100,000 by 2025 (AIHWb, 2022).

Figure 8. Registered nurse rate per 100,000 people – LGA - 2020

The GNE region has a lower rate of nurse practitioners than the LM region, with ten of the 15 LGAs with registrations below the Victorian average (1,068 per 100,000 people) being from the GNE.

Like the medical practitioner findings, the Loddon LGA has no registered nurse practitioners.

Figure 9. Registered nurse also midwife rate per 100,000 people – LGA - 2020

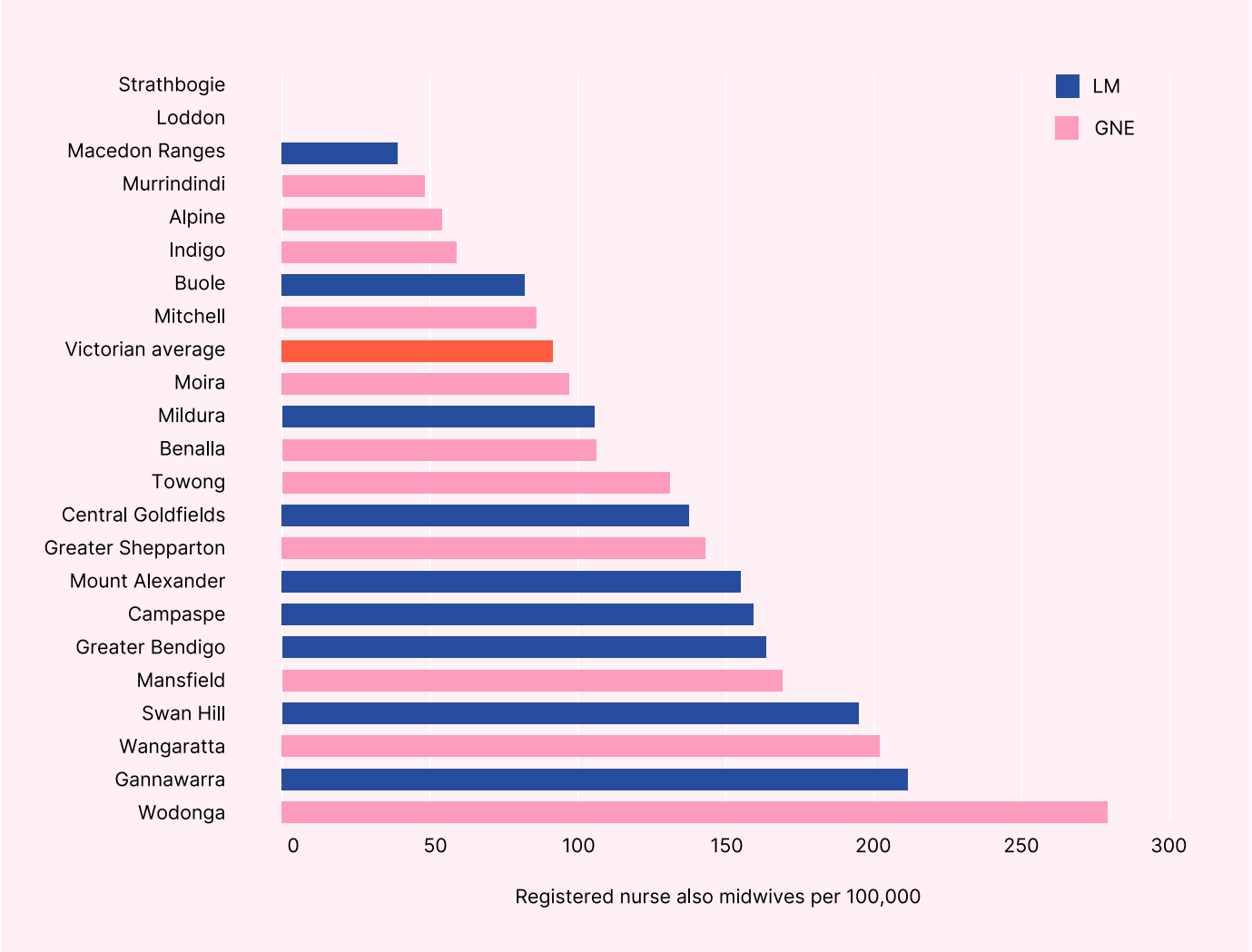


Figure 7 shows that there are significantly less nurses that are also midwives in comparison to registered nurse only (see Figure 7 above).

For registered nurses who are also midwives, 14 of the 22 LM and GNE LGAs had higher than state average levels (per 100,000 people). The leading LGAs were Wodonga (279), Gannawarra (212), Wangaratta (202) and Swan Hill (195).

However, eight LGAs were below state average, with Loddon and Strathbogie having no registered nurses who are also midwives located within their LGAs.

Alternative SRH care models including Aboriginal Community-Controlled Health Services (ACCHSs), Nurse/Midwifery-led care, Telehealth, Pharmacist and online platforms have proven successful to increase SRH service accessibility within rural and remote communities, particularly amongst vulnerable population groups (Caffery, Muurlink & Taylor-Robinson, 2022; Mullan, Armstrong & Job, 2023; Reeve et al., 2015; Wakerman et al., 2008).

Despite this and a projected 27.4% increase in the regional Victoria GP workforce in the coming years, there is a lack of available health practitioners in regional and rural areas who are skilled in SRH care (Deloitte, 2022; Malatzky & Hulme, 2022). The Her Health Matters strategy supports this finding, highlighting the need for more localised SRH services.

The lack of skilled practitioners may be due to a lack of specialised SRH practitioner training, funding restraints, and limited infrastructure, restricting service operating times, creating long waiting lists, and forcing women to travel long distances to access services (Cashman, Downing & Russell, 2021; Malatzky & Hulme, 2022).

The inability to access SRH services promptly can intensify SRH conditions and financial costs i.e. travel costs and/or prolonged treatment plans/timelines resulting in more complex care (Cashman, Downing & Russell, 2021).

A lack of skills and knowledge in cultural sensitivity and cultural responsiveness may deter women from multicultural communities and Aboriginal and Torres Strait Islander women from accessing SRH services (Cheng et al., 2021).

Strong community connections and the fear of confidentiality breaches when accessing SRH services may discourage service uptake amongst rural and remote women (Martin et al., 2023; Ninsiima et al., 2021).

Some women may not access SRH services due to self-stigmatisation, stigmatisation from others i.e. healthcare professionals, or enacted stigma – which is when SRH service providers refuse to provide the SRH care requested by a woman. This is more common amongst women and gender diverse people from the LGBTIQA+ community, Aboriginal and Torres Strait Islander women, women living with a disability, and women from multicultural backgrounds (Bohren et al., 2022; Del Tufo et al., 2023; Martin et al., 2023).

A fear of community stigmatisation, as well as internal/organisational inequalities and belief systems such as viewing SRH service delivery as the responsibility of female practitioners, may limit the SRH services offered in rural and remote areas (Malatzky & Hulme, 2022).

"I think when you do find someone that you're comfortable speaking with, it does make a world of difference and definitely kind of alters the narrative a little bit, personally."

—Participant quote

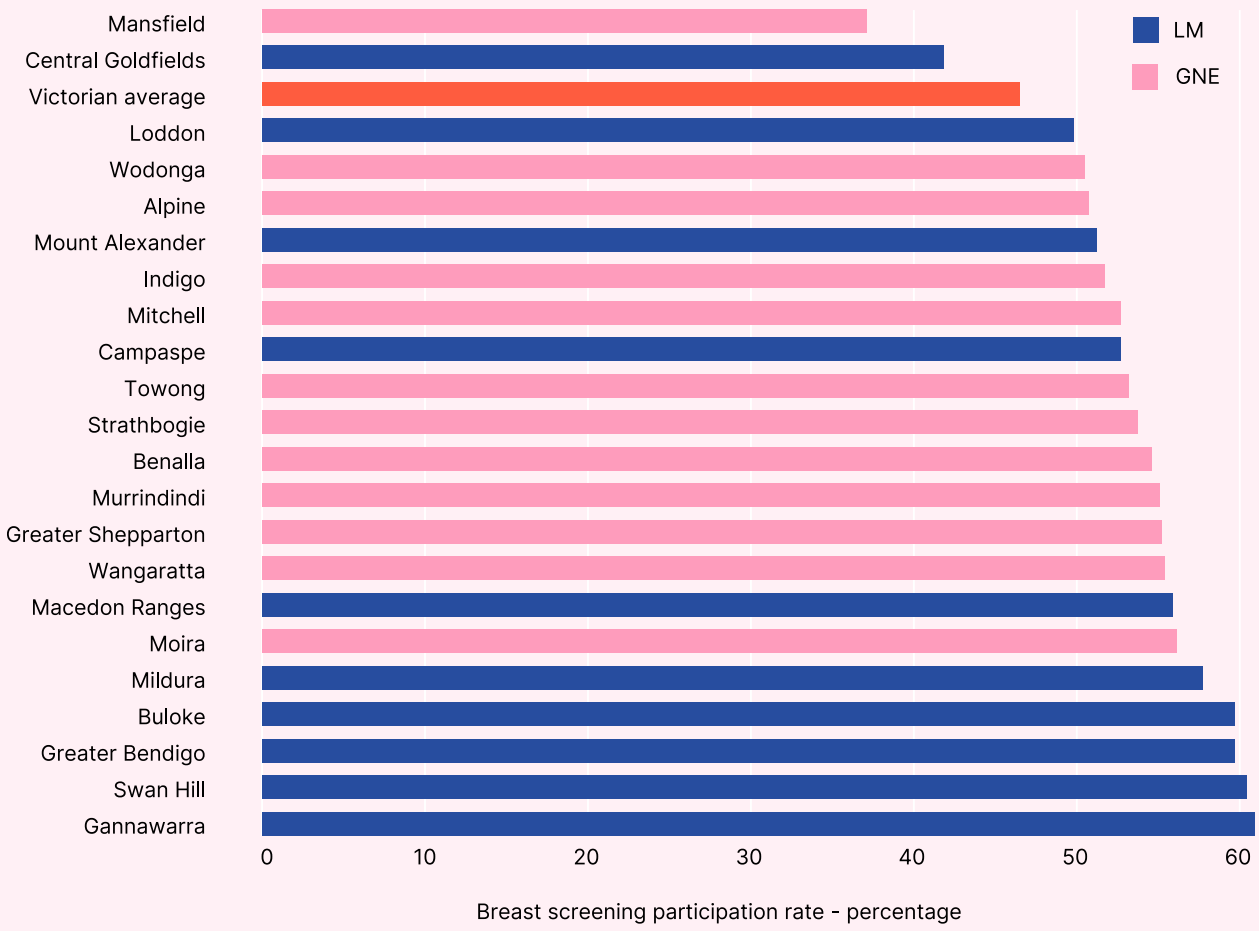
11.1.5 Preventative screening

Preventative screening tests save lives, as they are the most effective way to detect early signs of cancer (Cancer Council, 2024).

However, some population groups are less likely to engage in preventative screening than others, including multicultural communities and Aboriginal and Torres Strait Islander women, those from the LGBTIQA+ community, and those with a mental health condition (Conneely, 2019; Mengesha et al, 2016; Ukhanova et al., 2020).

The most common barriers to getting a breast screening test or a cervical screening test (CST) are a lack of female providers, time restraints, lack of awareness (health literacy), feelings of embarrassment, fear of results, and lack of symptoms (Breast Screen NSW, 2024; Nagendiram et al., 2020).

Figure 10. Breast screening participation rate 50 to 79 years – LGA - 2019-2020



Within Australia, women aged 50 to 74 are encouraged to have a breast screening test every two years.

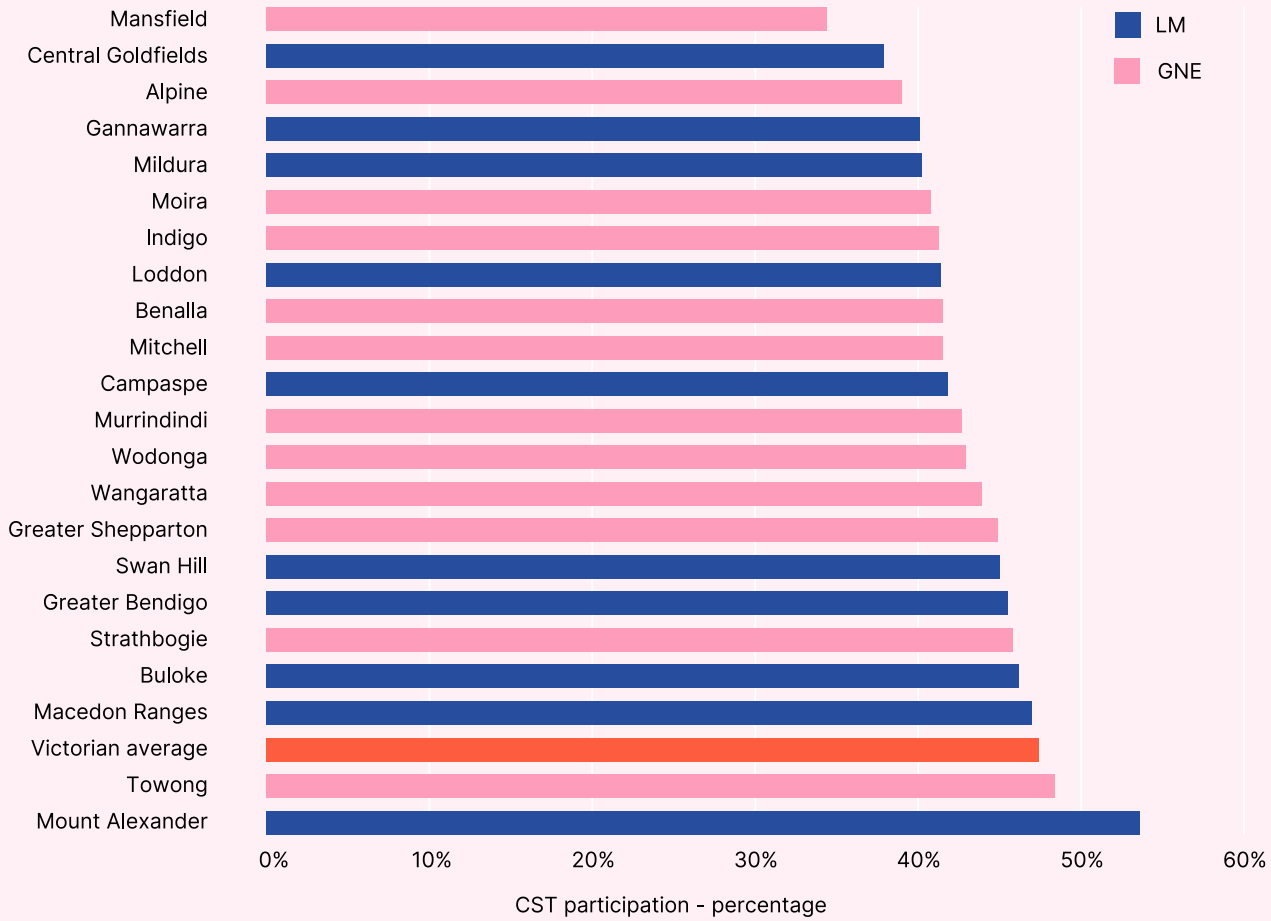
Breast screening uptake was high amongst 50 to 79-year-old women within the LM and GNE regions, with it being higher than the state average (46.5%) in 19 of the 22 LGAs.

The five leading LGAs were Gannawarra (62%), Swan Hill (61%), Greater Bendigo and Buloke (60%), and Mildura (58%) - all from the LM region.

Central Goldfields (42%) and Mansfield (37%) were the only LGAs falling below the state average (PHIDUc, 2023).

Transgender and gender diverse populations experience a range of barriers to attending breast screening services such as misgendering, transphobia, and feeling a lack of inclusion based on highly feminised promotional material and language (Conneely, 2019).

Figure 11. Cervical Screening Testing (CST) participation rate 25 to 74 years – LGA - 2018-2020



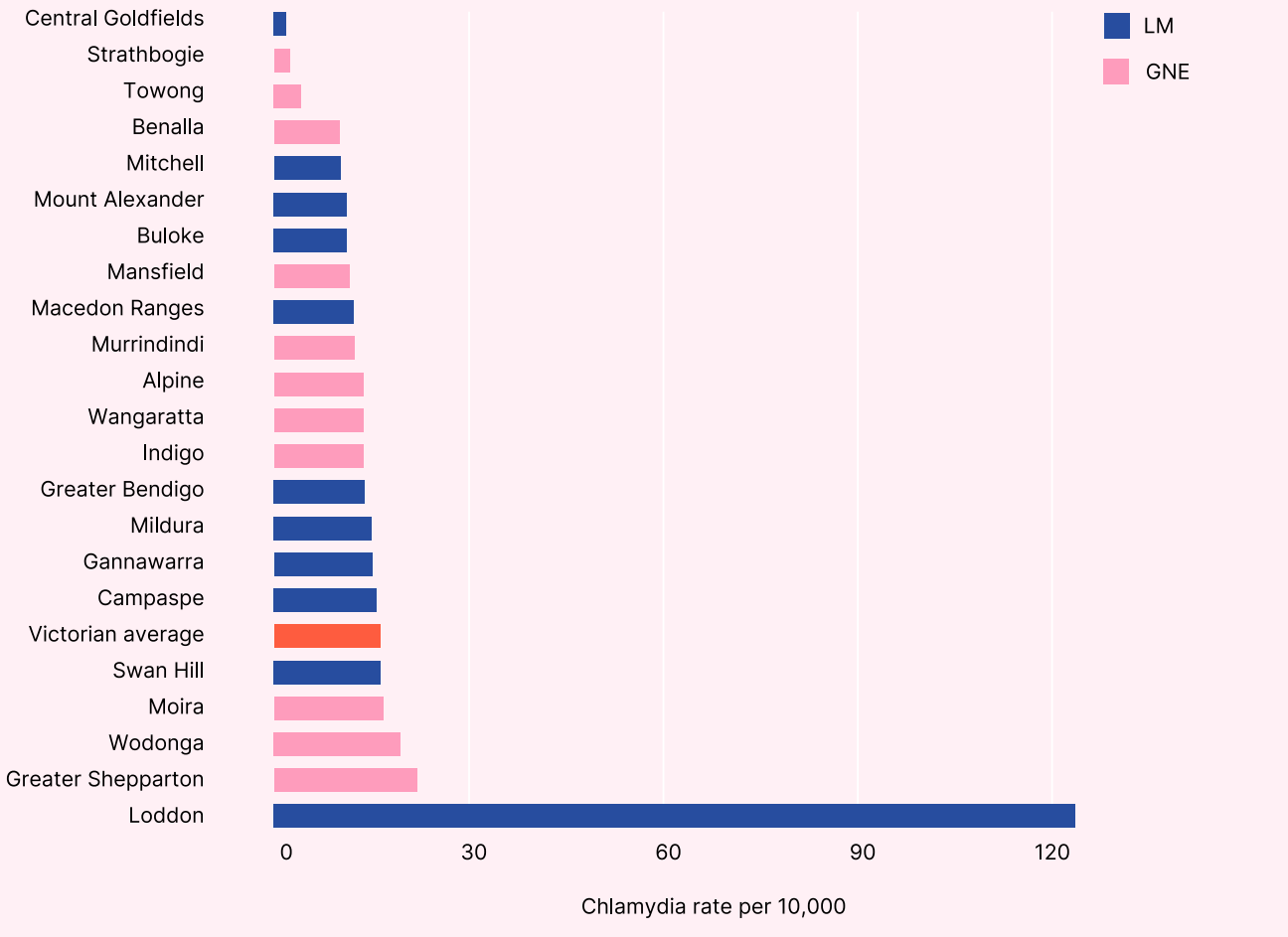
The national CST program targets women aged 25 to 74 years. Figure 11 highlights that just two, Mount Alexander (54%) and Towong (48%), of the 22 LM and GNE LGAs were above the state average (47.4%) for CST in 2018-2020 (PHIDUc, 2023).

Like breast screening, Mansfield (34%) is performing the lowest out of all the LGAs.

11.1.6 Sexually Transmitted Infections (STIs)

Chlamydia, Gonorrhoea and Syphilis are preventable and curable infections that are often asymptomatic. When left untreated they can damage a female's reproductive system (Traeger, 2022).

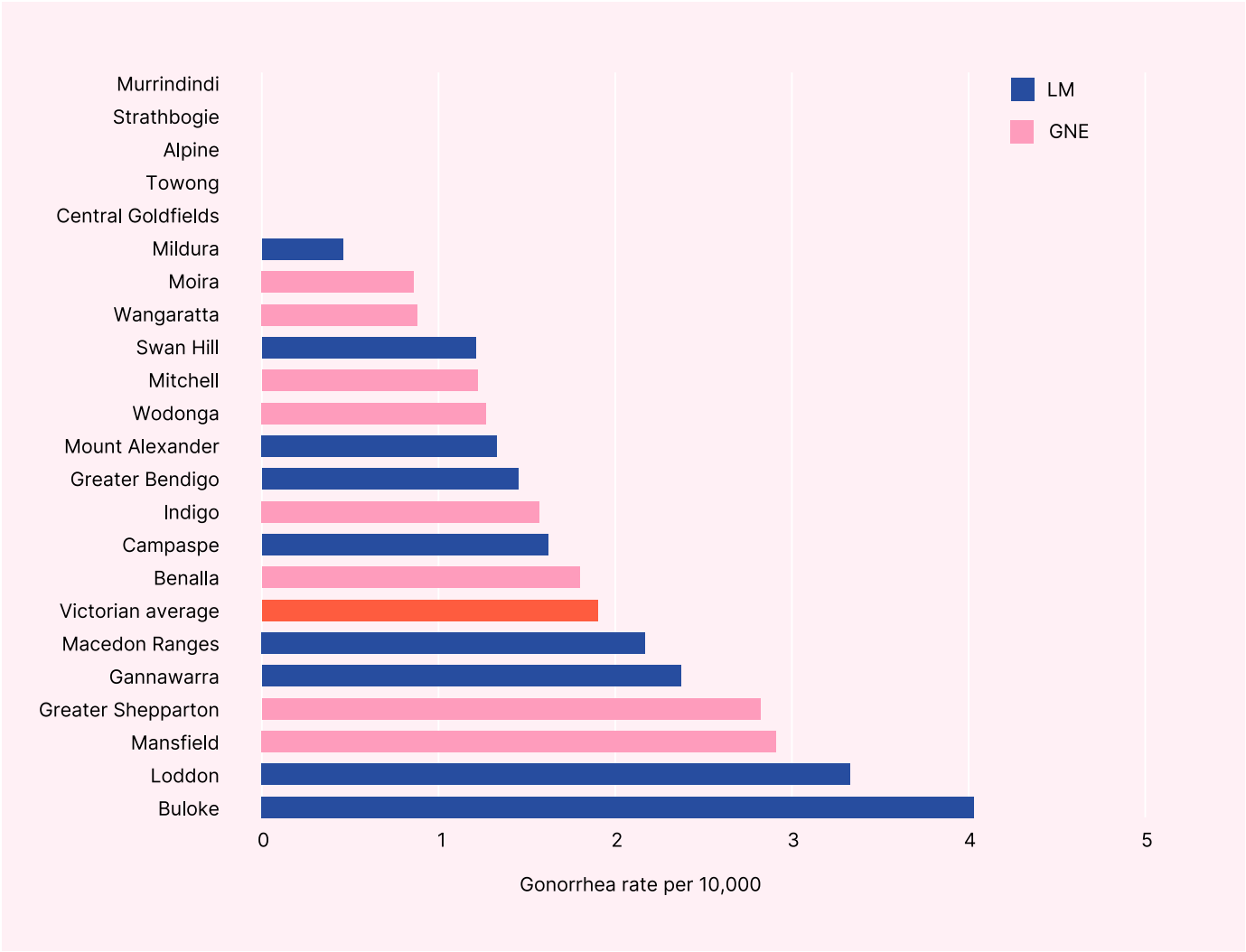
Figure 12. Chlamydia rate per 10,000 people - LGA - 2020



Chlamydia is the most common STI within the LM and GNE regions (Womens Health Victoria, 2022). In 2020, Chlamydia rates were greater than the state average (16.4 per 10,000 people) within five of the 22 LM and GNE LGAs.

The Loddon LGA rate was substantially higher than the state average and all other LM and GNE LGAs - being 123.8 per 10,000 people (Womens Health Victoria, 2022). This is just over 100 (per 10,000) more than the second highest rate being Greater Shepparton (22 per 10,000).

Figure 13. Gonorrhea rate per 10,000 people - LGA - 2020



The rate of Gonorrhea is greater than the state average (1.9 per 10,000 people) in six of the 22 LM and GNE LGAs in 2020. Within five of the LGAs there were no cases of Gonorrhoea reported (Women's Health Victoria, 2022).

Syphilis and Hepatitis B are not overly common but still prevalent STI's in the LM and GNE communities. Syphilis rates are greater than the state average (.5 per 10,000 people) in nine of the 22 LGAs, and Hepatitis B being greater than the state average (.8 per 10,000 people) within six LGAs (Women's Health Victoria, 2022).

Aboriginal and Torres Strait Islander people have higher STI rates than non-Aboriginal and Torres Strait Islander people, with national data showing that rates of Chlamydia and Gonorrhoea are 3 times and 18 times higher, respectively, among young Aboriginal and Torres Strait Islander people than young non-Aboriginal and Torres Strait Islander populations (Australian Government, 2021). Those Aboriginal and Torres Strait Islander people living in rural and remote communities are at the highest risk, with low education levels identified as a key social determinant facilitating the transmission of such SRH diseases (Lobo et el., 2020).

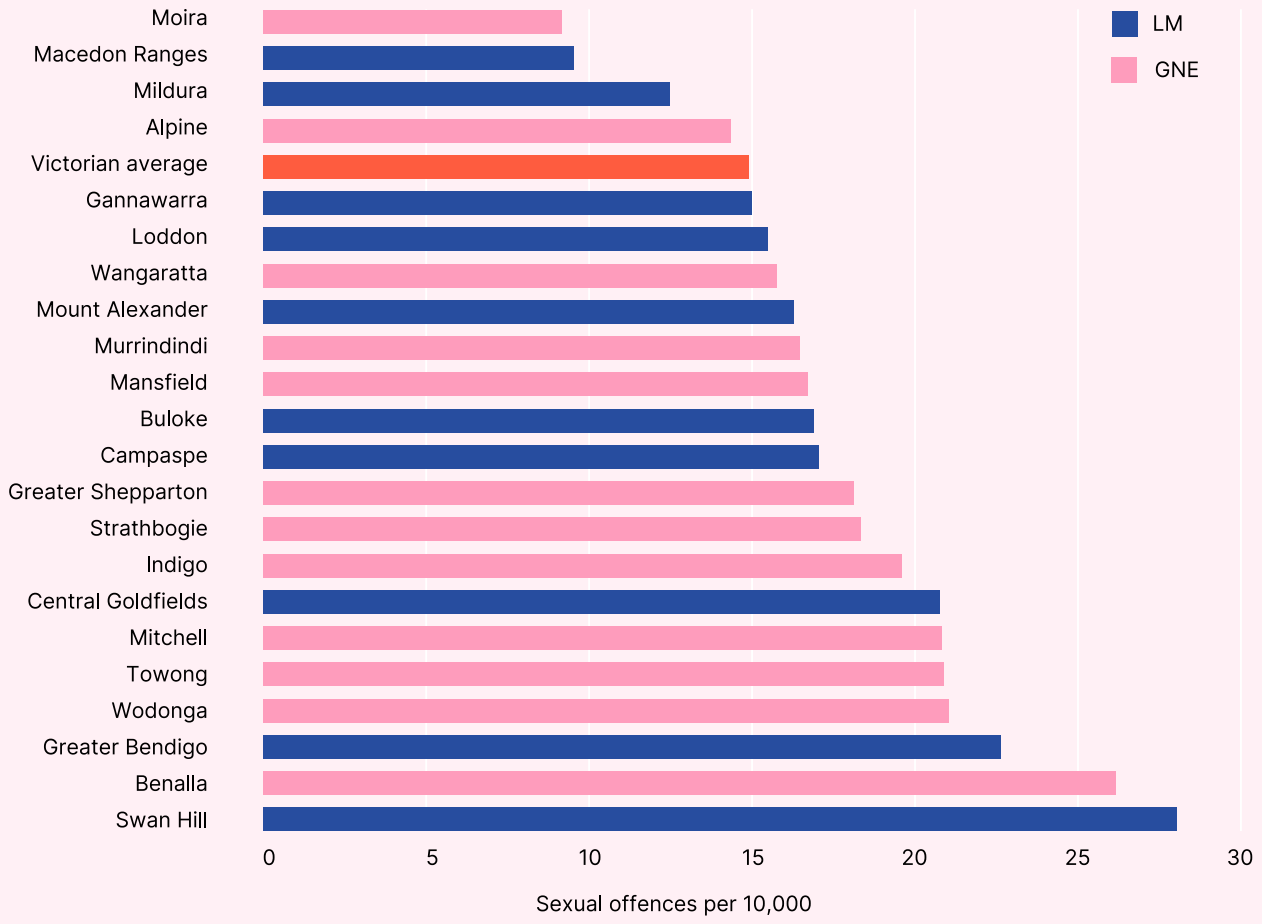
LGBTIQA+ communities are higher risk population groups of STI transmission. This may be influenced by stigma or fear of stigma from healthcare professionals when accessing STI screening (Matthews et al., 2018; Strauss et al., 2020).

At the population level, young people aged 16 to 24 are more vulnerable to STIs and have been identified as a crucial population for targeted STI health promotion activities (Chojenta et al., 2017).

11.1.7 Gender-based violence

Violence against women is a serious, prevalent and widespread problem in Australia (Our Watch, 2024).

Figure 14. Sexual offences per 10,000 – LGA - 2021

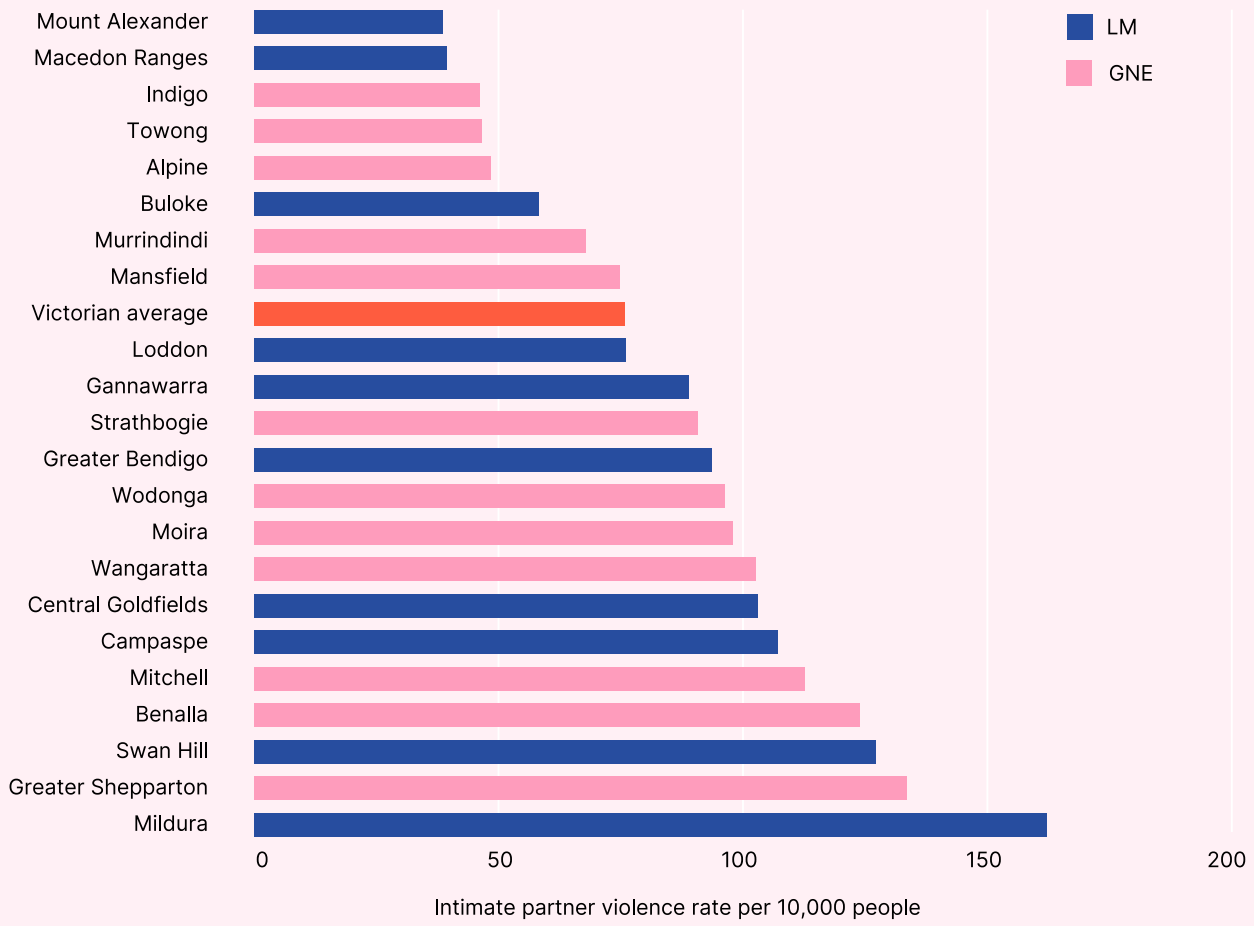


Sexual violence is a serious concern across the LM and GNE region, with reported offences being greater than the state average in 18 of the 22 LGAs.

The leading three LGAs are Swan Hill (28 per 10,000 people), Benalla (26 per 10,000 people) and Bendigo (23 per 10,000 people) (Women's Health Victoria, 2022).

Mildura (12 per 10,000), Moira (10 per 10,000 people) and Macedon Ranges (9 per 10,000) were the only LGAs with rates below the state average.

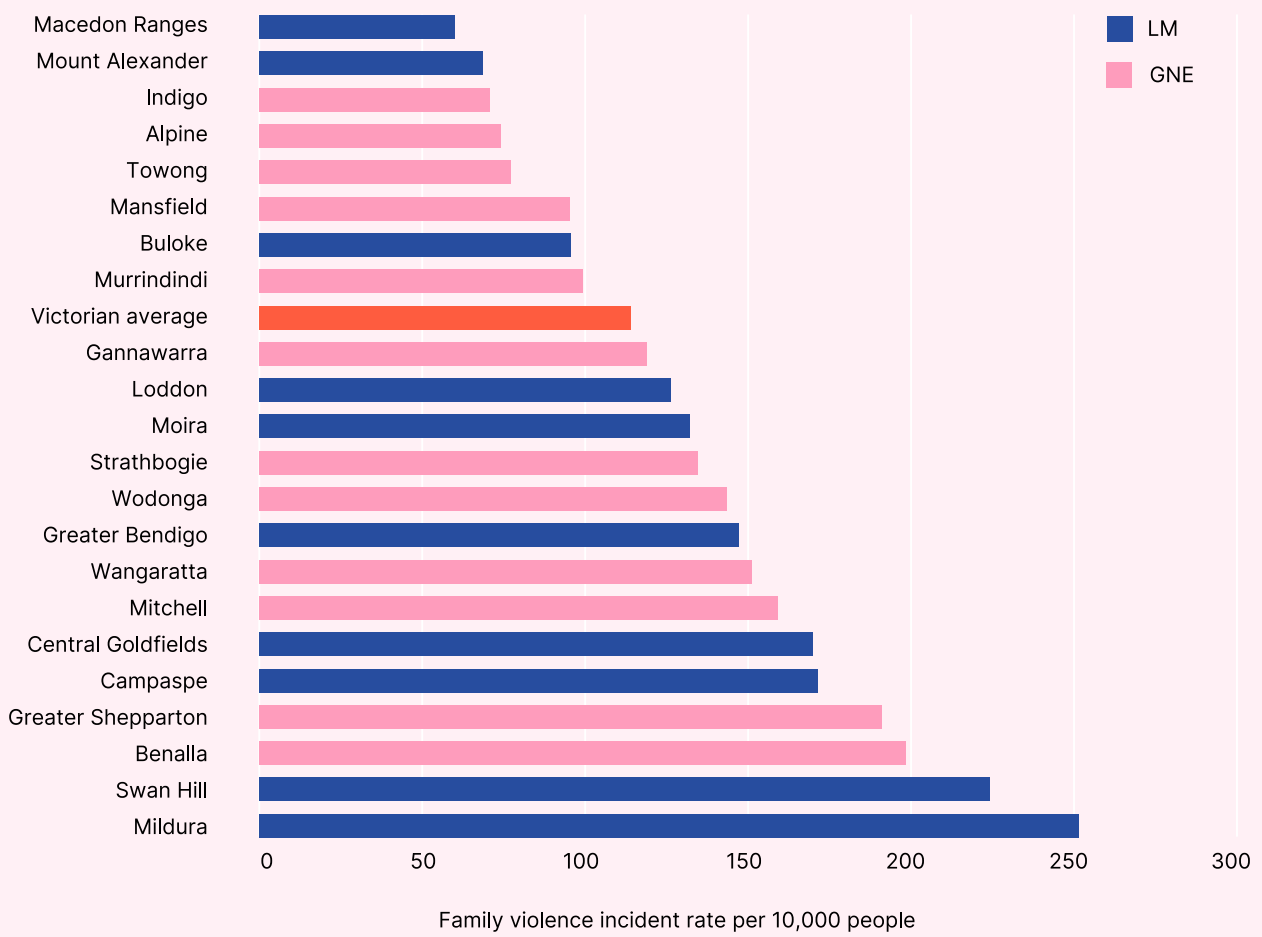
Figure 15. Intimate partner violence rate per 10,000 – LGA - 2021



The rate of intimate partner violence reported incidences in 2021 was greater than the state average in 14 of the 22 LGAs.

Leading LGAs were Mildura (162 per 10,000 people), Greater Shepparton (133 per 10,000 people), and Swan Hill (127 per 10,000 people) (Women's Health Victoria, 2022).

Figure 16. Family violence rate per 10,000 - LGA - 2021



The rate of reported family violence incidences in 2021 was greater than the state average in 14 of the 22 LGAs.

Like intimate partner violence (as per Figure 15), the leading LGA was Mildura (252 per 10,000 people), with Swan Hill (224 per 10,000 people) and Benalla (198 per 10,000 people) following closely behind (Women's Health Victoria, 2022).

Women from marginalised population groups are at greater risk of gender-based violence as often violence intersects with other forms of discrimination and disadvantage (Our Watch, 2024).

Telehealth has proven to be an effective method for women experiencing family violence or reproductive coercion, and for whom travel would compromise their safety, to engage with an SRH practitioner (Cheng et al., 2021).

There is a lack of confidence, training, and referral pathways (or knowledge of pathways) amongst rural and remote health care professionals when seeing patients experiencing reproductive coercion and abuse (Wellington, Hegarty & Tarzia, 2021). The delivery of coercive control training to pharmacists and primary care professionals is a key action highlighted within the Her Health Matters strategy.

11.1.8 Reproductive service access

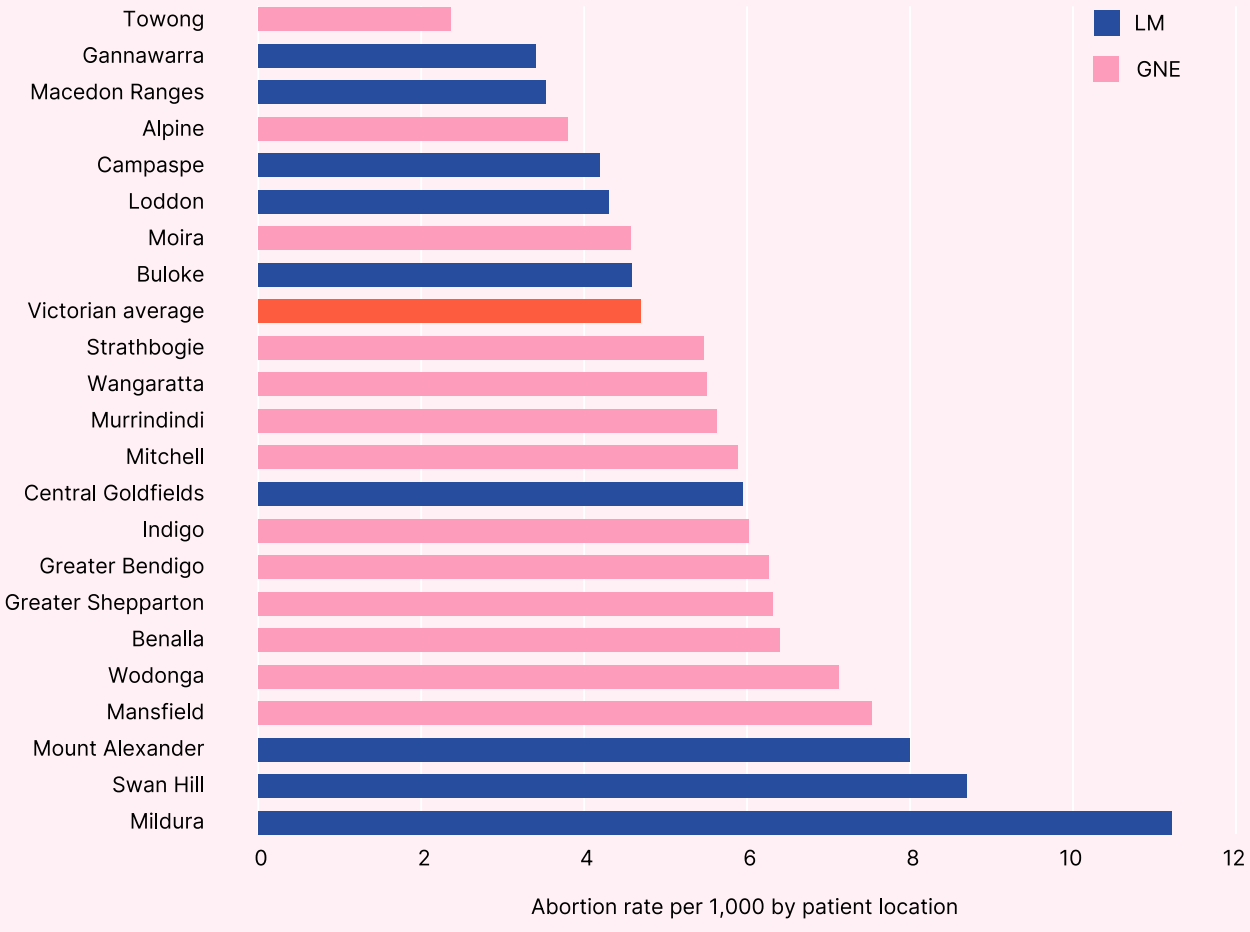
The Her Health Matters Strategy highlights the need for women to have reproductive choices, including contraception and abortion access.

The 1800 My Options information phone line and webpage provide crucial and timely services to regional and rural women seeking SRH information and services.

The 1800 My Options service is particularly popular among women living outside Melbourne, health care card holders, Aboriginal and Torres Strait Islander women, and women born overseas in South and Central Asia. However, women requiring an interpreter were less likely to utilise the service.

There are many SRH services available within the LM and GNE not listed on the 1800 My Options website. The reasons behind this inconsistency are not fully understood, or within the scope of gap analysis tasks undertaken, however it is speculated that stigma and fear of social sanctions may have contributed to the reluctance of some providers to advertise services openly (SPHERE, 2022).

Figure 17. Abortion rate per 1,000 by patient location – LGA - 2020



The above figure highlights that access to medical abortion is highly variable across both LM and GNE regions, with rates by patient location greater than the state average (4.6 per 1,000) within 14 of the 22 LM and GNE LGAs.

Mildura (11.2), Swan Hill (8.7), Mount Alexander (8.0), Mansfield (7.5) and Wodonga (7.1) are the five leading LM and GNE LGAs where this service was accessed (Women's Health Victoria, 2022).

Figure 18. Abortion rate per 1,000 – comparison of patient, prescriber location and pharmacy location – LGA - 2020

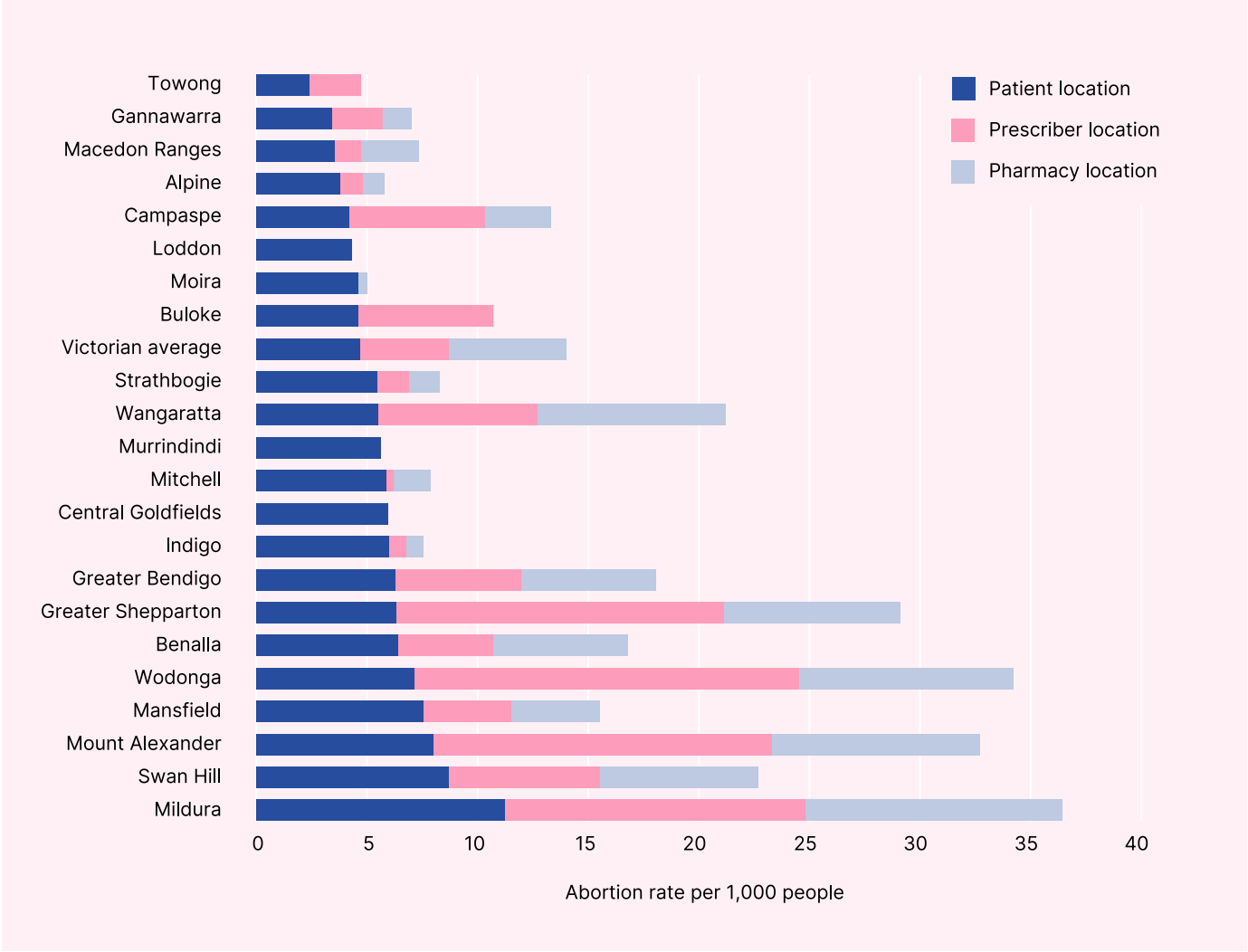


Figure 18 shows the medical abortion rates by patient location and compares this to abortion by prescriber and pharmacy location.

There was significant movement across LGAs within medication abortion by patient location when assessed against prescriber and pharmacy data, indicating that there are abortion service gaps within many of the LGAs.

Within Central Goldfields (above the state average for abortion by patient location) and Loddon (just below the state average for abortion by patient location) there was no rate by prescriber or pharmacy, indicating that medical abortion accessibility is unavailable. The above Figure highlights that accessibility was also limited in the Indigo, Murrindindi, Mitchell, Moira, Alpine and Strathbogie LGAs (Womens Health Victoriab, 2022).

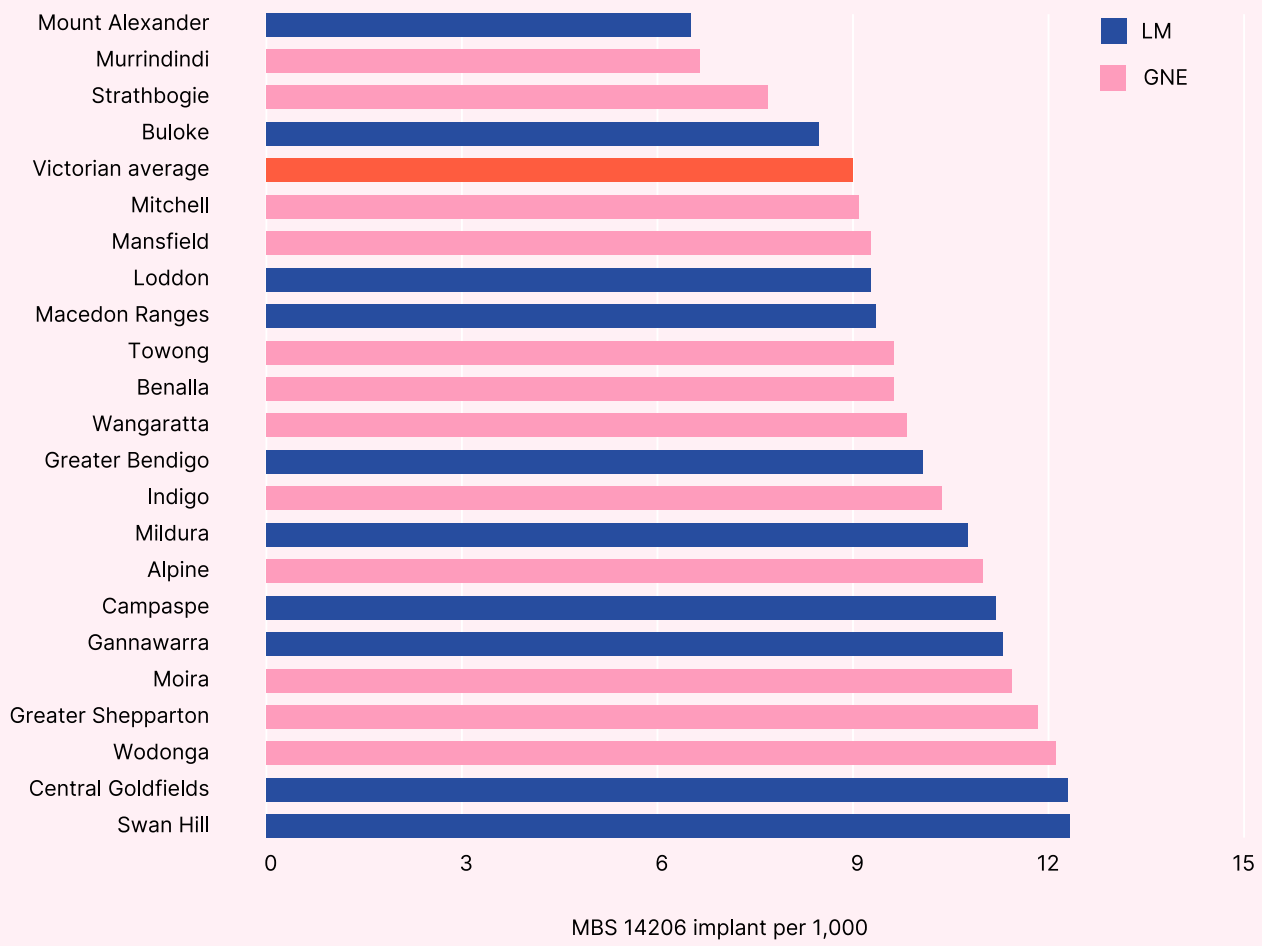
Women who seek abortion services may self-stigmatise, leading to feelings of shame and secrecy (Doran & Hornibrook, 2016).

They may also fear or feel stigmatised by healthcare professionals who express disapproval or judgmental attitudes towards their choices (Cashman et al., 2021; Johnston et al., 2015).

The fear of confidentiality breach is a major concern for women seeking abortion services which can lead to feelings of shame, embarrassment, or discrimination (Cashman et al., 2021).

Barriers to accessing abortion are likely to be more pronounced for adolescents as well as populations with low health literacy, English proficiency, and those from lower socio-economic populations (Cashman et al., 2021; Johnston et al., 2015).

Figure 19. MBS 14206 implant birth control rate per 1,000 by patient location – LGA - 2020



The uptake of Long Acting Reversable Contraception (LARC) methods such as hormonal implant birth control and intrauterine contraception (IUD) is relatively high across the LM and GNE region, with Figure 19 showing that just four LGAs were below the state average for the use of the MBS 14206 implant (Women's Health Victoria, 2022).

Figure 20. MBS 14206 implant birth control rate per 1,000 patient location vs. provider location - LGA - 2020

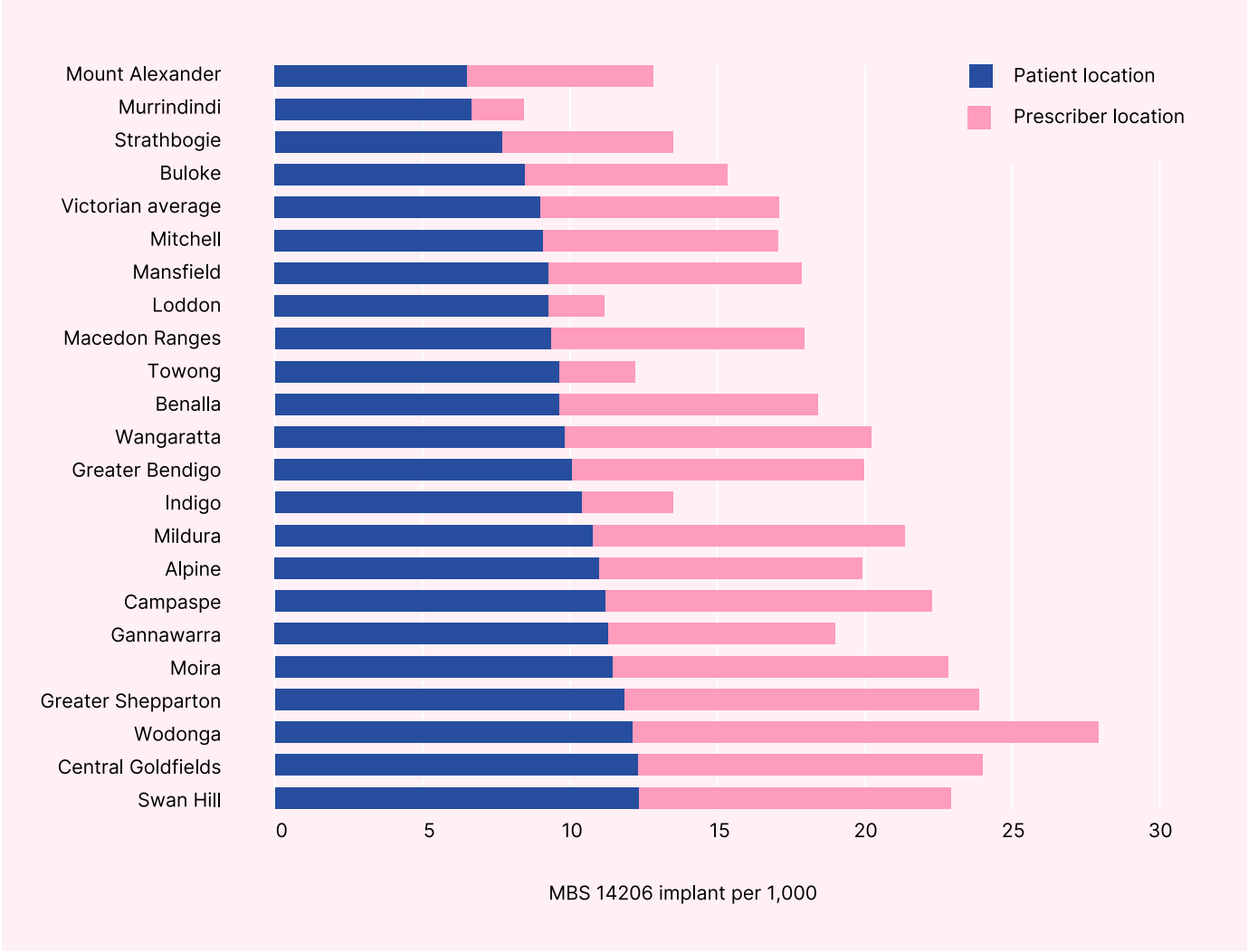


Figure 20 highlights that there appears to be some movement across both LGAs between patient location and provider location for implant birth control, indicating that women are unable to access this service within some LGAs.

However, service gaps are not as pronounced as for medication abortion data as seen in Figure 19 featured above.

"You want to know that people are on your side, you want to know that you're being cared for, that everything, you know, your best interests are at the center of everything that they're doing for you."

—Participant quote

11.2 Lived and Living Experience Research

Project objective:

Provide opportunities for women to have a voice in SRH service design and delivery.

This section of the report highlights the key findings from the community engagement process, including engagement levels, the limitations and effectiveness of the strengths-based solutions focused approach, and the solutions generated by women, gender diverse people and healthcare professionals to improve SRH outcomes within the LM and GNE regions.

Like the information presented in reference to the Regional Data Profile, correlations have been drawn between key findings and the peer reviewed literature (identified within the literature scan) where appropriate. Participant quotes have been included in pink boxes and in bold text throughout this section.

11.2.1 Engagement

The community engagement strategies captured the lived and living SRH experiences, opinions and perspectives of 80 women, gender diverse people and healthcare professionals.

Participants were recruited through a range of methods, including newsletters, presentations, email, social media, and via a dedicated webpage. Purposive and convenience sampling was used at times, with specific individuals contacted directly and asked if they would like to participate.

Although there were challenges in attracting community and health professionals to take part in focus groups, consultation, and surveys, engagement was higher than in the previous Storylines project, which reached 62 participants. Offering in-person focus group sessions and consultation was the preferred method, both for PWG and participants, due to better opportunities for open discussion.

11.2.2 Strength-based solutions focused approach

As a core project principle, a 'strength-based solutions focused approach' was adopted, encouraging women, gender diverse people, and healthcare professionals to look beyond the barriers to SRH information and service accessibility within their regions and to draw from readily available community resources/ assets to identify possible solutions to enhance SRH outcomes (Chapin, Nelson-Becker & MacMillan, 2006). Below the limitations and effectiveness of this approach are discussed.

Limitations:

When using the strength-based solutions focused approach, at times some women, gender diverse people and healthcare professionals highlighted barrier/s to SRH service provision but were unable to put forward possible solutions to address such barrier/s. Barriers expressed that were not accompanied by solutions were commonly structural and logistical in nature, for example, limited SRH professionals, SRH services, appointment times, and financial constraints. One woman highlighted how cost to accessing services was a major barrier stating,

> *"The costs could be so prohibitive, even just to see the GP. It can get so costly if you have multiple appointments, and then when you have to start seeing specialists for a lot of reasons, it just puts it out of the realm, you can't actually do anything. And they just then decide to live with it, because it's such a barrier, and it really does grow that inequity".*

Literature has identified that within Australia SRH services are highly concentrated within metropolitan areas, with accessibility lacking within regional and rural communities (Cashman, Downing & Russell, 2021; Coombe et al., 2021; Doran & Hornibrook, 2016). The below quote supports this finding, with a woman stating how

the lack of SRH within her rural community has forced her to travel to a metropolitan area to obtain the SRH care she requires,

> *"Living regionally obviously, things that are available to us aren't as great as what is available in the cities, and yeah – through my experiences, I have had to travel to get the care that I've needed". - Participant quote*

Not only can this prevent a woman from receiving timely SRH care – i.e. a woman shared throughout the community engagement process that she put her ***"...health on hold waiting till I'd go to Melbourne next"***, but it can also intensify SRH conditions (Cashman, Downing & Russell, 2021). A healthcare professional told the story about how the lack of timely SRH care in their rural community restricted a woman's control to her SRH rights, resulting in an adverse health outcome. They stated,

> *"I work with vulnerable women. A mother who is a parent of several children and a victim of family violence, requested surgical intervention for contraception. She was told she had to wait as it was not considered a high priority procedure. Subsequently to this situation she has another child...As much as she loves all her children this has been an added burden to her life, finances, health and housing." - Participant quote*

The difficulty in generating solutions to address these complex barriers and inequities may be because such barriers fall within socioecological model levels that have less power, control and influence within. As the socioecological model examines barriers and enablers at multiple ecological levels, the inequity between rural/regional and metropolitan areas may be created with the broader ecological levels of the model i.e. community and societal/policy levels, where women, healthcare professionals and other community-level stakeholders lack power, control and access to community assets/resources to create systems-level SRH change. To date, research has used the socioecological model to investigate and understand how the different levels of the socioecological model interact and influence specific behaviours, health conditions and service provision (Freedman et al., 2019; Jin et al., 2020; Reyes et al., 2023). However, no literature has investigated the socioecological model in conjunction with the strength-based, solutions-focused model to explore community ability to identify barriers and solutions to create systems-level SRH change.

Despite the overall project adopting an intersectional lens, and women from all backgrounds being invited to contribute their lived and living experiences throughout the consultation process, the strength-based solutions focused approach adopted did not consider how multiple types of oppression, including racism, sexism, heteronormativity, ableism and ageism can coexist at the same time and produce a complex synergy of barriers to SRH information and service provision (Carastathis, 2014). Therefore, some of the solutions generated may not be appropriate for all women, particularly those most marginalised. If this approach is used into the future, it is recommended that the approach is adapted to consider the impact of intersectional influences to ensure that solutions that can address more complex, structural and systemic barriers specific to marginalised women can be generated.

Effectiveness:

Overall, the strength-based solutions focused approach proved to be an effective method to engage with the community, including marginalised populations, and to generate a wide range of solutions to improve attitudes, destigmatise SRH, enhance SRH service access and availability, quality of care, and community-level education and awareness. These solutions highlight available community resources and assets WHLM, WHGNE and other relevant

stakeholders can access, and the power and control that they and community have to generate systems-level SRH change. Solutions and relevant supporting quotes are presented in detail on the following pages of this report.

As highlighted above, despite some women, gender diverse people and healthcare professionals being unable to generate possible solutions to certain SRH service provision and information barriers, considering the socioecological model alongside the strength-based solutions focused approach highlights where future effort is needed to build capacities and the stakeholders required to address specific SRH inequities.

Despite some of the stories and experiences that were shared by women, gender diverse people and healthcare professionals not providing direct community-driven solutions, they do contribute rich details and information towards understanding the SRH landscape within the LM and GNE regions and serve as useful data that both WHLM and WHGNE can draw upon for future projects and/or initiatives.

"Trauma informed, safety, trust, choice, collaboration, empowerment, respect for diversity and above all else, do no further harm. If you can't educate yourself to be trauma informed then there should be no place for you in medicine."

—Participant quote

11.2.3 Solutions for system reform

Through the application of the strengths-based solutions focused approach and drawing from available community resources and lived and living experiences, local women, gender diverse people and healthcare professionals put forward solutions to address the identified barriers to enhance SRH information and service provision within the LM and GNE regions.

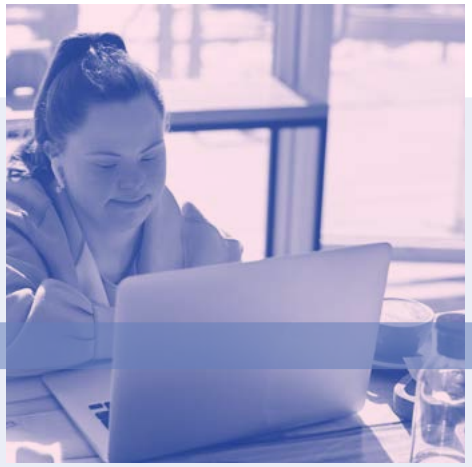
Solutions are listed below and have been categorised and presented within the following themes:

- Stigma and societal attitudes
- Access and availability
- Quality of care
- Education and awareness

Stigma and societal attitudes
What better looks like
➔ A health system and community that is committed to ensuring that everyone can access the care they need without fear of exclusion, stigma or bias.
➔ Normalising conversations around SRH inside and outside of health and education settings.
➔ Amplify the message that sex and reproduction are normal elements of women's lives and integral to their health outcomes.
➔ Destigmatisation and inclusive practices to be tailored to the diverse and varied needs of people within the community, through SRH care and information delivery.
➔ Increased support and resources are needed for people from multicultural communities, including access to interpreters versed in SRH terms for those who need them.
➔ Culturally sensitive approaches to healthcare from knowledgeable healthcare providers and efforts aimed at increasing community knowledge and acceptance of SRH.
➔ Diverse healthcare workforce, with inclusive policies and practices in place to ensure active inclusion and non-discrimination.

Sub-theme	Strength-based solutions	Participant Quotes
Privacy and Confidentiality	• Having different patient exit and entry points of SRH service buildings • Increasing internet connectivity so women can access Telehealth services from the privacy of their own homes • Ensure training, practice and policies enable confidentiality, with a focus on rural settings • Education/communication with patients to raise awareness about best practice confidentiality, especially in small towns • Multidisciplinary waiting rooms and automated check-in systems • Developing online systems and referral options which will protect privacy and confidentiality • Community health and outreach services • Upskilling pharmacists and other adjacent professionals to understand the impacts of a lack of privacy.	*"Training for reception staff on confidentiality and how to stop people from providing sensitive information while booking appointments"* *"Work at the local school and constantly running into students in a very, very open waiting area. So having different entry exit waiting points, yeah, would be something"* *"... inclusive design that allows people to maintain privacy is really important"* *"If you could have your exit with your payment away from the waiting room on the way out of the building, and you wouldn't have to deal with all the people that are sitting on the way in"*

Sub-theme	Strength-based solutions	Participant Quotes
Attitudes of health professionals and societal judgment	• Normalising the practice of patient-centred care • Upskilling around compassionate communication and listening • Training around women's pain, the causes, and the importance of considering hard to diagnose conditions when treating pain • Coordinated health promotion efforts to destigmatise SRH in midlife, e.g. menopause and loss of libido • CSE programs delivered to encourage sex positivity and consent talks in schools which would help reduce stigma, increase awareness and hopefully support a reduction in women experiencing sexual violence.	*"[We need] more sexual health nurses as it is easier to see them without any stigma from a GP"* *"Confidence in knowing it will be treated like any other medical need, not some shameful thing"* *"I think about hopefully, in the future, sexual and reproductive health being a very safe, non-judgemental space where people have the autonomy to do what they feel right without any judgement"* *"... doctors to be more accepting of using alternative health provision, like Naturopathy because there have been lots of doctors who stand against and discouraging women from doing so"*
Gender inequity and heteronormativity	• Embedding a gender equity lens on policy and practice at all levels of the healthcare system • Coordinated health promotion activities communicating the impacts of gender inequity on health and wellbeing • Challenging stereotypes, rigid gender norms and encouraging sex positive approaches to SRH in a range of settings • Ensure healthcare providers are inclusive and do not assume gender and sexuality.	*"Every service should be inclusive, and every service should be supportive"* *"Our health system can better support a community by making sure that we've got gender diverse and gender supportive services"*



Sub-theme	Strength-based solutions	Participant Quotes
Inclusive access and support	• Ensuring cultural safety and diversity are valued and embedded in the workforce through policies and practices • Normalise inclusive language with attention to the LGBTIQA+ community • Health promotion activities to support people of diverse social and cultural backgrounds in accessing services and information.	*"If I may speak as a resident of Wodonga, I just think some of the strategies will be having that educational care into the workforce. And trying to also promote and embrace that diversity in the work healthcare system as well. Yeah, because there's different patients from different backgrounds"* *"... normalising language"*

Access and availability

What better looks like

- ➔ Greater availability of services and the removal of barriers to access in rural and regional areas.
- ➔ Affordable services for people in rural and regional areas and for those who do not have Medicare as an option.
- ➔ Primary care services that have space and availability for new patients, while also maintaining capacity for continuity of care.
- ➔ Services to be available to them and their communities locally, so they don't have to travel – whether it be through bricks and mortar or community outreach/travelling services.

Sub-theme	Strength-based solutions	Participant Quotes
Service navigation and regional access	• More welcoming and inclusive practitioners • More female health practitioners • More SRH specialist services in regional areas • Increasing the workforce capacity by upskilling nurses/people living in small towns with scholarships • Deployment of more people to work in regional/rural areas • Offer integration of services, expanded nurse-led models and inter-service collaboration to ensure easy access to a range of referrals and support • Greater access to low cost/bulk billed services • Funding for greater availability of appointments, including walk-in appointments, after-hours and Telehealth appointments • Embed pathways of support for patients who might be isolated or experiencing hardship – i.e. continuity of care, scope for Centrelink to provide referrals and information, collaboration between healthcare providers and support services in community • Outreach to rural areas and promotion of services and information for wider access • Primary care services to more actively connect/refer patients with those more specialised services, i.e. through SRH clinics • Provide women with easier and more accessible service navigation, with place-based services connecting them to the breadth of care they require	*"Access for women to all services regardless of income or location"* *"We need more women doctors with long-term tenures"* *"Shorter wait times, more thorough testing. Care with an element of care, not service"* *"I think the thought or question, I had was whether this data and all this information we're collecting could be used to help strengthen the workforce in the form of like upscaling local people in this area, in a way that like scholarships. Obviously, we know that there's a shortage in GPs and all that sort of stuff. I guess there's so many nurses and skilled people out there that are looking for other opportunities. And wanting a bit of a change, and things like that, so utilise those skills and upskill people that you know, potentially got families in small towns that don't want to move to different region or there's no options for them to move"*

Sub-theme	Strength-based solutions	Participant Quotes
Time and effort	• Streamline appointment booking processes • More appointments open to new patients • Reduce wait times and ensure a certain number of same day appointments • Incentives for health professionals to work regionally/clinics to retain more staff	*"Better processes for booking procedures and less wait times for appointments"* *"Provide training for receptionists about other referral pathways when not taking new patients rather than leaving patients with no answers"*
Finding a preferred healthcare provider	• Ensure reciprocal rapport and trust between patients and healthcare providers is prioritised • Incentives for female GPs and SRH providers to offer appointments regionally/rurally • Upskill healthcare providers to understand SRH through a gender lens • Support continuity of care • Proactive policy and action around inclusivity from healthcare services – asking for pronouns, tailoring services for young people as well as LGBTIQA+ and multicultural communities • Ensure staff are supported to provide inclusive care.	*"[Better looks like] keeping fully informed of current practices and listening, listening, listening"* *"I know we have the women's clinic here, so that's somewhere that maybe you'd reach out to if you had a problem like that because you now that they've had more training in that area"*
Access to support	• Increased community support for women around SRH • Connecting women in with broader support services • Ensuring access to interpreters for women from multicultural communities • Considering the needs of women holistically when providing medical care i.e. the specific needs to the LGBTIQA+ community, and digital literacy support for older women and those from multicultural communities.	*"Really good interpreters who really know the medical terms and are able to just specifically interpret issues with patients"*

Sub-theme	Strength-based solutions	Participant Quotes
Communi-cation and accessing information	• Improve standard of communication between Health Professionals and patients using plain language and active listening techniques • Clarify referral pathways and provide clear instructions for follow ups • Develop more resources to support communi-cation between Health practitioners and peo-ple whose first language is not English • SRH services to promote themselves more broadly so that the community is aware of their presence and function.	*"People need to be empowered to be more proactive with their health. Communities need things explained to them using platforms that suit them, ie. at their own events, in their own language or in comfortable surroundings"* *"I asked around and the women's clinic was one that people recommended. I think they do a good job and it's an expectation, because of the nature of the clinic, of covering bases when it comes to sexual and reproductive health. But I think it is definitely something that could be brought into the narrative more naturally in other clinics"* *"[Better looks like] clear communication and promotion of local services so people know what's available and there is an increase in services openly available that don't get backlash for supporting women's choice"*

Quality of care

What better looks like

- ➔ Stronger focus on sex positivity and compassion in SRH service delivery.
- ➔ SRH care to focus on the wellbeing of patients, considering factors like the impacts of SRH and treatments on mental health, the role trauma and shame play in shaping experiences around SRH, and how interpersonal interactions influence the perceived quality of care from the patient's point of view.
- ➔ Care to be centred on how healthcare professionals and the system as a whole treat women and gender-diverse people seeking SRH care.

Sub-theme	Strength-based solutions	Participant Quotes
Maternity care	• Patient centred maternity care which considers bodily autonomy and choices • More attention to holistic care during the maternity cycle, particularly around preventative mental health discussions • Readily available referral pathways for women to seek support during and after pregnancy • Patient centred fertility treatments prioritising wellbeing and communication.	*"And I trusted her, so I already had a relationship - it wasn't just any doctor, it was her. And she asked if I wanted my membranes ruptured, because it was all there [in the birth plan]. And I was lucky enough to have my husband support me, going "You're doing so well," and all of that. So that moment of me going 'Just get it out of me', sort of went"*
Interpersonal factors and communication	• More time for healthcare practitioners to build rapport and invite communication • Greater opportunities for continuity of care • Upskilling for primary care practitioners around relationship building and communication.	*"I was seeing a different GP and she just randomly asked me, 'Are you on any contraceptives? Would you like to talk about – is there anything you'd like to know?' It kind of started that conversation about sexual health and other options, which I found really comforting because I was like, 'Oh, I can go talk to this person openly about this'. But it just started off with a little question being like, 'any contraceptives? Do you want to talk about that?' and I think it really opened up that conversation"* *"I think when you do find someone that you're comfortable speaking with, it does make a world of difference and definitely kind of alters the narrative a little bit, personally"*
Patient centred care	• Patient centred, trauma informed care embedded into training/ policies • Culturally safe practices to be embedded into training/policies • A focus on holistic wellbeing of patients seeking SRH care.	*"You want to know that people are on your side, you want to know that you're being cared for, that everything, you know, your best interests are at the center of everything that they're doing for you"* *"[Better looks like] trauma informed, safety, trust, choice, collaboration, empowerment, respect for diversity and above all else, do no further harm. If you can't educate yourself to be trauma informed, then there should be no place for you in medicine"*

Sub-theme	Strength-based solutions	Participant Quotes
Expertise	• Ensure SRH is a standard area in tertiary curriculums • Standardised upskilling and training around SRH for primary practitioners • Greater resources and more SRH specialist clinics without need for referral.	*"Having a doctor that is trained and focusing on sexual health is very important because of the questions they can ask you. They're obviously non-judgmental and all the rest. Otherwise…I'll go in and say, 'can I get checked for chlamydia and gonorrhoea as well?' They'll just say yes but there's no questioning around that, why I want to do that. Didn't ask about symptoms, didn't ask about anything, so I don't know. I just think the expertise in that would be helpful"* *"Better is not having to see multiple doctors to find one that will look into women's health issues without minimising your concerns or to just go on the pill"*

Education and awareness

What better looks like

- ➔ Widespread knowledge in the community and healthcare settings about SRH.
- ➔ More research into women's health and women's bodies.
- ➔ More initiatives to ensure SRH knowledge is normalised in the community and within the healthcare sector.
- ➔ Multiple settings and pathways of SRH education and wanted skilled, knowledgeable primary care practitioners who were competent in communicating around SRH.

Sub-theme	Strength-based solutions	Participant Quotes
Health literacy	• Education for healthcare professionals, including providing regular PD for doctors to keep them informed about the dynamic and diverse environment in SRH, and tailoring training for health practitioners according to community research and community needs • Government and organisational support for education and training • Access to professional development and training for time-poor rural and regional practitioners • Training for IUD insertion • In language resources and better SRH information access for multicultural populations • Community knowledge improvement and the importance of continuity of care • More SRH specific training for primary care practitioners • Improved access to information about treatments and where they are provided • Clear referral pathways for GPs to follow in their region • More community awareness/ education, continuity of care, and normalising conversations about SRH.	*"More resources in language in one place"* *"The thing that really is standing out for me is the need for respectful, inclusive sexuality, education that's accessible. Maybe outside of the formal setting, like a school, that's delivered by people who have the skills and broad knowledge and the respect for diversity"* *"Better understanding of women's issues and that it is not just 'all in our heads'. This can be for both the medical field and general community. We are allowed to speak up about it and not be shut down with 'oh she's just on her period' or it's just hormones"* *"Keeping fully informed of current practices and listening, listening, listening!"* *"More community education and open discussions"* *"Teach open communication strategies to health providers"*

Sub-theme	Strength-based solutions	Participant Quotes
Sex positivity and empowering women	• A greater focus on sex positivity in SRH education and wider society • Ensure health professionals foster a sex positive, safe environment with easy access to information, with professional development in this area available to staff • Normalising conversations around women's sexuality and health • Better education for men and boys around women's SRH • Addressing societal issues that have repercussions on SRH i.e. pornography.	*"More honest and open education for women and men to understand the changes in women through no fault of their own"* *"Women and girls have access to sex ed that's not just about harm minimisation and not getting pregnant. But simple things like the anatomy of the clitoris, the way that a woman's sexual response works as sex, sexuality, and sexual pleasure is actually, you know, basic human rights"* *"What is important for me is that allowing for more open discussion about sexual and reproductive health issues"* *"Better information sharing and knowledge for young women"* *"Education for girls and women should be a high priority"* *"Males knowing about contraception could make a space where potentially they bring it up more and stuff like that, rather than it being something that only women are left to kind of bring up in a conversation more often than not"*

Sub-theme	Strength-based solutions	Participant Quotes
Settings and information provision	• Capitalise on mother's/parent's/social groups as information sharing settings by providing reliable resources on SRH with group facilitators • Support families to contribute to SRH education in the home • Upskill teachers to be more confident and comfortable teaching CSE • Respectful, inclusive CSE needs to be accessible outside of formal settings and should be delivered/facilitated by people with skills and broad knowledge with respect for diversity • Peer-learning circles where women with commonalities can come together to have discussions • Increase information availability in community and healthcare settings.	*"It's about knowing who to go to for information and support – hearing about current issues and getting explanations in a local environment"* *"I think education is key and to inform the youth ASAP on good sexual and reproductive health and wellbeing"* *"Promote inclusion via talks, posters and health promotion days. Provide evidence-based information"*
Awareness of services and options	• More attention to strategic promotion of SRH services • Widely accessible information on place-based options around services and contraception options • More transparent referral pathways and options • Greater attention to providing information about procedures to patients in healthcare settings • Educating health professionals and community members about different models of health, including nurse-led models, could provide alternative pathways for care • Educating community through the development and dissemination of resources around how to navigate current healthcare models.	*"SRH services need to promote themselves and their services more broadly. Ensuring they reach under serviced populations such as migrant, Aboriginal and Tores Strait Islander, disabled and LGBTIQ+ - going to where communities come together"* *"Clear communication and promotion of local services so people know what's available and there is an increase in services openly available that don't get backlash for supporting women's choice"*

Sub-theme	Strength-based solutions	Participant Quotes
Networking and Innovation	• Connecting SRH healthcare services to improve coordination and communication channels • Expanding the SRH networks to include nurse practitioners and sexologists from the region • Dedicated, universal online hub of SRH information for practitioners • Increased networking opportunities across regional zones with a focus on research, events and collegial support • Offering flexible solutions to health practitioners in terms of networking and professional development • Organising SRH specific events to promote health information and services for community.	*It will be great to know different perspective based around sexuality, sexual health and reproductive health and know what's going on, and a chance to have a community of practice where people could share knowledge or opportunities"*
Life stages	• Normalising conversations about SRH at different life stages • Expanding capacity of primary care practitioners to initiate conversations about relevant life stage SRH issues • More readily available information about menopause and perimenopause • Make information on fertility and its potential relevance later in life accessible and relevantly framed to younger women.	*"I think that women in their early 30s should be sent out information about perimenopause so they know what to look out for so that they can get appropriate treatment"* *"Better information and knowledge sharing for young women"*

"Looking forward to the advocacy outcomes of the project and helping decision makers to 'get it'. Services must be tailored to reflect the unique needs of our regions."

—Participant quote

12. Recommendations

Key recommendations have been developed through the analysis of local SRH data, literature and other/evidence, lived and living experience narratives of barriers and solutions, and existing Statewide and Women's Health Services SRH policies and strategies.

These recommendations relate to the final project objective outlined below.

Project Objective

Advocate for systems-level change to develop a safe SRH system that is person-centred, culturally appropriate, rights-based, and that meets the timely SRH needs of women.

Other relevant information supporting the development of the recommendations is also provided in this section.

10.1 Supporting information

As outlined previously in this document, the following key recommendations are underpinned by a rural, feminist and intersectional gender lens.

The recommendations should act as a call to action from WHLM and WHGNE in partnership with multiple stakeholders, including, but not limited to, governments, funding bodies, service providers, GPs, health professionals, health promotion specialists and community groups. They call for leaders and decision makers to advocate, implement and support the delivery of projects, programs and initiatives which promote gender equality through the creation of supportive SRH environments, growing an SRH evidence base, and building healthy public policy.

As many interrelated factors and influences affect the health of women and gender diverse people, a systems approach has been adopted, with the recommendations targeting various ecological levels of the socioecological model to empower women and communities, increase organisational understanding of women's SRH issues, and strengthen the delivery of person-centred, culturally appropriate and rights-based SRH information and services that are delivered free from stigma and discrimination.

While the Victorian Women's Sexual and Reproductive Health Plan (2022–30) - a guiding strategic document of the LSS project, provides a comprehensive overview of strategies to improve women's SRH, the LSS project recommendations prioritise achieving lasting improvements in SRH access for rural and regional women and gender diverse people. This requires a focus on strengthening the sex and gender inclusive health support system for delivering SRH services, also referred to as the 'infrastructure of care'. This infrastructure encompasses all the elements that enable effective service delivery, including accessible healthcare facilities, a qualified workforce of healthcare professionals, reliable transportation options for reaching services, and effective communication strategies to reach women in need. By adopting a rural lens to this infrastructure, we can ensure that the specific circumstances, health impacts, and needs of regional communities are considered when designing new services and making improvements to existing models. Additionally,

it is crucial to incorporate an intersectional approach that acknowledges and addresses the unique barriers faced by marginalised groups, including Aboriginal and Torres Strait Islander women, multicultural women, older and younger women, LGBTQIA+ individuals, and women with disabilities. This approach ensures that the diverse needs of all individuals are met, promoting equitable access to SRH services for everyone.

10.2 Priority areas and recommendations

The recommendations have been grouped and presented within the following priority areas and are detailed below:

1. Creating Supportive Environments
2. Growing the Evidence Base
3. Building Healthy Public Policy

1. Creating Supportive Environments:

- **1.1 Advocate for increased SRH service provision in regional, rural and remote communities, that are delivered free from stigma and discrimination.**

– 1.1.1 Scope partnerships between existing and planned community infrastructure and SRH service providers within small regional areas to deliver SRH services and primary prevention activities, i.e. community houses, libraries and mobile women's health clinics.

– 1.1.2 Build community partnerships to explore and implement innovative and/or community identified strategies to address barriers that restrict SRH service provision amongst women, particularly those from marginalised populations groups, within the LM and GNE regions.

– 1.1.3 Explore opportunities to embed and expand regional infrastructure (e.g. integrated SRH Hubs and Women's Health Hubs) to ensure sustainable, equitable access to holistic, person-centred, culturally appropriate services are available to all rural and regional women.

– 1.1.4 Promote or support the facilitation of regional networks and local action plans that enable collaboration between local stakeholders and strengthen community partnerships that increase intersectional, sex positive SRH approaches that are responsive to the place-based needs of regional women.

– 1.1.5 Utilise the Victorian Women's Health Network to scope a state-wide strategy that aligns with the Victorian Women's SRH Plan (2022-30) to address barriers and increase access for women living in regional, rural and remote communities.

– 1.1.6 Advocate for the expansion of nurse and midwife led models of care, to inform a comprehensive state-wide program, including resources dedicated to upskilling nurses as qualified prescribers in regional areas.

- **1.2 Implement and support primary prevention activities to increase regional and rural women's access to safe and appropriate SRH information and services.**

– 1.2.1 Undertake place-based health promotion and education initiatives in partnership with LGAs, education institutions, health, and community organisations to increase SRH literacy across the life course.

– 1.2.2 Promote local SRH clinics and e-clinics to improve service navigation and ensure better access to SRH for all women and gender diverse people.

– 1.2.3 Support capacity building activities for local service providers around trauma-informed care, reproductive coercion, intersectionality, culturally safe SRH, referral pathways, and LGBTIQA+ inclusion.

– 1.2.4 Support SRH networking opportunities (e.g. Community of Practice) for SRH stakeholders to grow regional networks that focus on support, mentorship, and knowledge and capacity building to provide quality, integrated, best-practice SRH care.

- 1.2.5 Explore partnerships with community champions to counter stigma by providing gender-inclusive and sex-positive messaging around SRH.
- 1.2.6 Utilise and expand existing community engagement models to build social/peer networks and supports, and increase SRH literacy, e.g. clubs, societies and peer-led learning circles that support women.
- 1.2.7 Explore informal peer networks that allow for SRH knowledge sharing amongst the marginalised backgrounds (e.g. Aboriginal and Torres Strait Islander, LGBTIQA+, those living with a disability, and multicultural communities).
- 1.2.8 In partnership with key stakeholders, explore regionally available SRH training for primary care professionals to build SRH capacity and expertise.

- **1.3 Provide safe and respectful SRH environments that are person-centred, culturally appropriate, and rights-based.**

- 1.3.1 Utilise lived and living experience evidence to inform opportunities that support health services to create inclusive and accessible spaces for all women, particularly those from marginalised backgrounds.
- 1.3.2 Encourage service providers to consider/review the delivery of inclusive practice and confidentiality training to clinical and non-clinical staff to support a whole of practice approach to provide non-stigmatising, non-judgmental and confidential care, i.e. culturally safe and informed services, referral pathways, and storage of sensitive information.
- 1.3.3 Investigate approaches that provide an avenue for women's voices to inform service design, delivery and policy, and to ensure SRH environments are meeting the needs of regional women.
- 1.3.4 In accordance with the Victorian Gender Equality Act (2020), engage with health services to audit policies, procedures and services (including physical design) to ensure an intersectional gender lens is applied to meet the SRH needs of regional women and gender diverse people.

2. Growing the Evidence Base:

- **2.1 Collaborative partnerships for data collection and dissemination of key SRH learnings.**

- 2.1.1 Advocate for the availability of deidentified, sex-disaggregated qualitative and quantitative data to address intersectional SRH and social determinants of health knowledge gaps.
- 2.1.2 Advocate for ongoing monitoring and evaluation of SRH initiatives, policies and practices to capture the progression towards improving SRH outcomes for women living within the LM and GNE regions.
- 2.1.3 Increase understanding of how and where regional and rural women access health information to inform best practice health promotion and information dissemination activities.
- 2.1.4 Strengthen existing partnerships between key stakeholders to build a collective understanding of local SRH community and workforce needs, according to regional population demographics.
- 2.1.5 Explore partnerships with research institutions and key stakeholders to develop an economic evaluation demonstrating the cost effectiveness of investment in community infrastructure to support access to SRH for regional and rural women.
- 2.1.6 Explore partnerships with research institutions to build a regional SRH research database inclusive of both primary prevention evidence from across the health promotion continuum and service delivery evidence.
- 2.1.7 Continue to capture authentic lived and living experience data to inform practice through an intersectional gender lens.

3. Building Healthy Public Policy:

- **3.1 Use and align state-wide policy and legislative obligations to guide and inform best practice within the LM and GNE regions.**

– 3.1.1 Utilise and expand on existing policy levers such as the Victorian Gender Equality Act (2020) to continue to build and improve safety, inclusion, and privacy for women accessing health services.

– 3.1.2 Explore how higher-level policy and strategy can influence and guide workplace policies, programs and initiatives to support the SRH of rural and regional women.

– 3.1.3 Embed SRH as a key priority within state, regional and municipal health and wellbeing plans and strategies.

– 3.1.4 Promote the value of amplifying women's voices and using lived and living experiences from across the life course to policymakers to ensure the needs of rural and regional women inform the development and review of policies.

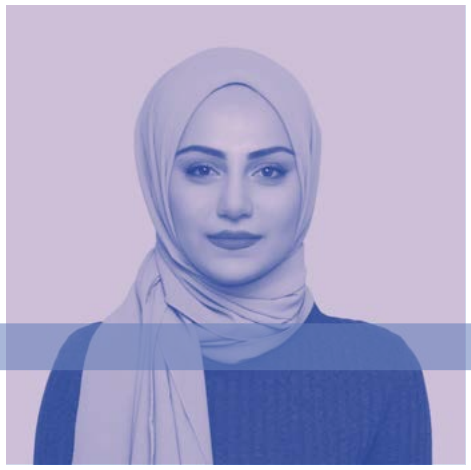
- **3.2 Support the implementation of the state-wide Victorian Women's Sexual and Reproductive Health Plan 2022-30 by building local workforce capacity to enable greater regional and rural access.**

– 3.2.1 Expand the delivery of quality SRH care by upskilling stakeholders to respond to the needs and experiences of regional women.

– 3.2.2 Promote regional SRH and community service delivery as a growth area for specialised services through the provision of incentives for skilled health professionals to work in regional, rural and remote communities.

– 3.2.3 Encourage regional SRH stakeholders to explore student placement, mentorship and graduate opportunities.

– 3.2.4 Encourage stakeholders to consider flexible scheduling of online in-person training to ensure regionally relevant training is delivered equitably.



"Having a doctor that is trained and focusing on sexual health is very important because of the questions they can ask you. They're obviously non-judgemental and all the rest."

—Participant quote

13. Concluding Remarks

This project provides localised, evidence-based data that has been built through multiple project activities, conducted at multiple points in time, across 22 LGAs in Victoria.

This project has shown that since the original Storylines project women's SRH experiences across the LM and GNE regions have remained largely unchanged. Barriers persist, and women reflect on the challenges that inhibit their ability to secure the quality care they require, highlighting the complex systems, structures and policies that continue to prevent their voices and needs from being heard and actioned.

Systems-level change is required to improve SRH outcomes for regional and rural women, particularly those from marginalised backgrounds. To achieve this, the recommendations stemming from the core activities undertaken within the LSS project are multi-leveled, and focus on creating supportive SRH environments, growing an evidence base, and building healthy public policy.

These recommendations will guide WHLM, WHGNE and key stakeholders in the design, implementation and delivery of future SRH projects, programs, initiatives and strategies. They emphasise using tailored systemic, structural, and cultural approaches that address specific health disparities and develop a health system that anticipates and incorporates the needs of marginalised communities including Aboriginal and Torres Strait Islander women, multicultural women, LGBTQIA+ individuals, and women with disabilities. Other leaders and decision makers are also encouraged to use key findings and recommendations to inform system reform.

The implementation of these recommendations may be incremental, and outcomes long term, but a continued prioritisation of rural and regional SRH needs and experiences of women and gender diverse people will inform greater recognition and impact of evidence-based approaches to address SRH and improve health outcomes across the LM and GNE regions.

"Looking forward to the advocacy outcomes of the project and helping decision makers to 'get it'. Services must be tailored to reflect the unique needs of our regions" - CAG member

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15. Appendices

13.1 Glossary

Definitions in relation to the context in which terms are used within this document include:

Term	Definition
Comprehensive sexuality education (CSE)	Curriculum-based process of teaching and learning about cognitive, emotional, physical and social aspects of sexuality, that aims to empower students to take control of their sexual and reproductive health (SRH).
Discrimination	The unjust or prejudicial treatment of different categories of people, especially on the grounds of ethnicity, age, sex, or disability.
Domestic violence	Acts of violence that occur in domestic settings between two people who are, or were, in an intimate relationship. It includes physical, sexual, emotional, psychological and financial abuse.
Family violence	Is a broader term than domestic violence, as it refers not only to violence between intimate partners but also to violence between family members. This includes, for example, elder abuse and adolescent violence against parents. Family violence includes violent or threatening behaviour, or any other form of behaviour that coerces or controls a family member or causes that family member to be fearful.
Gender	Encompasses gender identity and expression. Gender identities can exist outside of the binary of boy/man and girl/woman. A person may identify as non-binary or gender diverse. Our gender identity is how much we feel like a man, woman, or as something else outside the binary. Gender identity is a spectrum.
Gender-based violence	Gender-based violence refers to harmful acts directed at an individual or a group of individuals based on their gender. It is rooted in gender inequality, abuse of power and harmful norms.

Term	Definition
Gender equality	The equal rights, responsibilities and opportunities of women, men, girls, boys and gender diverse people. It is not the belief that men and women must be the same, e.g. act, dress and behave the same. It is the belief that they are of equal value and deserve the same rights and opportunities. The interests, needs and priorities of women, men and gender diverse people need to be taken into consideration, recognising the diversity of different groups.
Gender equity	Fairness and justice in the distribution of rights, responsibilities and resources between women, men and gender-diverse people according to their respective needs. Gender equity is process to achieve gender equality.
Gender lens	The application of a lens to acknowledge the different experiences of women, men and gender diverse persons. Like looking through a pair of glasses to correct our vision, a Gender Lens will help focus our attention on gender differences and aspects of our society/workplace that may require change, to ensure an equal and inclusive environment for all. It requires personal reflection and being more aware and critical of our own language, actions and attitudes and how we can unconsciously limit others. Adding a gender lens is important as it ensures that our organisations are not unfairly disadvantaging or excluding women, men or gender diverse people.
Health equity	Everyone has a fair and just opportunity to be as healthy as possible. Health inequalities exist because of inequalities in the conditions of daily life, also known as the social determinants of health.
Health promotion	The process of enabling people to increase control over, and to improve, their health.
Human rights	Rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, healthcare, and many more. Everyone is entitled to these rights, without discrimination.
Intersectionality	The theory that the overlap of various social identities, such as gender, race, sexuality, ability and class, contributes to specific types of systemic oppression and discrimination experienced by an individual.

Term	Definition
Lived and living experience	A person's direct experiences, choices and decisions, and the knowledge and understanding gained. It is made up of a person's thoughts, feelings, opinions and attitudes.
Primary prevention	Actions or initiatives that aim to prevent disease or injury before it occurs. The target population is healthy individuals/groups.
Qualitative data	Data that is numbers based, countable, and measurable.
Quantitative data	Data that is interpretation-based, descriptive, and relating to language.
Reproductive coercion	Behaviour that interferes with the autonomy of a person to make decisions about their reproductive health. It includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making and can take a variety of forms. It is varied and can include: sabotage of another person's contraception: e.g. deliberately removing or damaging a condom or hiding or disposing of oral contraceptives; pressuring another person into pregnancy; controlling the outcome of another person's pregnancy; forcing another person to continue a pregnancy or forcing another person to terminate a pregnancy; forcing or coercing a person into sterilisation.
Rights-based approach	Focuses on how human rights are achieved and turning human rights from legal instruments into effective policies, practices, and practical realities. Key principles of this approach include participation, accountability, non-discrimination and equality, empowerment and legality.
Rurality and remoteness	To date there is no universal definition for rurality and remoteness. Instead, the Accessibility/Remoteness Index of Australia (ARIA+) is used to determine the level of rurality/remoteness. Scores rank from 0- high accessibility, to 15 – high remoteness. Scores are based on road distances from localities to population centres, which is a proxy measure for service availability.
Settings-based approach	Interventions that target the whole system of the setting and therefore larger groups of people, such as a school, workplace or sporting club, rather than solely actions at the individual level.
Sexual and reproductive health (SRH)	A state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people can have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so.

Term	Definition
Sexual and reproductive health (SRH) literacy	How people access, understand and use information in ways that benefit their SRH.
Social determinants of health	Are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples include access to education and healthcare, language and literacy skills, employment opportunities, and household income.
Socio-ecological model of health	A theoretical framework of health that emphasizes the interconnection and interdependence of factors across multiple levels, from individual physical factors to broader societal influences, in determining health outcomes. This model highlights how people interact with their physical and sociocultural environments, and how these interactions influence health.
Social norms	Unwritten rules of conduct that are acceptable to a specific culture/society.
Stigma	A set of negative and often unfair beliefs that a person, group or society have about or towards something.
Sex	Assigned at birth, it describes the biological and physiological differences between the bodies of males and females. This category is fixed and may be different from one's gender identity as they develop.
Women	The diverse range of individuals who identify as women. This definition encompasses cisgender women, transgender women, and those who are nonbinary or gender diverse and align themselves with the female experience.

13.2 Full summary of community engagement strategies

	February - May 2023	February 2023	March 2023	May 2023	June 2023	February – June 2023	July 2023	August 1 - 31 2023	September 2023 - March 2024	October 2023	November 2023	February 2024
Strategy	Data report	Community Advisory Group (CAG)				Literature scan	Health Professionals Consultation Workshop (HPCW)	Health Professional survey	Online Questionnaire	Focus Group		
Activity	Local demographic and SRH data was analysed to identify trends and issues that exist within the LM and GNE. Data analysed related to demographic profiles, socio-economic indexes, prevention screening, supporting infrastructure, SRH services, menopause, STIs, sexual, domestic/ family and intimate violence.	**CAG formed**	**Meeting 1 - Zoom**	**Meeting 2 - Zoom**	**Meeting 3 - Zoom**	Completed by the PWG, this literature scan was undertaken with the intention of exploring the health inequities surrounding SRH faced by regional and rural Victorian women with key recommendations for future practice provided.	**Zoom**	**Open online**	**Open online**	**1. Shepparton**	**2. Wodonga**	**3. Online/Zoom**
Aim/ objective/s		• Contributed to the design of community conversations, including who will be spoken to, what will be spoken about, and how to consider the needs of our most marginalized community members • Led the identification of key priorities for LM and GNE regions • With support of the LSS project team, planned community conversations to hear women's experiences around SRH • Supported the LSS project team to utilise lived and living experience to identify community-driven solutions to support ongoing advocacy and project work for rural and regional women.					Capture the perspectives of clinicians and health professionals from across the region.		Provided women and gender diverse people from the GNE region with the opportunity to share their experience and draw from their perspectives to collaborate in developing place-based, lived and living experience solutions to the challenges of seeking SRH care in rural and regional communities.			
Participants demograph-ics		Consisted of 20 women and gender diverse people aged 19-67 years, living in LM and GNE regions. 10 were from LM, 10 were from GNE. Eight of the 10 LGAs in the LM, and six of the 12 LGAs in the GNE were represented. Three members were from multicultural communities, two were non-binary, and one was Aboriginal and Torres Strait Islander.					Eight health care professionals attended consisting of two health promotion officers, two project officers/ coordinators, and one nurse, midwife, doctor (GP), and doctor of Chinese medicine. One of the attendees was male, seven were female.	10 survey results were received. One respondent identified from midwife/ antenatal services, four as nurses, one as a maternal and child health nurse, two as nurse practitioners, and two as doctor/ GPs. All respondents were female.	29 GNE female respondents aged between 18 to 64 years.	Nine GNE women aged between 18-64 years	Two GNE women aged between 18-64 years.	Two GNE women aged between 18-64 years.
Session/ activity details		Recruitment was through an Expression of Interest (EOI) process. 28 EOI's received, reviewed and shortlisted using an intersectional lens.	Session content: • Introduce WHLM and WHGNE • Feminist lens overview • Pre-evaluation indicator survey • Review of CAG Terms of Reference (ToR) and Group Agreement • Overview of Storylines, findings and latest SRH news • Group discussion of SRH	Session content: • Recap CAG role and previous meeting discussions • Presented common SRH themes that resulted from meeting 1 • Analysis of current picture of women's SRH experiences in regions • Group discussion on the data • Overview of Storytelling principles • Group discussion – how to collect and present women's voices in LSS project and beyond	Session content: • Recap of themes and data from meetings 1 and 2 • Planning of focus groups • Discussion on how to present women's stories • Brainstorm of new project name		Session content: • Overview of project • Themes identified by the CAG were introduced alongside relevant quantitative data • Breakout room discussion. Attendee responses were given using a 'strengths-based' approach focusing on solutions	Respondents were asked how each theme identified by the CAG impacted the respondents' practice/ service. This was followed by a follow-up question which asked about what the solutions might be in the themed area.	Open, short answer format so respondents could share their lived and living experience-based perspectives and possible solutions as openly as they chose	Attendees were asked a series of predetermined questions and prompts, with facilitators adapting comments and questions tailored to responses to gain an understand of participants lived and living SRH experiences and possible solutions.		

13.2 Full summary of community engagement strategies

	February - May 2023	February 2023	March 2023	May 2023	June 2023	February – June 2023	July 2023	August 1 - 31 2023	September 2023 - March 2024	October 2023	November 2023	February 2024
Informed consent		Obtained from all CAG members for audio recording of the CAG sessions and use of data - both prior to meeting via forms sent out and returned via email and verbally at start of meeting					Participants were sent informed consent documents for the Zoom recording and use of the qualitative data collected in future advocacy and resource development. All forms were returned by participants prior to the workshop.	Statement of information and consent was included in the survey for respondent to agree to before proceeding.	Introduction to the survey contained consent and additional information which respondents were required to agree to prior to completion.	Participants were sent consent forms and information about data usage prior to the focus group and asked to complete and return before attending.		
Data collection		Meetings were audio recorded. Digital collection of evaluation data was conducted via an online survey, using Microsoft forms.					The responses of participants in the online workshop were recorded via the Miro whiteboard platform.	All responses were collected via google forms in open question format, through which respondents/participants were able to provide short written answers.	The online questionnaire contained 12 questions via the Survey Monkey platform linked on the LSS webpage. Five questions were around lived and living experience perspectives to collect qualitative data, with the other seven questions collecting demographic data.	Recorded using an audio recorder, with an additional team member taking notes. Following each session the audio recording was submitted to a transcription service to be transcribed.		
Data analysis		Audio recordings were transcribed by the PWG. To identify key SRH themes which were used to guide discussions in CAG meetings 2 and 3, the transcripts from the first CAG meeting were coded and thematically analysed using an inductive approach - which means that data was analysed with no preconceived categories or theories. Two PWG member were involved in this process, with any discrepancies resolved through discussion These findings were presented back to the CAG members for validation, further strengthening the validity and trustworthiness of the analysis.					The responses from each data collection method were combined in a new document under the headings identified by the CAG, using a simple table format. Responses were then coded to identify themes and group common responses under each sub-heading. Once the themes had been identified, collated, the solutions were drawn out, extrapolated via similar sentiment, and grouped under each subheading, in order to inform recommendations and highlight solutions as the focus of the LSS project.	The responses from each data collection method were combined in a new document under the identified theme headings, using a simple table format. Responses were then coded to identify themes and group common responses under each sub-heading. Once the themes had been identified and collated, the solutions were drawn out, extrapolated via similar sentiment, and grouped under each subheading, in order to inform recommendations and highlight solutions as the focus of the LSS project.	The focus group and the written responses from the online survey were analysed together. Data was coded by key members from the PWG, who combed the data for key words and phrases which stood out. The 'code words' representing data points were then recorded and reproduced when encountered again. During this process, major themes began to emerge and to be identified by the analysts. Codes were input into Microsoft Whiteboard where they were organised into major themes based on the frequency of the codes, and the commonality of themes they represented, as agreed upon by the analysts. Codes were grouped together when they were representative of a similar category/subtheme. Initially, eight tables were set up to organise this data. Under the major theme headings were sub-themes, major categories and minor categories. The data in the tables was then refined to include the final sub-themes, major and minor categories. During the process the major themes heading each table were reduced to five to best represent the data when the whole picture was complete.		

LONG STORY SHORT

RESHAPING THE NARRATIVE OF WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH

Women's Health
LODDON MALLEE

WOMEN'S HEALTH
Goulburn North East