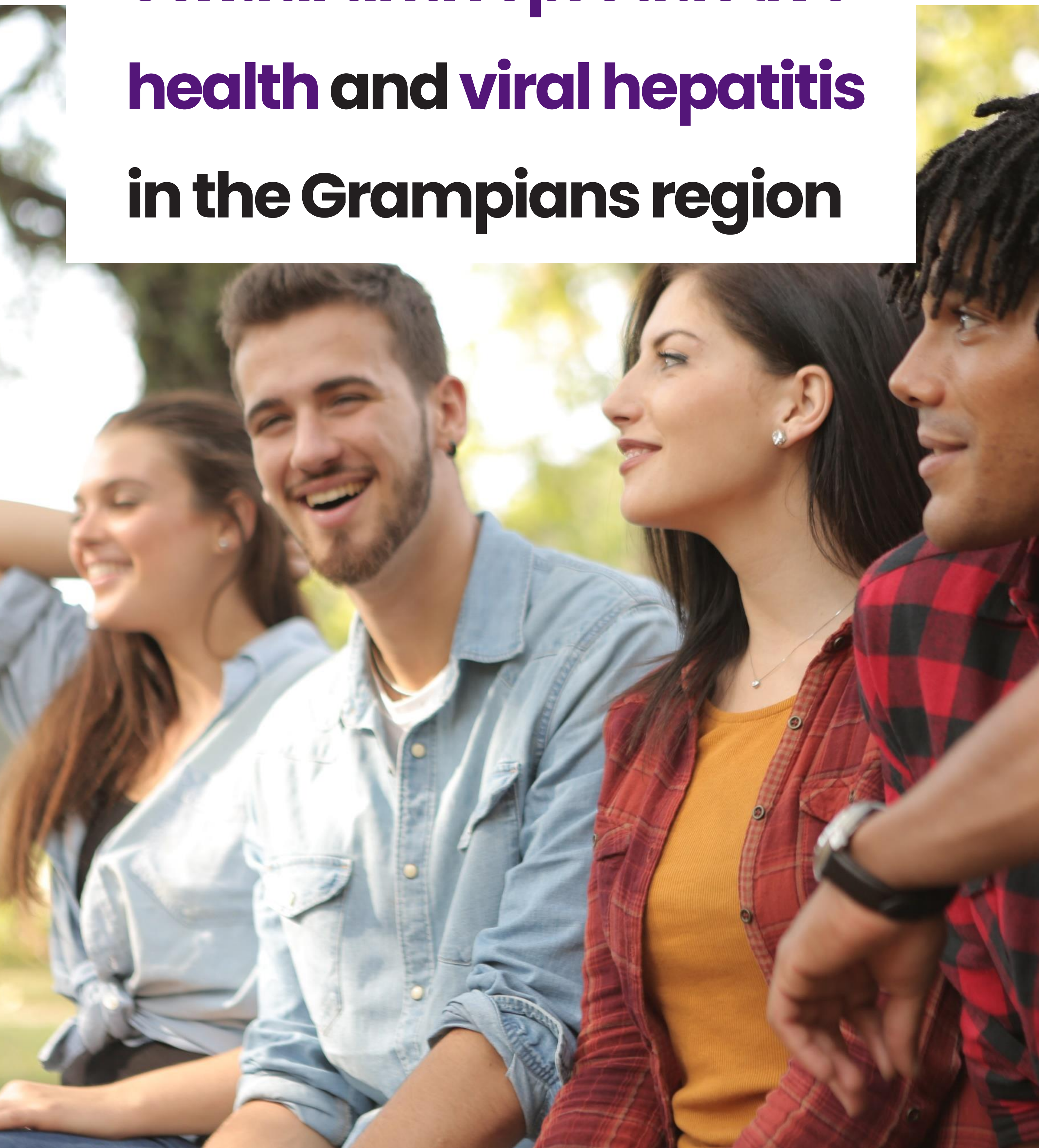
Project Report 2023 - 2029

Sexual and reproductive health and viral hepatitis in the Grampians region



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Acknowledgement of Country

We proudly acknowledge Victoria's First Peoples and their ongoing strength in practising the world's oldest living culture. We acknowledge the Traditional Owners of the lands and waters on which we live and work, and pay our respect to their Elders past and present. We acknowledge that the lands of the Grampians region were never ceded. Always was, always will be, Aboriginal land.

We acknowledge the First Peoples of the Wimmera Southern Mallee, Gariwerd/Grampians and Central Highlands regions of Victoria, their connections to land, waterways and community, and that we together live and work on *Wotjobaluk, Jaadwa, Jadawadjali, Wergaia and Jupagalk, Djab Wurrung, Eastern Maar, Dja Dja Wurrung, Wurundjeri* and *Wadawurrung country.*

Victoria's Aboriginal communities continue to strengthen and grow with the ongoing practice of language, lore and cultural knowledge. We recognise the contribution of Aboriginal people and communities to Victorian life and how this continues to enrich our society more broadly. We acknowledge the contributions of generations of Aboriginal leaders who have come before us, who have fought tirelessly for the rights of their people and communities. We acknowledge Aboriginal self-determination is a human right as enshrined in the *United Nations Declaration on the Rights of Indigenous Peoples*, and we commit to working towards a future of equality, justice and strength.

Finally, we acknowledge that there are long-lasting, far-reaching and intergenerational consequences of colonisation and dispossession. The reality of colonisation involved the establishment of Victoria with the specific intent of excluding Aboriginal people and their lores, culture, customs and traditions. Over time, the development of Victorian laws, policies, systems and structures explicitly excluded Aboriginal Victorians, resulting in and entrenching systemic and structural racism. We acknowledge that the impact and structures of colonisation still exist today. Despite the past and present impacts of colonisation, Aboriginal people, families and communities remain strong and resilient.

Adapted from

Victorian Aboriginal Affairs Framework 2018-2023 (the VAAF)
https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023

Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027
https://www.dffh.vic.gov.au/publications/korin-korin-balit-djak

Executive Summary

The challenge of providing healthcare to rural and regional Victoria is well known. But this challenge is all the more difficult when dealing with health conditions that occur in diverse populations, that are marginalised by stigma, or are influenced by limited provider supply or exclusive practice models. The conditions covered in this report all have complexities in the accessing and receiving of essential health services. This contributes to further eroding rural health outcomes.

The ***Victorian sexual and reproductive health and viral hepatitis strategy 2022-30*** describes the impact of these conditions on the population in the setting of discordant or restricted health services. The policy goes on to describe the key action areas needed to address these. The detailed reports compiled by Women's Health Grampians and data compiled by Women's Health Victoria in the Victorian Women's Health Atlas further describes the enormity and complexity of the issue. Key points include limited access to early medical abortion and long-acting contraception.

In setting up this report attention was paid to the work already done in the area both locally and across the state. Many reports and productions from other agencies have been considered in developing the recommendations in this report. Importantly a regional project steering group was formed with key membership from relevant organisations including the Community Health Sector, Women's Health advocacy, health and social care providers and the Public Health Unit. This provided strategic oversight on the findings and suggestions for improvement.

The methodology of investigation, as described in the report, involved detailed and respectful conversations across many service points in the community and beyond. This has given a very clear picture of what is happening, what is not happening and what needs to be done.

Complex problems require multifaceted solutions. To do this, attention has been focused on the existing service models with a view to potential enhancements; where integration with existing providers and with out-of-region providers is supported. For all of the conditions it has been necessary to propose alternative pathways to care, where generating the knowledge in the community, facilitating the care navigation, and developing new systems are core.

A summary of the findings of the consultation are;

A responsive sexual and reproductive health service that meets the needs of the population is required, which supports individuals and communities to enjoy positive sexual and reproductive health and wellbeing, free of stigma, racism and discrimination.

- A system that provides the Grampians population needing abortion or contraception with access to best practice evidence-based treatment and care
- A system that provides the Grampians population who have, or are at risk of a Sexually Transmitted Infection, access to best-practice evidence-based prevention, treatment and care
- A system which supports the Grampians population to reduce their risk of acquiring hepatitis and supports those living with hepatitis to have access to best practice evidence-based

treatment and care, where stigma, racism and discrimination are not a barrier to hepatitis prevention, testing, treatment, and care.

Key recommendations in this report are;

To build a Responsive Sexual Health Service that will meet the needs of our population, through the

- Provision of care navigators for unplanned pregnancy
- Facilitated provision of State-wide referral tools
- Targeted support and up-skilling of existing provider networks

Capacity Building in the Health and Community Sector

- Region wide service provider education
- Establishment of relationships with key workers and community members
- Build a network of supportive services: primary care, telehealth access, social services, health promotion organisations

Health Promotion

- Provision of a sexual health and viral hepatitis health promotion officer/s
- Development of a health promotion program in partnership with existing health promotion programs
- Prevention and treatment awareness for unintended pregnancy, sexually transmitted infections and blood borne viruses

Key investments required to action these recommendations include:

- Provision of a sexual health and viral hepatitis health promotion officer/s
- Provision of care navigators for unplanned pregnancy
- Resourcing and delivery of region-wide health promotion
- Provision of sector-wide education programs

I commend this report as a way forward to address these pressing issues, and congratulate the 3 principal authors, Juliana Betts, Genevieve Lilley and Karen Worthington for their detailed analysis and strategic approach to address the problems identified.

Dr Rob Grenfell, Executive Director – Strategy and Regions, Grampians Health

The Sexual and Reproductive Health and Viral Hepatitis Steering Committee comprises of the following members:

Women's Health Grampians
Shannon Hill

Ballarat Community Health
Louise Feery
Michelle Orr
Joanna Labbett

Grampians Health
Dr Robert Grenfell

Grampians Public Health Unit
Dr Tara Purcell
Suzannah Burton

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Terminology used in this report

Woman: In this report "woman" refers to any woman or gender-diverse person who has a uterus and needs to access women's sexual and reproductive health services.

Unplanned pregnancy: The term "unplanned pregnancy" is used to refer to any pregnancy that has occurred without the express intention of the woman to conceive. In many cases these pregnancies will be wanted pregnancies. We also note that circumstances may result in a woman choosing to abort a pregnancy that had been planned and/or wanted. Regardless of the above circumstances, access to abortion is an essential component of women's reproductive health care.

Medical and surgical abortion: The terms "medical abortion" and "surgical abortion" are used to refer to elective termination of pregnancy.

Abbreviations used in this report

BCH: Ballarat Community Health

CALD: Culturally and Linguistically Diverse

GH: Grampians Health

GP: General Practitioner

GPHU: Grampians Public Health Unit

IHCN: Integrated Hepatitis C Nurse

LGA: Local Government Area

MSM: Men who have sex with men

PHN: Primary Health Network

PPH: Prevention and Population Health

STI: Sexually Transmitted Infection

1 Introduction

Sexual and reproductive health and viral hepatitis in the Grampians region 2023-2029 outlines the methodology and findings of a rapid sexual and reproductive health and viral hepatitis needs assessment of the Grampians region, the processes used to synthesise this information and the resultant project plan for implementation. The Grampians Public Health Unit (GPHU) has worked closely with Ballarat Community Health (BCH) and a broad range of stakeholders, to understand the current sexual and reproductive health landscape in the region- including key strengths and resources, barriers to accessing sexual health care and possible solutions for improving outcomes, with a focus on improving health equity.

Sexual and reproductive health is a significant population health issue because it is fundamentally linked to the health, social and economic outcomes of communities. When viewed holistically and positively, sexual health is about well-being, not merely the absence of disease. It involves respect, safety, and freedom from discrimination and violence (WHO, 2023).

Viral hepatitis has been incorporated into this stream of work, in line with the Victorian Government's *Sexual and reproductive health and viral hepatitis strategy 2022-30*, which recognises the common element of "treatment as prevention" for viral hepatitis and sexually transmitted infections. A concerted effort to address health inequalities among priority population groups and counteract stigma is a common mechanism to improving both sexual health and viral hepatitis outcomes.

There are many strengths and assets to build upon within the Grampians region to improve sexual and reproductive health and viral hepatitis outcomes. Some of these community strengths include:

- an effective sexual and reproductive health hub run by BCH (part of the strong, supported network of 11 Victorian Government funded SRH hubs throughout the state)
- a specialist sexual health clinic run by BCH
- a number of experienced sexual and reproductive health nurses and health promotion experts within the Grampians catchment region
- evidence that people living with hepatitis C are engaging in treatment uptake at rates above the state and national averages
- the presence and work of Women's Health Grampians – a strong local voice advocating for the health and wellbeing of Grampians women
- a commitment from all eleven Local Governments in the region to prioritise action to prevent violence against women and promote gender equity in their municipal public health and wellbeing plans

Despite these strengths, the Grampians region as a whole demonstrates a profound lack of accessible sexual and reproductive health services, particularly for the timely access to abortion and sexual health care. In addition to this, throughout every local government area in our region, higher than average rates of intimate partner and sexual violence have been demonstrated which has significant ramifications for sexual health and wellbeing.

In order to improve sexual and reproductive health and viral hepatitis outcomes it is essential that a population health approach focusing on the principles of co-design, equity and sustainability is adopted, which builds on existing community strengths.

This plan outlines three separate goals (Figure 1), which will lay the initial foundation for this stream of work within the larger *Grampians Region Population Health Plan 2023 -2029*. These goals are:

- To build a responsive sexual health service that will meet the needs of our population
- To build capacity in the health and community sector through partnerships, networks and education
- To develop a designated sexual and reproductive health and viral hepatitis health promotion program focusing on primary and secondary prevention

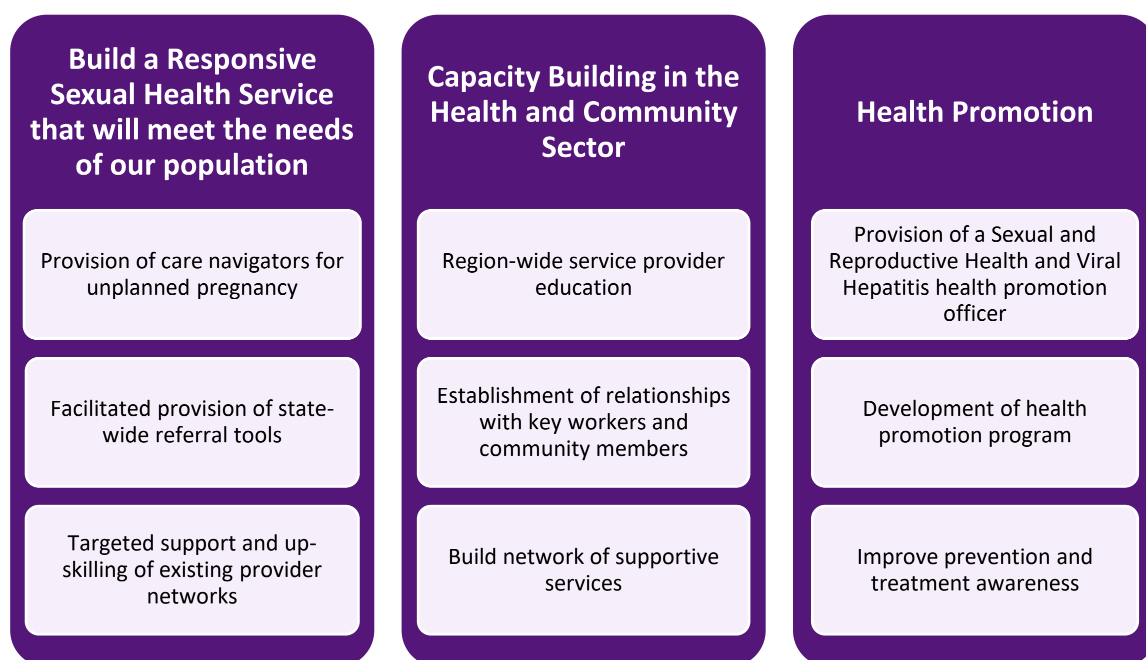


Figure 1: Goals and actions for improving sexual and reproductive health and viral hepatitis outcomes in the Grampians region

The fulfilment of these goals will be instrumental to achieving our vision of a future where people across the Grampians region will access information, advice and services for sexual health and viral hepatitis, when they need them. They will have the knowledge, resources, and support to do this.

High-quality health promotion and education will increase health literacy and empower people to seek the support they need. A regional sexual and reproductive health Care Navigator will act as a resource for personalised advice, and assistance to access services. Thirdly, the role of health and community services to improve sexual health and hepatitis prevention and management will broaden over time through targeted capacity building and engagement strategies.

Systematic processes will ensure that people at risk of hepatitis B and C are diagnosed and when necessary, linked to care and have access to treatment. These processes will engage priority populations in culturally appropriate ways, without exacerbating stigma. Existing prevention strategies will be maintained and strengthened.

Partnerships between health and community organisations will be fortified, building a supportive network. The network – built through social marketing, workforce training, and the nurturing of a motivated and engaged community of practice – will provide multiple points of contact with priority populations, promoting opportunistic connections, and ensuring that contact with expert advice can occur when the need arises. People will trust health care providers to meet their needs without fear of shame, disclosure, or discrimination.

We will see improved outcomes over time with the implementation of these changes, alongside a shift in the degree of stigma associated with sexual health issues and infectious diseases such as hepatitis. With a focus on addressing equity of access for rural residents but especially those experiencing additional disadvantage, we foresee a region where excellent health care and better health outcomes in these areas is a given for everyone.

2 Methodology

2.1 Governance

This report presents the work of the Sexual and Reproductive Health and Viral Hepatitis Stream of the broader *Grampians Region Population Health Plan 2023-2029,* and as such, ultimately reports to the *Grampians Region Population Health Plan* Steering Committee and Grampians Health (GH) Board's Primary Care and Population Health Advisory Committee (PCPHAC).

A working group consisting of sexual health nurses and health promotion staff from BCH alongside medical officers from GPHU reported to a Sexual and Reproductive Health and Viral Hepatitis Steering Committee consisting of public health and clinical experts in the region who specialise in sexual and reproductive health and viral hepatitis.

2.2 Needs Assessment

A mixed-methods needs assessment was undertaken with the key objectives of discerning:

1. What is the population profile of the Grampians region with respect to sexual and reproductive health priority populations?
2. What is the incidence of sexually transmitted infections in the region?
3. What is the incidence and prevalence of hepatitis B and hepatitis C infection in the region?
4. What local services are available for people seeking care related to:
    a. abortion and contraception;
    b. prevention and management of sexually transmitted infections; and
    c. prevention and management of viral hepatitis (Hepatitis B and hepatitis C).
5. What barriers and enablers exist for people seeking access to sexual and reproductive health and viral hepatitis services?

Data were obtained from publicly available data sources as referenced, (e.g., Australian Bureau of Statistics) and disaggregated by local government area (LGA) where possible. (See ***Appendix 1*** for Data tables and sources).

Interviews with key informants involved in the delivery of prevention and management services for sexual and reproductive health and viral hepatitis in the region were conducted to provide insight into how people experience health care. They were asked to describe the factors affecting people's decision making along a "patient journey" and what they see as helping to improve sexual health and hepatitis management for our community.

2.3 Data synthesis and the development of recommendations

Thematic analysis was undertaken to arrive at the key findings with regard to the current barriers and enablers for access to abortion and contraception, and the prevention and management of sexually transmitted infection and viral hepatitis, in the region and the current service provision landscape.

To investigate access to abortion and contraception, the working group brainstormed a "problem tree" of the current barriers in the region based on key informant interviews, with consideration to key upstream determinants for targeted preventive action (see ***Appendix 2***).

Proposed solutions highlighted through this process were formally presented to the Sexual and Reproductive Health and Viral Hepatitis steering committee for review and feedback, and the final recommendations have been endorsed by the steering committee through an iterative process.

2.4 Implementation, monitoring and evaluation plan

The recommended actions from this report point to a series of activities for implementing the plan in the region. In keeping with the broader *Grampians Region Population Health Plan 2023-2029*, the LETTERS framework will be used which incorporates the following elements:

- Leadership and governance
- Engaging with people, processes and evidence
- Training and Education
- Tools and resources
- Evaluation and audit
- Reporting and communication
- Sustainability

Interventions based on the recommendations of this report, alongside a monitoring and evaluation plan, will be designed and implemented using a process of co-design which will include implementers and end-users to ensure feasibility and sustainability.

Evaluation and audit processes will be informed by the RE-AIM framework, the explanation of which is outlined in Table 1 below.

Table 1: Explanation of RE-AIM domains (Adapted from Glasgow and Estabrooks, 2018)

RE-AIM Domain	Explanation - Definition
Reach	WHO is (was) intended to benefit and who actually participates or is exposed to the intervention? Measured by number and similarity of participants to your target group.
Effectiveness	WHAT are (were) the most important benefits you are trying to achieve and what is (was) the likelihood of negative outcomes? Measured by change on key outcome(s) and consistency across subgroups.
Adoption	WHERE is (was) the program or policy applied and WHO applied it? Measured by what settings and staff take up the intervention and which do not.
Implementation	HOW consistently is (was) the program or policy delivered, HOW will it be (was it) adapted, HOW much will (did) it cost, and WHY will (did) the results come about?
Maintenance	WHEN will (was) the initiative become operational; how long will (was) it be sustained (setting level); and how long are the results sustained (individual level)? Measured by longevity of effects (individual level) and program sustainability (setting level).

3 Needs Assessment

3.1 What is the population profile of the Grampians region with respect to sexual and reproductive health priority populations?

Sexual and reproductive health is applicable to people of all ages, genders, and ethnicities, however, key priority populations relevant to the Sexual and Reproductive Health and Viral Hepatitis stream include:

- Aboriginal people
- People from culturally and linguistically diverse (CALD) backgrounds
- Young people (15-29 years)
- Women of reproductive age (15-44 years)
- Gay, bisexual and other men who have sex with men (MSM)
- Trans and gender diverse people
- People experiencing intimate partner violence and sexual violence
- People in custodial settings

There is a broad range of ethnic backgrounds represented throughout the Grampians Catchment area. All except one local government area (LGA) demonstrated a higher proportion of people who identified as Aboriginal or Torres Strait Islander compared with the state in the 2021 census (range 0.8% - 2.1%, state proportion: 1.0%). People from CALD backgrounds, including refugees, live across the region although at lower rates than across other parts of Victoria (see ***Appendix 1*** for data sources and tables).

Overall, the number of young people in the region is lower than the state average across most age groups which has particular relevance for calculating disease incidence rates. Horsham, Ballarat and Moorabool LGAs have a slightly higher proportion of people aged 15-19 years than the state average (see ***Appendix 1*** for data sources and tables).

The proportion of women who are of reproductive age varies throughout the region from 25.3% (Hepburn) to 37.9% (Ballarat), state average (35.2%).

Data from the 2017 Victorian Population Health Survey showed variability across LGAs in terms of the proportions of the population identifying as LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex and queer). The highest proportion of people identifying as LGBTIQ+ was in Ballarat LGA at 9.6% of the population, while the lowest was in Yarriambiack LGA at 1.8%. This is likely an underestimation due to the ongoing stigma experienced by LGBTIQ+ people in regional areas. There is currently no data available on the proportion of the population who identify as MSM.

Data demonstrated higher than average rates of sexual and intimate partner violence across the region, which is an indicator of poor sexual health outcomes. Of note, rates of sexual offences for females were higher than the Victorian average across 8/11 LGAs in the Grampians region (range: 4.2 per 10,000 (Hepburn) - 25.1 per 10, 000 (Northern Grampians), LGA average: 14.9 per 10, 000). Rates of intimate partner violence against females were higher than the state average across 5/11 Grampians region LGAs and tended to be 3-5 times the rate of intimate partner violence against males.

The Grampians catchment includes two correctional facilities; Hopkins Correctional Centre located in Ararat and Langi Kal Kal Prison located in Pyrenees. Prisoners are provided with on-site medical care.

3.2 What is the incidence of sexually transmitted infections in the region?

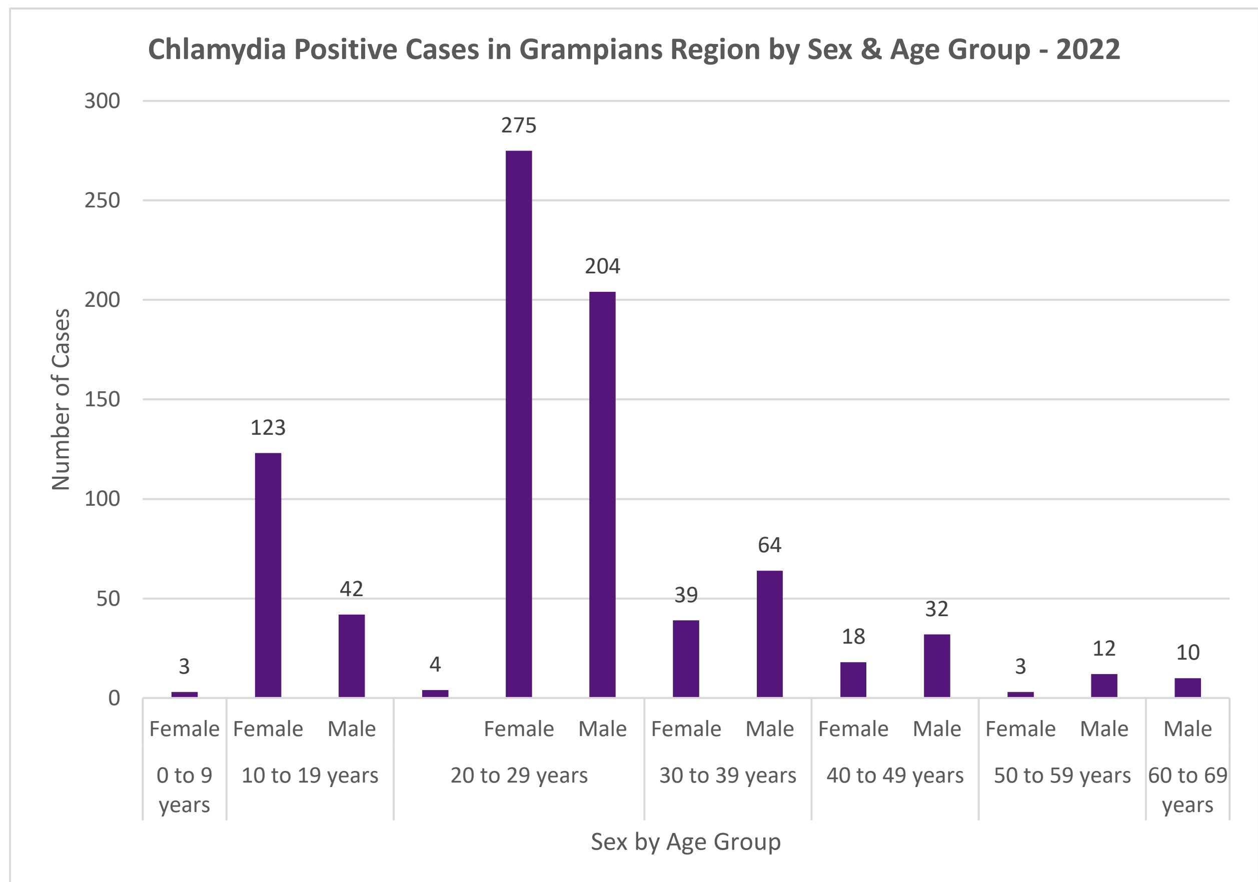
Overall, based on data from 2022, STI notification rates were lower across the region compared with the state-wide rate. However, there were several notable exceptions to this, with Pyrenees LGA demonstrating higher than state average rates of chlamydia, and Hepburn LGA demonstrating a higher rate of notification for infectious syphilis (see ***Appendix 1*** for data tables and sources).

Chlamydia

The most commonly notified STI in the region is chlamydia with crude rates ranging from 148.4 per 100,000 in Yarriambiack LGA to 369.8 per 100,000 in Pyrenees LGA (Victorian average 367.4 per 100, 000).

As depicted in figure 2, the vast majority of chlamydia notifications in the Grampians region pertain to people aged 20-29 years.

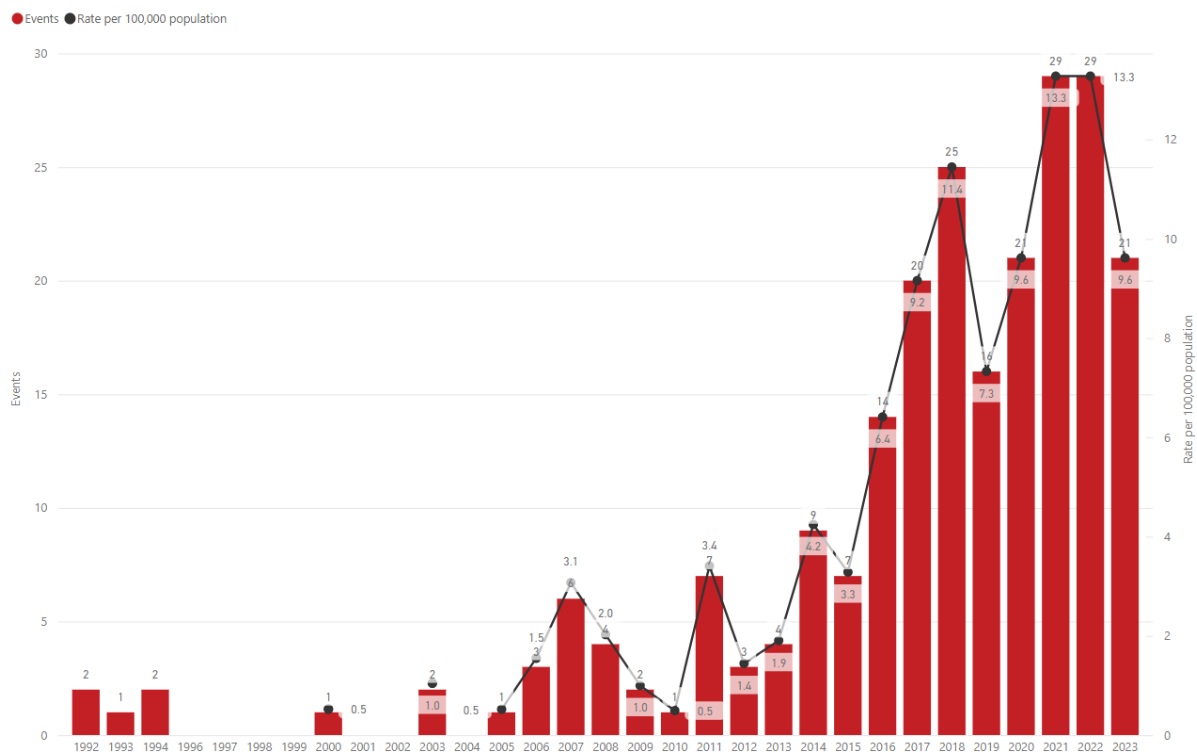
Figure 2: Chlamydia positive cases in the Grampians region by sex and age, 2022 (Source: NNDSS , 2023)



Syphilis

Cases of infectious syphilis have increased over the past 5 years in the Grampians and in Victoria generally, with 2022 notification rates exceeding previous years (Figure 3). In Victoria, and Australia, this increase has been accompanied by a notable increase in notifications among women of reproductive age (Borg et al, 2023). In the Grampians region, an increase in notifications among women of reproductive age has also been observed over the past five years, although notifications among males still predominate (83% of all infectious syphilis notifications in the region in 2022).

Figure 3: Number of infectious syphilis notifications (events) and rate per 100, 000 for the Grampians region over time. (Source: Department of Health (Victoria) 2023, [data updated 12 September 2023]).



Rates of infectious syphilis ranged from 0.0 per 100, 000 (West Wimmera, Hindmarsh and Central Goldfields LGAs) to 45.0 per 100,000 in Hepburn LGA in 2022. The 2022 Victorian average rate of infectious syphilis was 27.4 per 100,000. One case of congenital syphilis was recorded in the region in 2018 in Northern Grampians LGA.

3.3 What is the incidence and prevalence of hepatitis B and hepatitis C infection in the region?

Hepatitis B

For the whole Grampians catchment region, there have been 21 incident cases of hepatitis B over the past 10 years, demonstrating low case numbers (Department of Health, 2023). The prevalence of chronic hepatitis B (as determined by notifications for “unspecified” hepatitis B) are also considerably lower than the state average. Using a combination of notification and census demographic data, the Viral Hepatitis Mapping Project were able to estimate the prevalence of chronic hepatitis B in the region. The estimated prevalence of chronic hepatitis B infection was lower than the state average across the Grampians region (range: 0.42% (Maryborough/Pyrenees SA3) – 0.47% (Ballarat SA3), state average: 0.96%). However, access to hepatitis B management (measured through evidence of viral load monitoring and/or treatment with relevant antiviral medication) was considerably lower than state average across the region.

Estimating the coverage of hepatitis vaccination across the region is challenging because there are no publicly available data sources which incorporate vaccination records prior to 1996 and data on historical childhood vaccination coverage does not take into account population mobility. Hepatitis B vaccination has been included on the immunisation schedule for all infants in the first year of life since 2000. The Grampians region generally demonstrates higher than state average rates of vaccination coverage for children at 1 year of age (state coverage: 94.3%) (PHIDU, 2023).

Hepatitis C

Rates of newly acquired hepatitis C reported to the Victorian Department of Health tend to be higher across the Grampians region than the state average (Department of Health, 2023). With comparatively low population density, this reflects an approximate average of 4 cases per year over the past 10 years. The majority of new notifications reside in Ballarat LGA.

The prevalence of chronic hepatitis C infection in the region was estimated to be above state average across most of the Grampians catchment area (WHOCCVH, The Doherty Institute, 2021). The proportion of people living with chronic hepatitis C who accessed treatment was estimated to be between 48.3% (Ballarat SA3) and 75.9% (Creswick, Daylesford, Ballan SA3) (state average: 55.2%).

3.4 What local services are available for people seeking care related to:

- abortion and long-acting reversible contraception;
- prevention and management of sexually transmitted infections; and
- prevention and management of viral hepatitis (hepatitis B and hepatitis C).

Abortion and long-acting reversible contraception

There are few abortion providers in the region. One public hospital and two private clinics provide surgical abortion in Ballarat and Maryborough (Grampians Health (GH) Ballarat Choices Clinic, Ballarat Women's Clinic and Nightingale Clinic Maryborough). Abortion services for women with gestation greater than 12 weeks are not available in the Grampians region.

Two public clinics providing medical abortion were identified in Ballarat (GH Ballarat Choices Clinic, BCH), and only four private providers listed on 1800 My Options in other areas (Ochre Health Medical Centre (Creswick and Clunes), Hamilton Street Medical Centre (at Goolum Goolum Aboriginal Co-operative, Horsham), Nightingale Clinic (Maryborough) & Ballarat Women's Clinic (Ballarat)) (Western Victoria Primary Health Network, 2023 and 1800 My Options, 2023).

This is in keeping with the finding that rates of PBS 10211K prescriptions (for medical abortion drugs) per 1,000 population by prescriber location tended to be lower than the state LGA average for all locations except for Horsham and Central Goldfields (see ***Appendix 1-*** Table A1.6). The rate of PBS 10211K prescriptions per 1,000 population by patient location however, demonstrated a significant demand for services throughout the region. Ararat in particular demonstrated a rate of PBS 10211K prescriptions by patient location of 10.6 per 1,000 population, yet the rate of prescriptions by provider and pharmacy location is 0, indicating no local service provision. This demand and supply mismatch is reproduced throughout most LGAs in the region, particularly so for Moorabool and Pyrenees LGAs, where the rate of prescription by provider and pharmacy location is 0, despite these LGAs demonstrating higher than average numbers of people residing in the area obtaining medical abortion. These findings indicate that people living within the Grampians catchment area are seeking termination of pregnancy from outside of their local government area and likely outside of the Grampians catchment area. Of note, the number of abortion services available in the Geelong region is close to triple that which is available in the Grampians region (Western Victoria Primary Health Network, 2023). At the time of writing this report, two Grampians region health services (East Grampians Health Service in Ararat and Maryborough District Health Service) were in the process of establishing women's health clinics with an intention of offering medical and surgical abortion.

As with abortion services, data demonstrates that women across large parts of the region must travel long distance to access long-acting reversible contraception.

Sexually Transmitted Infections

Specialist sexual health services in the region are limited to Ballarat. BCH runs a Sexual Health Clinic at their Lucas site, a Women's Sexual and Reproductive Health Hub at their Wendouree site, and provides a weekly Sexual Health Nurse Clinic at Headspace Ballarat. Only seven GP clinics in the Grampians region currently choose to promote their services on 1800 My Options for STI testing

(Hamilton Street Medical Centre Horsham, Read Street Medical Centre Horsham, Springs Medical Daylesford, Nightingale Clinic Maryborough, Ararat Medical Centre, UFS Medical in 3 Ballarat locations, and Elms Family Medical Centre in Bacchus Marsh). It is likely other GP clinics are providing these services in the region when requested by patients.

There are two clinics in the Grampians region providing HIV care, HIV post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PREP) (BCH Sexual Health Clinic and Springs Medical, Daylesford). PEP is also available at Grampians Health Ballarat and Horsham emergency departments. Provision of STI screening and contraception is reported to be a regular clinical service of the Doctors in Secondary Schools (DISS) program. Nine secondary schools in the Grampians region participate in DISS, and a similar program is provided to Daylesford Secondary College by Springs Medical independent of DISS. Unfortunately, the established DISS program at Ararat Secondary College is currently not running due to GP shortages.

There are three Aboriginal Community-Controlled Health Organisations (ACCHOs) offering clinical services in the Grampians region (Ballarat and District Aboriginal Co-operative (BADAC) in Ballarat, Budja Budja Aboriginal Co-operative in Halls Gap, and Goolum Goolum Aboriginal Co-operative in Horsham). All three services report regular STI screening occurring as a part of regular Aboriginal and Torres Strait Islander health checks.

Viral Hepatitis

Management of hepatitis B in the Grampians is highly centralised with only two hepatitis B s100 prescribers in the eastern end of the region. The bulk of hepatitis B management in the region is undertaken by the GH Ballarat Liver Clinic. The current model of care has testing performed in GP clinics, community health (in some cases as part of refugee intake health assessment), prisons and hospitals. New cases are also notified to GPHU via BUPA Health Undertakings (generated when an individual applies for permanent migration). The diagnosing clinician is responsible for either managing or referring, and in the case of a health undertaking, the individual has an obligation to link with a care provider (these individuals are contacted by GPHU and advised of their obligation and options for care). According to the GH Ballarat Liver Clinic, GPs in the region are generally not involved in the monitoring of their patients with hepatitis B, instead referring to GH Ballarat Liver Clinic for monitoring and/or treatment. There are no outreach services from GH Ballarat Liver Clinic for the region, but the clinic is able to offer more care via telehealth since the COVID-19 pandemic. The BCH Integrated Hepatitis C Nurse (IHCN) is able to support the GH Ballarat Liver Clinic by performing “FibroScan” (a type of liver ultrasound) for their patients with hepatitis B and hepatitis C across the region.

While hepatitis C can now be managed in primary care, management is still occurring predominantly in specialist services in the Grampians. The current model of care has testing performed in GP clinics, prisons and hospitals. The diagnosing clinician is responsible for either treating or referring to specialist care for treatment. Few clinicians are providing treatment in the Grampians region and none outside of Ballarat. Current referral options are the GH Ballarat Liver Clinic, and the BCH IHCN. The two services work together and share referrals ensuring the most appropriate care pathway. The GH Ballarat Liver Clinic manages all referrals in Ballarat central, passing on cases outside of Ballarat to the IHCN. The IHCN can travel across the region as needed. The number of cases is currently adequately managed between the GH Ballarat Liver Clinic and the IHCN.

3.5 What barriers exist for people seeking access to Sexual and Reproductive health and viral hepatitis services in the Grampians region?

Table 1: Key barriers to accessing care for sexual and reproductive health and viral hepatitis in the Grampians region

	Reproductive health / access to abortion	Sexual Health	Hepatitis B	Hepatitis C
Community-level factors	• Stigma • Remoteness • Misinformation/ cultural beliefs/norms • Patchy implementation of SRH education in schools	• Unavailability of condoms (behind shop counters) • Stigma	• Temporary visa holders, CALD groups not well captured in data sources • Stigma	• Stigma
Service-level factors	• High rate of Conscientious objectors (GPs and pharmacists) • Lack of services • Lack of funding • Expensive • Funding for GPs – business model • Concerns around competency • Concerns around confidentiality and privacy • Service providers unaware of local referral pathways	• Lack of local services • Concerns around confidentiality and privacy • Concerns around competency of health professionals • Underutilisation of nurses with training in SRH in the region (lack of clinical governance, funding and support) • Social care providers (e.g. youth workers) lack training in SRH • High staff turnover • Workforce shortages • Funding models (business model of GP – not as lucrative with smaller population density) • Waiting lists (long)	• Lack of local services • Services not meeting the language and cultural needs of the population • Cost and geographical barriers to accessing health services • GPs Knowledge of hepatitis risk factors and management	• Diagnostic testing can be technically difficult (IVDU) • Grampians community health AOD workers don't have access to testing (no GP, clinical governance / POC test available) • "Hard to reach" population – complex social factors impinge on access to care • Cost barriers to accessing health services • GPs knowledge of hepatitis risk factors and management / new treatment modalities • Knowledge of referral pathways (eg IHCN) • Loss to follow- up (especially for those diagnosed during pregnancy)
Individual-level factors	• Health literacy, leads to delays in seeking care, poor knowledge of prevention • Often multiple other health and social issues – competing priorities • Young people reliant on parents for transport and funding	• Asymptomatic nature of many STIs • Health literacy – especially for people with disabilities	• Asymptomatic nature of the disease • Knowledge of risk factors for the disease • Knowledge of how to navigate the health system in Australia	• Testing (venepuncture) can be difficult/painful/embarrassing with history of IVDU • Shame/stigma associated with IVDU • Asymptomatic nature of the disease • Knowledge of risk factors for the disease and new treatment / health literacy • Pregnancy / breastfeeding contraindication to treatment

3.6 Reproductive Health services: Access to abortion and contraception

There has been a comprehensive enquiry conducted by Women's Health Grampians into access to abortion and other reproductive health services in the Grampians region. They have been a key informant in our investigation, along with community nurses from Maternal and Child Health, Bush Nursing Centres, Sexual Health Services, General Practice, Alcohol and other Drug programs, the School Nurse program, Refugee Health and maternity services. We also spoke with community organisations working with migrants, Neighbourhood Houses, medical services, among others.

Key themes emerged around stigma, confidentiality, a lack of services, remoteness and barriers imposed by existing service models. Health literacy was commonly cited as contributing to people not accessing preventive care or delays in seeking help, which significantly affects outcomes, especially regarding abortion access. Additionally, shared information in small communities has a powerful effect on the types of interventions people are happy to consider, leading to suspicion about best-practice contraception.

> *"The women are worried, even scared about having foreign objects in their body (such as an IUD or implanon) as they have heard mixed, unfavourable reviews about the effects on their body and the insertion of the devices."*

(Maternal Child Health Nurse)

Funding for community sexual health nursing is extremely limited, despite a long-standing shortage in access to primary care. Nurses with qualifications in sexual health are limited to providing cervical screening, although they could offer testing for sexually transmitted infections, contraception choices or provide care in the abortion pathway. Goolum Goolum Aboriginal Health Service, which is the only abortion provider (medical only) in the western part of the region is the exception to this. The Women's Health Nurse provides information and support to women and girls seeking abortion. If the person seeking abortion is not an existing patient of the clinic, the nurse will direct them to an external GP for clinical workup. Once investigations are complete, they then attend Goolum Goolum Aboriginal Health Service for medical abortion prescription and follow up.

A higher-than-average number of GPs in our region are conscientious objectors to the provision of abortion (Keogh et al 2017), and with no provision of medical or surgical abortion in 6 out of 11 Grampians LGAs, many women have no local option for this essential women's health service. Discrimination occurs in subtle ways, blocking service access to women experiencing low socio-economic status, or other complex care issues such as drug use.

> *"Our clients need an advocate to take them to the GP. Sometimes it's too hard for them to know which problem to tackle first and the GP doesn't have enough time to work it out. Then [the client] can't take in any information"*

(Alcohol & Other Drug worker)

School sexuality education is limited and patchy, and not all schools prioritise sexuality education. Access to contraception such as condoms and emergency contraception is difficult due to barriers imposed by businesses providing these, and the absence of other alternatives.

> *"A 19-year-old wanting emergency contraception was turned away from a pharmacy because she didn't have ID"*
>
> *"[School-age] kids can't get to a doctor without their parents taking them, and it's a 2 hour round trip"*
>
> *"I would like more support from the school for us to spend more time with the students"*

(School Nurse)

Concern around expertise in services is high, compared with specialist services in bigger towns and cities. Uptake of best practice contraception particularly in young women is low and influenced by the limited capacity of our services to provide them.

We found key services were unaware of the availability of 1800 My Options (a state-wide referral service) as a source of information on sexual health services.

> *"A worker from [a remote town] had a client who wanted an abortion and asked us for information. I said she might have to go interstate but I didn't know. I think she ended up keeping the baby"*

(Youth Health Service Worker)

> *"The women using our service need really specialised pregnancy choices counselling. I tried to find someone to help at the hospital. I couldn't find anything"*

(Family Violence Service Worker)

In a strategy designed to reduce the risk of women in remote parts of the region from trying and failing to access a local service, the marketing of 1800 My Options through local health promotion was limited to primary care and community health, and incorporated attempts to recruit clinical services to list on the directory. Our research shows that increased efforts and innovative strategies to achieve this outcome, as well as broader promotion of 1800 My Options is required to ensure that women in regional towns have a service to call on when needed.

The problems described here are all compounded for women from CALD backgrounds, those using alcohol and other drugs, First Nations women and women experiencing family violence. The current private service model for primary care (general practice) across large parts of the region, but particularly in the more remote parts, requires women to self-advocate in the process of accessing services that are scarce, blocked, stigmatised, hard to find, remote, and/or costly. For women of reduced means this makes access extremely difficult if not impossible.

All of our interviewees were keenly aware of the lack of sexual and reproductive health services and were frustrated by the lack of referral options or information about services. All were keen to participate in finding solutions and getting help for their clients in the form of services and health

promotion activities. Offers of support were also made in the form of organising community groups, providing rooms to use, and contributing to funding for a sexual health nurse.

Sexual Health Services

The prevention, detection, and management of Sexually Transmitted Infections in the Grampians region encounters similar barriers to abortion access. If anything, stigma, fear about confidentiality, as well as concerns around competency are amplified. One interviewee said that (particularly as a gay man) he would not even try to get sexual health care locally, due to concerns about privacy and expertise and this attitude has been repeated by others.

> *"Go to Melbourne. Just go to Melbourne. You get everything sorted there and then by someone who knows what they're doing."*

(Community Member)

Concerns around privacy cannot be overstated, with the perception that in rural areas it is almost impossible to guarantee. This is due to the likelihood of encountering an acquaintance who works at one of the services, but also to experiences of a *laissez faire* attitude by health services staff to privacy in rural areas.

As described in the previous section, nurses with training in sexual health are underutilised across the region.

> *"I could do the STI testing, I've done the training. But I can't get access to pathology testing."*

(Community Nurse)

> *"The [person with symptoms] was sent away from ED because [their condition] wasn't seen as urgent enough. But [they] hadn't been able to get into a GP. I felt really bad for the patient, because I could have managed it"*

(Emergency Department Nurse)

As with reproductive health, health literacy regarding STIs is likely to be impacted by inconsistent sexual health education across the region. People with disabilities particularly have been identified as missing education in this area.

Youth workers interviewed reported not feeling comfortable initiating conversations about sexuality, sexual health and sexual relationships with young people, even when they had quite specific concerns, as they had never had any training in how to do this. Young people in residential care were identified as a highly vulnerable group and support workers in youth residential care reported needing training and education in sexual health to meet the complex needs of their residents. BCH has assisted in delivering training to youth workers in residential care in the Ballarat area, however high staff turnover in these settings requires flexible delivery of staff training with regular revision and support.

Condom access is limited in most areas to shops where they may be kept behind a counter to reduce theft. Condom dispensing devices are not widely available, and some are at sites that are inaccessible after hours. Women's Health Grampians have supported some local councils with the installation of

condom vending machines (CVM) or free condom dispensers, however there are 6 Grampians LGAs with no access to after-hours council installed CVMs, and 3 LGAs without any CVMs or free dispensers.

> *"[Young people] have to ask for condoms at the supermarket"*
>
> (School Nurse)

Recruiting skilled workers is harder in regional areas and this was an oft-repeated concern. Headspace in Horsham is equipped with two clinic rooms which have never been used. New management have engaged a local GP clinic which has committed to providing priority access to patients referred by Headspace, but the young person will need to go to the GP clinic to see the doctor. Management is keen to support a clinician to use the space and provide in-house sexual health services to their clients but have not been able to recruit anyone. An additional challenge with running a "youth-friendly" clinical model – which has been tried in various iterations over the years, is the population density. Without the high numbers you have in a metropolitan setting, the clinician's time will not likely be seen to be used efficiently, and will not appear to be cost-effective.

GP access is extremely limited and getting an appointment can take weeks. Getting triaged urgently for a sexual health problem is impacted upon by numerous barriers such as health literacy, stigma, and embarrassment. This leaves people needing to travel significant distances to access a specialist service. The only sexual health clinic in the region is in Ballarat – a 2-hour drive from Horsham, or 3 hours from Edenhope, Nhill or Hopetoun. However, this clinic is already over-extended, with both GPs booked well in advance and 22% of the patients coming from outside the Ballarat LGA.

Given the complexity of these issues, innovative and novel approaches are required. People living in rural areas accept that healthcare is more difficult to access, and interventions that address these challenges in a feasible and practical manner are required.

Viral Hepatitis

Hepatitis B

Establishing exactly how well hepatitis B is managed has been a challenge and further work will be required in this area. We found inconsistencies in reports from people working with at risk populations which may reflect stigma around the disease, or simply a lack of knowledge. While the number of people living with hepatitis B in the Grampians region is considered low, rates of engagement in care and treatment for those affected are estimated to be lower than Victorian state levels (WHOCCVH & The Doherty Institute, 2021).

Specialist care is centralised with only two S100 prescribers in the eastern end of the region, neither of them offering bulk billing. The only clinical pathway for management of the majority of hepatitis B patients is referral to the GH Ballarat Liver Clinic. Clinic staff report out-of-date knowledge in referrals received from Grampians clinicians, and incorrect knowledge around living with hepatitis in patients and their families. This presents challenges around ensuring patients have the correct information and maintaining supportive relationships with their primary care provider.

> *"Hepatitis B patients are still being told that they are only carriers and that they don't have to worry – it won't affect them"*

(Hepatitis Nurse)

Prior to the pandemic all appointments with the GH Ballarat Liver Clinic were face-to-face imposing an extensive travel burden for some people. The clinic reports failure to attend appointments and subsequent discharge from the clinic occurred regularly during this time.

Another barrier to accessing care is the asymptomatic nature of hepatitis B. It is likely that competing priorities take precedence when patients feel well and their condition is not impacting on their day-to-day life.

> *"Many patients don't think that hepatitis B is a big deal, because they don't feel unwell."*

(Hepatitis Nurse)

With the majority of new cases of hepatitis B in the region occurring in people from culturally diverse backgrounds, the use of interpreter services is frequently required, and this does not always occur without effort.

> *"They travelled hours for an appointment with the specialist but the GP had not indicated that an interpreter was required on the referral. They were sent back home without seeing the doctor. I don't know why they couldn't get one on the phone or even have the person escorting them interpret"*

(Settlement Case Manager)

Multiple workers involved in support services with communities provided differing reports about exactly where people go for follow up, with some suggesting a preference to attend a refugee and asylum seeker health service in Melbourne. Confirming these arrangements will require sensitive engagement with affected people and the services they use. Prior to establishment of Victoria's local public health units, linkage to care was not always confirmed for notifications of hepatitis B.

Identifying geographical areas to focus health promotion is a challenge. Refugee intake assessments are mainly undertaken in Horsham and Nhill, but this would not necessarily represent the geographical spread of people from high prevalence countries arriving in the region under other types of temporary or permanent migration.

Hepatitis C

Treatment of hepatitis C is reported to be high in the region, although there are pockets where more work needs to be done. Specialist treatment services report that general practitioners in the Grampians region are not treating hepatitis C. It is unclear whether this is because they prefer to refer, or if they are unaware that hepatitis C can often be managed in primary care. There have been reports of GPs who have previously prescribed hepatitis C treatment referring to the GH Ballarat Liver Clinic or IHCN because they do not bulk bill and their patients cannot afford to return to them for treatment.

Knowledge of referral pathways available in the Grampians is lacking, with some cases in the far west being referred out of the region for care, despite the availability of an IHCN able to travel to provide care across the region.

For people who inject drugs and have accompanying mental and social issues, including unstable housing, initiating or adhering to treatment is difficult. Supportive services for people with complex issues including injecting drug use are needed. People who inject drugs may not experience primary care services as supportive or safe due to stigma and the complexity of their health issues. In the absence of specialised health services, it can be extremely challenging for them to get their needs met.

Specific populations such as prisoners and pregnant women present unique challenges to treatment. The State-wide Hepatitis Program is successfully diagnosing and treating hepatitis C in prisons, with those released to the Grampians region while on the treatment pathway being referred to the IHCN for ongoing support as needed. However, ongoing risk behaviours during incarceration leaves this population at risk of hepatitis C infection or re-infection during their time in prison. Women diagnosed with hepatitis C via antenatal screening are unable to commence treatment until after pregnancy and completion of breastfeeding. Subsequent pregnancies can further delay commencement of treatment making this group a challenge to follow up.

> *"I had a referral for a woman who was first diagnosed in pregnancy 13 years ago. She went on to have 2 further pregnancies and was engaged in maternity care. She received no follow up from the hospital about scheduling hepatitis C treatment. She found the details of our clinic online and referred herself"*

(Hepatitis Nurse)

Interviewees reported that more health promotion and targeted work with clinicians is required to ensure that information about current treatment modalities reaches affected people who may be avoiding or declining treatment based on out-of-date knowledge. General community knowledge of hepatitis C risk factors is lacking, leading to late diagnosis in individuals who do not present as obviously at risk to health services.

Testing for hepatitis C currently requires the collection of a venous blood sample in most settings. This process can be difficult and stressful for people who have injected drugs. Additionally, the stigma associated with injecting drugs poses a barrier to accessing testing. Opportunistic testing, ideally undertaken by nurses working in Alcohol & Other Drug (AOD) support roles, is currently not routinely occurring. Many of these roles are within Grampians Community Health (GCH), an organisation which does not provide medical services. As such, it cannot provide the clinical governance or Medicare funding pathway for required testing. Nurses in these roles state that the ability for them to offer testing would increase the likelihood that people with hepatitis C could be tested, diagnosed, and treated.

4 Sexual and Reproductive Health Actions

The actions we propose to address barriers to sexual and reproductive health are divided into three categories:

1. To build a system that can be responsive to the needs of our most vulnerable community members which is pragmatically aimed at facilitating referrals to existing but enhanced/expanded services, using a sexual health care navigator,
2. To build capacity in the health and community sector to allow the above referral pathways to work,
3. To establish a wide ranging and evidence based sexual and reproductive health promotion program.

4.1 Build a Care System Utilising a Care Navigator

Care Navigator

We propose the employment of a Care Navigator (Sexual and Reproductive Health Nurse) for the region to act as a central point of contact between people in the community and health services. The role is envisaged as undertaken by a Clinical Nurse Consultant. This category of nursing expertise is defined by the nurse's acting as a clinical resource as well as undertaking related projects and development activities. We note that Nurse Practitioners are proposed to offer a solution to the problem of medical workforce shortage. Nurse Practitioners are advanced practice nurses who are endorsed by legislation to provide a range of medical services (such as specific pathology and radiology tests and medications according to their specialty). There is currently a Women's Sexual and Reproductive Health Nurse Practitioner working part time at Ballarat Community Health. The pathway to becoming a Nurse Practitioner can take several years, and while we would welcome additional capacity at this level, we also recognise that it may take years before it became available, if at all. Our proposal is a pragmatic one in the face of chronic medical workforce shortage in the region which is now being experienced nationwide.

A Clinical Nurse Consultant in the Care Navigator role can provide expertise in the field of sexual and reproductive health care and minimise the need for medical workforce investment throughout the patient journey (see ***Appendix 3*** for the proposed care navigator pathway). Medical (or Nurse Practitioner) collaboration remains an essential part of the model of care, however the time required is significantly reduced. The model thereby makes efficient use of limited resources, without compromising on patient care. It is a strategy developed by the local rural health sector to solve a rural health problem.

Access to abortion can be facilitated by the Care Navigator who can:

- undertake an initial assessment (via telehealth)
- provide pregnancy options discussion and referral to counselling if required
- organise required investigations (pathology and radiology)
- provide access to surgical or medical abortion (in consultation with a partnering doctor), and
- provide initial follow-up, including contraception counselling

Importantly, the Care Navigator will have the knowledge and skills to facilitate access for priority population groups in the region: women in remote towns, First Nations women and those experiencing socio-economic disadvantage have been found to be more likely to miss the early window of eligibility for a medical abortion, necessitating further travel to access surgical abortion, if they are able to proceed (Mazza et al, 2020). A Care Navigator familiar with the local environment can reach out to these particularly vulnerable groups to improve their access to services when they are required. While the service would be accessible to all women it is anticipated that it will provide the most intensive support to people with greater levels of disadvantage.

Care Navigator Role Extension to Sexually Transmitted Infections

Including support for the management of STIs in the care navigator pathway will be contingent on the nurse's capacity (time and expertise) and would ideally be included from the outset. The support would entail the provision of telephone assessment, advice, and potentially also arranging remote testing and treatment, using a telehealth model with links to medical support and treatment providers – at the person's location where possible. This is a complex pathway to predetermine, as assessment may require physical examination, and treatment may involve urgent initiation of therapy including injectable antibiotics. Realistically, equity of access to these services across the region is unlikely to be possible. However at least some presentations could be managed this way, reducing the number of people delaying testing and treatment, or needing to travel several hours.

Enhanced Sexually Transmitted Infection (STI) Management with Minimal or No Care Navigator Support

Without adequate investment in the Care Navigator role and successful recruitment to it, it may be necessary to adopt a less intensive approach to supporting STI management. An enhanced local information and referral system taking advantage of existing "remote" testing systems such as that offered by Melbourne Sexual Health Centre (MSHC) could be established. Steps must also be taken urgently to address local access. The development of the local workforce to provide better sexual health services and the marketing of information about where this is occurring will help. The two models outlining how this could work are shown in ***Appendices 4*** and ***5.***

4.2 Capacity Building in the Health & Community Sector

Promoting Nurse Models

Over time, the Care Navigator can build the capacity of the region to provide more care options and improve quality of care. This can be achieved through mentoring other sexual health nurses and promoting nurse-led or nurse-assisted models of care. This training would extend beyond the provision of abortion care and include support for nurses in the region to offer STI screening and treatment, and insertion of long-acting reversible contraception (LARC). These models have been tried and tested in many places outside our region and are considered an essential part of increasing access to services by experts in the field (Mazza et al, 2020). The Care Navigator can also work with other health partners such as pharmacists, pathology providers and radiology practices to reduce stigma and improve services; professional organisations may also be able to provide training. Capacity building will be enhanced through partnerships with organisations such as Sexual Health Victoria, Royal Women's Hospital, and the Primary Health Network (PHN).

Building Community Partners

The Care Navigator will have some capacity to travel in the region when face-to-face meeting with the client is important, for example if the client has special needs. Networks with community services such as Neighbourhood Houses and maternal and child health centres will be fostered to establish a network of spaces that clients can access for consultations, telehealth, or private discussions with service providers.

Workforce Capacity Building

The current climate of support for sexual and reproductive health rights provides an environment in which opportunities to promote change should be seized to build momentum and create a broader shift across the health sector.

Providing leadership in local SRH training and education will increase the skills on the ground and make further shifts easier. For example, a skilled practice nurse – who can assess, inform, and prepare a woman for an early medical abortion – makes the steps a GP needs to take to complete the service much simpler, leaving the GP more time to provide other medical services. Changes recently announced to prescribing requirements, notably the removal of the requirement to undergo training, may also add momentum to improvements in access.

Long-acting reversible contraceptive provision remains a challenge in the western part of the region due to scarce services, with a current waiting time of over 6 weeks for IUD insertion. Promoting IUDs for women, as is best practice, will be a challenge without services to provide timely access. Part of the solution to this issue could include working closely with primary healthcare partners to increase local access to effective long-term contraceptive methods, which is likely to be perceived as less risky and/or stigmatised than the provision of abortion services. This work could include supporting training for practice nurses to insert and remove Implanon and to inform and prepare women for IUD insertion.

Greater awareness by health care providers will reduce delays in people accessing services and reduce the stigma people experience if they are unsuccessful in seeking help. In our research we identified instances where attempts to engage GPs in upskilling in sexual and reproductive healthcare had been unsuccessful, due to lack of time, interest, and stability of medical workforce in rural areas. While we do still aim to engage GPs, we need to look at nursing models in which skills, knowledge and scope of practice are extended and utilised.

Activities to promote knowledge and skills in sexual and reproductive health include:

1. Build on the existing local community of practice (COP) established by Women's Health Grampians, e.g., recruit interested colleagues in the nursing workforce across the region to promote education and training in sexual health and build on the skills of those already working in this field
2. Promote partnership in existing COPs such as the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS facilitated by SPHERE) and the Victorian Clinical Network for Abortion and Contraception Care (VCNACC facilitated by CERSH)
3. Establish relationship with PHN to network with potential GP partners – including working with practice nurses only or with reception to establish triage processes that will improve timely access

4. Work with pharmacies/the Pharmacy Guild of Australia/local version of same to increase capacity of pharmacies to provide appropriate care in SRH. For example, making access to emergency contraception easier by removing barriers imposed inadvertently or unnecessarily
5. Ensure all radiographers involved in providing dating ultrasounds for women considering abortion have guidelines for sensitive practice
6. Mentor nurses to expand scope of practice thereby building strength and capacity into the network over time
7. Build nursing skills to provide contraception counselling and insertion of long-acting reversible contraceptive implants and devices
8. Support local health organisations to increase staff awareness and compliance with privacy and confidentiality regulations and to foster a culture of respect regarding patient information

4.3 Health promotion

A comprehensive health promotion strategy is needed to address health literacy, and raise awareness of, and facilitate access to, services. We recognise the work of Women's Health Grampians and Ballarat Community Health in delivering health promotion in sexual and reproductive health across the region. Our enquiry shows that these programs need to be strengthened and broadened and we propose a partnership between these organisations and the GPHU to create a strategic approach across the region.

The health promotion plan has three key priority areas. Some of these can be conducted by a health promotion team and others will need clinical expertise. For example, improving the capacity of health services may involve organising a third party to provide training, or the Care Navigator or other clinicians may be directly involved in this task.

- To raise awareness of and link people to the regional sexual and reproductive health Care Navigator
- To promote sexual health literacy through targeted health promotion and improved health education, and
- To develop a supportive environment that will enable people to enjoy good sexual and reproductive health and access sexual health services more easily

Link People to a Care Navigator

Our investigations revealed the need for innovative strategies to reach target populations – both community members and support workers who can promote linkage between people and services. Working together with health promotion organisations and local groups will help to create the right messages that will reach the right people and be noticed. This will involve traditional strategies using different media, and engagement with sites that can help promote information. This element of the health promotion plan is contingent on the position being funded. If the position is not funded, the existing 1800 My Options advice service should be promoted locally, alongside strategies to increase referral options through workforce development strategies.

Build Health Literacy

Creative avenues for building health literacy need to be developed and could include peer education programs, and the use of social media to deliver messages to local networks. Community engagement should be undertaken to improve the chance of creating messages that will be powerful and effective.

Trusted community health workers can also become a source of information for clients in target groups, and may be an effective conduit for reliable and accurate health information. Building a network of community health workers that can help deliver simple and consistent messages could be an effective way to improve health literacy.

Health literacy in younger people can be built through targeted education and health promotion programs in schools and other educational institutions. A comprehensive plan requires working across the education sector with the aim of ensuring all students receive high quality interventions in sexual health education. The *Healthy Schools Achievement Program* provides a best practice frame work for the provision of sexuality education in schools and addresses physical environment, policies and practices, and health promoting activities. Sexual and reproductive health education can be undertaken "in-house" with support, or with external providers if required and possible. Costs can pose a notorious challenge, and this would need to be considered when planning how the intervention is to occur.

Staff training should comprise part of this, with expert advice ensuring that programs are evidence-based and sustainable. Sexual Health Victoria provide state-wide relationships and sexuality education for schools, teachers, parents and carers, and could provide advice and support to Grampians region secondary schools if the resources were available to use them.

The School Nursing Program also provides an avenue for health promotion and needs to be supported to do more work in sexual health. Young people in alternative education programs need to be considered, and specific programs used to ensure they are also reached.

Develop a Supportive Environment

We aim to build a network of supportive and skilled partners across the community to promote awareness, reduce stigma, and increase access to support. If the healthy choice is the easy choice, that means contraception, abortion and STI testing are accessible to everyone who needs them. For that to be the easy choice, people need to feel confident that they will get the help they need when they ask for it without fear of judgement, exposure, expense that they cannot afford, or excessive delays.

We need to build an environment in which as many community sites as possible are partners in the dismantling of barriers to knowledge and care. These could include Maternal and Child Health Centres, Bush Nursing and other Community Health Centres, we well as organisations that provide social and other support, such as Neighbourhood Houses. Workers at these sites already provide care and advocacy to those who need it and have indicated that they are willing to extend their existing role to help support people in achieving sexual and reproductive health. They also have close knowledge of their communities and other services that can be linked into.

Working with health services to reduce delays and stigma caused by conscientious objection is a priority. GH and other services within the region need to have a publicly accessible policy that outlines their stance on the provision of abortion services and ensures that neither staff nor clients are disadvantaged because of a conscientious objection to abortion. Staff who have a conscientious objection should be supported to be transparent about this and to understand their legal responsibilities, consistent with *section 8 of the Abortion Law Reform Act 2008*. This includes requiring the objecting practitioner to refer the person to another health practitioner who does not have a conscientious objection to abortion.

Supporting local councils to ensure affordable and anonymous access to condoms is a relatively simple action that would remove some of the barriers to access that exist currently. Women's Health Grampians have worked with several Grampians LGAs to incorporate sexual and reproductive health into their Health and Wellbeing plans. We propose that the GPHU's PPH team support Women's Health Grampians to continue this work with local council in all Grampians LGAs to ensure condom vending machines and/or free condom dispensers are available, accessible, and promoted. We will work with councils to identify barriers and overcome objections where possible. Funding to ensure ongoing supply of condoms for free dispensers has been an issue for some LGAs, and GPHU could work with local council to find funding sources to sustain the program ongoingly.

5 Viral Hepatitis Actions

Hepatitis B

Streamline Diagnosis/Monitoring/Treatment Tracking and Follow-up

Our minimum goal for hepatitis B is to ensure a streamlined process for monitoring engagement in care and following up newly diagnosed people through processes employed by the GPHU Health Protection Team.

LINC-B is a pilot program aimed at working with LPHUs to achieve hepatitis B treatment goals by maximising access to hepatitis B services. Project workers can assist people diagnosed with hepatitis B to receive the information and care they need in a culturally appropriate, safe and timely manner. Individualised treatment plans will promote adherence to monitoring regimens, and hopefully can be made in a context of increased options for care, including local options.

Re-Engage People Living with Hepatitis B Who are Not Engaged in Care: Case Tracking and Health Promotion

Finding people who have been previously diagnosed but are not engaged in care will potentially prevent significant morbidity and mortality and is a goal we should aspire to. There are numerous strategies that could be employed towards this end. Individual case tracking through targeted practices, such as those that provide refugee health assessments (Lister House and West Wimmera Health Service for example), and Aboriginal Health Clinics might allow identification of people in this group. The PHN may be able to assist with the process of engaging practices and identifying patients within the practice using chronic hepatitis B algorithms. Other clinical services, such as the GH Ballarat Liver Clinic and GH Antenatal Clinics may also be able to participate in historical case tracking.

Parallel community education and engagement programs would highlight the issue and provide people with the knowledge that may motivate them to accept an invitation to attend for clinical review. LiverWELL is also able to offer support in community engagement, education, and health promotion, and would be a valuable partner. Prevention strategies such as vaccination remain essential and can be promoted alongside education. All programs need to be delivered in a sensitive way to achieve awareness without stigma, racism or the risk of discrimination.

Build Skill in Primary Care

Building the capacity of primary care providers in target areas is vital to ensure that appropriate care and follow up is offered to anyone diagnosed with hepatitis B. This will be challenging given the demands on GPs’ time, and the mobility of the GP workforce in the more remote parts of the region. Again, the PHN will be a key partner in understanding how to best engage with GPs in the region for this type of capacity building. The Doherty Institute have offered to assist the GPHU in providing education and support for GPs on hepatitis B care in the Grampians region. Cancer Council and LiverWELL also provide educational resources that may be of use.

Ideally, the GPHU and/or PHN could work with GPs in areas of need to support becoming S100 prescribers and providing hepatitis B care. An S100 prescribing GP in Horsham would relieve some of

the travel required for patients accessing treatment for hepatitis B and limit the need to travel to Ballarat to only those with more specialised needs (for example known complications and/or liver cirrhosis).

Hepatitis C

Linkage of New Cases to Treatment

As with hepatitis B, our minimum goal for hepatitis C is to ensure a streamlined process for ensuring access to treatment in newly diagnosed people through processes employed by the GPHU Health Protection Team. The region's IHCN is employed by BCH, and therefore operating outside of the GH system. Formalising the relationship between the GPHU and IHCN with a memorandum of understanding would allow sharing of new notifications to enable more timely linkage to care and access to treatment. The IHCN can offer support to the diagnosing clinician to provide treatment directly to patients without the need to refer out, or they can assist in linkage to specialist care if required.

Reach "Old" Diagnoses and Engage in Treatment

Encouraging patients who have deferred, declined, or interrupted past hepatitis C treatment to re-engage with treatment services is a goal in the *Victorian Hepatitis C Plan 2022-30*. The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) 'Beyond the C' project can support GP clinics, community health centres and ACCHOs to identify patients within their system who have been diagnosed with hepatitis C in the past, but have not attempted treatment, or have been unsuccessful with treatment. Where possible, these patients can be supported to access treatment. Engaging practices in the "Beyond the C" program through practice nurse recruitment may be an effective strategy that could be facilitated with the involvement of the PHN or Practice Nurse Association.

Given the potential for long delays to treatment and risk of loss to follow-up, the responsibility for follow-up of pregnant women diagnosed with hepatitis C should sit with the GPHU rather than individual providers. Maternal and Child Health nurses are another group who may be helpful in identifying and supporting these women and should be supported to update their knowledge of current treatments and local treatment providers.

Promote Access to Local Treatment

Referral for treatment outside of the region makes follow-up difficult and brings with it the challenge of travelling long distances to the treating service. Locally accessible treatment is an option, and we need to ensure that all clinics – including GPs, community health and other organisations are familiar with the IHCN's role in making this possible.

Health Promotion

Community education and engagement programs, in parallel with targeted re-engagement strategies, will be needed to motivate those invited to re-engage in treatment, and encourage others to identify as eligible for treatment. The GPHU PPH team will work with local community organisations in relevant sectors (harm reduction, alcohol and other drugs) to continue promoting awareness of changes to treatment experience, encouraging those cases who have previously failed or declined to re-consider and/or re-attempt accessing treatment.

Increase Testing: Raise Awareness and Make it Accessible

The goal of eliminating hepatitis C as a public health concern by 2030 relies on diagnosing all positive cases through testing. Gaps in knowledge around hepatitis C risk factors and eligibility for testing were recognised as a problem in our interviews. This could be addressed through the provision of GP education. The PHN, with support from the Doherty Institute, is ideally placed to deliver an education series on viral hepatitis, focusing on evidence-based guidelines on testing and treatment options.

To promote testing, health promotion materials for patients need to be circulated in all primary care sites. This material should raise awareness of hepatitis C risks and treatments and normalise testing for those who do not present as currently at risk. Health promotion activities should also occur beyond primary care and raise awareness in the general community of risk. LiverWELL is able to support PPH health promotion activities, with education programs targeting specific groups (e.g. Alternative school settings/TAFE) as needed.

The region's capacity to diagnose new cases will be improved by supporting options outside of testing in general practice. Supporting expansion of nurse-led models of care in Needle and Syringe Programs and Alcohol and Other Drug settings will allow for more opportunistic testing of harder to reach populations. Additionally, access to point of care/finger-prick testing outside of research settings would make undergoing the test less onerous for many people. Training of pathology collectors to provide non-judgmental and skilled services needs to be provided to reduce the experience of stigma and trauma during blood collection. If possible, a particularly skilled collector could be referred to for people who are very reluctant due to previous experience.

Prisoners

Individuals leaving prison who have engaged in injecting drug use or tattooing are at high risk of hepatitis C. While screening on admission and treatment in prisons is occurring, ongoing injecting drug use or tattooing whilst still in prison leaves these individuals at high-risk for blood-borne viruses. Actions that could improve hepatitis C prevention, diagnosis and treatment for prisoners are well described (Winter, R.J et.al 2023). Testing prisoners on release would detect those who have been infected (or re-infected) during their stay, but is a goal that presents a challenge. GPHU could partner with the Department of Justice to encourage hepatitis C screening after release from prison, and work with clinicians to design an acceptable pathway to testing for this population. Direct referral to the IHCN for testing would provide an easier pathway to testing, and would allow prompt initiation of treatment if positive.

References

1800 My Options. (2023). 1800 my options: online search for abortion services. Available at: https://pubgeomapping.1800myoptions.org.au/#7,37.02886944696474,145.14038085937503

Abortion Law Reform Act 2008 (Victoria) s8.

Borg, S. A., Tenneti, N., Lee, A., Drewett, G. P., Ivan, M., & Giles, M. L. (2023). The Reemergence of Syphilis Among Females of Reproductive Age and Congenital Syphilis in Victoria, Australia, 2010 to 2020: A Public Health Priority. Sexually Transmitted Diseases., 50(8), 479–484. https://doi.org/10.1097/OLQ.0000000000001825

Department of Health (Victoria). (2023) *Victoria, local public health areas and local government areas surveillance summary report.* https://www.health.vic.gov.au/infectious-diseases/local-government-areas-surveillance-report

Glasgow, R. E., & Estabrooks, P. E. (2018). Peer reviewed: Pragmatic applications of RE-AIM for health care initiatives in community and clinical settings. *Preventing chronic disease, 15*.

Keogh, L., Croy, S., Newton, D., Hendron, M. & Hill, S. (2017). Rural GPs and unintended pregnancy in the Grampians Pyrenees and Wimmera Regions. Available at: https://whg.org.au/wp-content/uploads/2019/08/Unintended-Pregnancy-Grampians_2017_-Final.pdf

National Notifiable Disease Surveillance System, 2023. Available at: https://nindss.health.gov.au/pbi-dashboard/

Mazza, D., Burton, G., Wilson, S., Boulton, E., Fairweather, J., & Black, K. I. (2020). Medical abortion. *Australian Journal of General Practice*, *49*(6), 324-330.

PHIDU, Torrens University Australia. (2023). *Social Health Atlas of Australia, Data by Local Government Area (2021 ASGS)* [database]. https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlases-of-australia-local-government-areas

Western Victoria Primary Health Network (2023) *Western Victoria Health Pathways: Termination of Pregnancy.* https://westvic.communityhealthpathways.org/

Winter, R.J. et.al. (2023). Consensus recommendations on the management of hepatitis C in Australia's prisons. *The Medical Journal of Australia*, 218(5), 231-237. https://www.mja.com.au/journal/2023/218/5/consensus-recommendations-management-hepatitis-c-australias-prisons

Women's Health Atlas Victoria. (2023). *Maps by priority health area.* https://victorianwomenshealthatlas.net.au/#!/

World Health Organization 2023. *Health Topics: Sexual Health*. Available at: https://www.who.int/health-topics/sexual-health#tab=tab_1

World Health Organization Collaborating Centre for Viral Hepatitis, The Doherty Institute (2021) *Viral Hepatitis Mapping Project: Online Portal* [database] https://ashm.org.au/vh-mapping-project/

Appendices

Appendix 1. Data tables and sources

Appendix 2. Abortion access problem map

Appendix 3. Care Navigator supported pathway – abortion

Appendix 4. STI testing and treatment service plan with Care Navigator

Appendix 5. STI testing and treatment service plan without Care Navigator

Appendix 6. Health promotion plan detail

Appendix 1. Data tables and sources

Table A1.1 Aboriginal and/or Torres Strait Islander peoples, persons born overseas and languages spoken in the Grampians catchment area (2021 Census Data) (Source: Australian Bureau of Statistics, 2023)

	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victoria
Aboriginal and/or Torres Strait Islander peoples	0.8%	1.6%	1.6%	1.6%	1.6%	1.8%	2.0%	2.1%	1.8%	1.0%	1.4%	1.0%
Persons born overseas	6.7%	10.5%	7.1%	6.7%	9.2%	11.3%	9.6%	9.2%	11.3%	14.0%	14.3%	35.0%
5 most common countries	England NZ Philippines India Germany	England Myanmar Thailand Philippines India	England India Philippines NZ Thailand	England NZ India Philippines Netherlands	England Philippines India Taiwan NZ	England NZ India Philippines Taiwan	England NZ Netherlands Philippines Scotland	England NZ Philippines Netherlands Scotland	England India NZ Philippines China	England NZ Netherlands Germany USA	England India NZ Scotland Malta	India England China NZ Vietnam
Uses a language other than English at home	2.4%	7.1%	4.7%	2.9%	5.4%	5.0%	2.2%	3.0%	7.0%	4.8%	7.8%	30.20%
5 most common languages	Tagalog Italian German Gujarati Malayalam Filipino	Tagalog Malayalam Vietnamese Filipino Greek Nepali Samoan	Malayalam Italian Mandarin Nepali Tagalog	Malayalam Spanish Greek Nepali Punjabi	Mandarin Tagalog Filipino Punjabi Spanish	Mandarin Punjabi Urdu Samoan Filipino	French Italian Japanese Tagalog German	Filipino Nepali Greek Mandarin Tagalog	Mandarin Punjabi Malayalam Hindi Urdu	Italian German Mandarin French Serbian	Punjabi Italian Hindi Spanish Greek	Mandarin Punjabi Vietnamese Greek Arabic

Table A1.1 Age Structure for Total Population, by Local Government Area (2021 census data) (Source: Australian Bureau of Statistics, 2023)

	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victoria
0-4 years	6.0%	5.0%	5.7%	4.3%	4.9%	4.9%	4.1%	3.9%	5.8%	4.1%	6.3%	5.8%
5-9 years	5.1%	4.9%	6.2%	5.0%	5.0%	5.1%	5.0%	5.1%	6.4%	4.8%	6.8%	6.2%
10-14 years	5.7%	5.0%	6.4%	6.3%	5.1%	5.2%	5.6%	5.7%	6.5%	5.3%	7.0%	6.0%
15-19 years	4.1%	5.4%	5.8%	5.3%	4.7%	4.7%	5.1%	5.1%	6.1%	4.4%	5.7%	5.6%
20-24 years	3.4%	3.9%	5.6%	3.7%	4.7%	4.7%	3.9%	4.1%	6.3%	2.8%	5.1%	6.3%
25-29 years	4.6%	5.6%	6.3%	4.2%	5.4%	5.7%	3.9%	4.3%	7.1%	3.5%	6.0%	7.3%
30-34 years	4.5%	5.2%	6.3%	4.7%	5.8%	6.4%	4.6%	4.4%	6.6%	4.3%	6.7%	7.7%
35-39 years	5.0%	4.7%	5.8%	4.5%	4.9%	5.5%	4.9%	4.0%	6.4%	5.0%	6.9%	7.5%
40-44 years	4.8%	4.6%	5.3%	4.4%	4.5%	5.5%	5.1%	4.2%	6.0%	5.5%	6.7%	6.6%
45-49 years	5.1%	5.0%	5.9%	4.8%	5.5%	6.0%	6.6%	5.5%	6.2%	6.7%	6.6%	6.4%
50-54 years	7.8%	6.6%	6.0%	6.5%	6.8%	6.8%	8.1%	7.0%	6.0%	7.9%	6.9%	6.3%
55-59 years	8.4%	7.4%	6.6%	8.0%	7.6%	7.1%	7.5%	7.6%	5.9%	8.5%	6.4%	5.9%
60-64 years	8.7%	8.6%	6.8%	9.2%	8.2%	7.6%	8.5%	8.1%	5.8%	9.1%	5.9%	5.6%
65-69 years	8.1%	7.3%	5.8%	8.2%	7.9%	7.3%	9.0%	8.5%	5.5%	9.5%	5.4%	4.9%
70-74 years	7.3%	6.5%	5.3%	7.2%	7.2%	6.6%	8.0%	8.2%	5.0%	7.9%	5.0%	4.4%
75-79 years	4.4%	5.4%	3.9%	5.7%	5.4%	4.5%	5.1%	6.2%	3.6%	4.9%	3.2%	3.1%
80-84 years	3.6%	3.9%	3.0%	3.7%	3.2%	3.2%	2.7%	4.4%	2.4%	2.9%	1.7%	2.2%
85+ years	3.6%	5.0%	3.2%	4.5%	3.2%	3.1%	2.5%	3.7%	2.5%	2.8%	1.7%	2.2%

Key:

Lower than the state aggregated figure

Higher than the state aggregated figure

Table A1.3 Proportion of people who identify as Lesbian, Gay, Bisexual, Transgender, Queer (or questioning) and Intersex (LGBTIQ+) in the Grampians region (Source: Victorian Agency for Health Information, 2020)

	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victoria
Adults who identify as LGBTIQ+ (2017)	2.5%	3.2%	3.3%	1.8%	5.1%	2.2%	3.8%	5.2%	9.6%	7.5%	4.0%	5.70%

Table A1.4 Family and sexual violence indicators, by Local Government Area (Source: Women's Health Atlas Victoria, 2023)

	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victorian LGA average
Rate of sexual offences (per 10,000) – Female	25.0	22.8	24.5	16.8	25.1	23.6	19.6	20.8	13.5	4.2	10.9	14.9
Rate of sexual offences (per 10,000) – Male	0.0	2.6	2.0	2.3	3.4	1.3	2.0	3.7	1.9	0.9	1.3	2.1
Aggregate 2 year % known to victim – Female	100.0%	83.3%	78.5%	94.3%	80.0%	83.1%	84.5%	86.2%	79.8%	90.5%	83.8%	76.4%
Aggregate 2 year % known to victim – Male	37.5%	100.0%	77.8%	100.0%	100.0%	80.0%	100.0%	81.8%	59.6%	100.0%	77.8%	71.5%
Rate of intimate partner violence (per 10, 000) – Female	64.9	68.5	150.3	59.5	144.8	113.6	60.0	103.1	100.8	54.2	61.4	75.8
Rate of intimate partner violence (per 10, 000) – Male	12.5	21.1	37.7	18.3	26.8	26.1	17.0	37.1	27.2	13.3	19.7	18.9

Table A1.5 Notification rates for Sexually Transmitted Infections and Blood Borne Viruses in 2022 (per 100,000 population) (Source: Department of Health (Victoria), 2023)

	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victorian LGA average
Chlamydia^	255.6	243.9	181.7	148.4	146.8	170.8	369.8	253.6	349.1	269.9	315.4	367.4
Gonorrhoea	25.6	17.4	15.1	14.8	0.0	25.6	0.0	23.1	73.5	77.1	101.0	151.3
Syphilis – infectious	0.0	0.0	15.0	14.8	17.3	8.5	27.4	0.0	11.6	45.0	9.2	27.4
Hepatitis B – newly acquired	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.9	0.0	0.0	0.2
Hepatitis C – newly acquired	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.1	0.5
HIV – newly acquired	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9
Mpox	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Shigella	0.0	0.0	0.0	14.8	0.0	0.0	0.0	0.0	1.9	0.0	0.0	0.0

^ Data based on 2021 notifications

Table A1.6 Hepatitis C and Hepatitis B - estimated prevalence and care uptake, by Level 3 Statistical Areas (SA3) (Source: World Health Organization Collaborating Centre for Viral Hepatitis, The Doherty Institute (2021))

LGA	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victoria (State)
SA3	Grampians						Maryborough/ Pyrenees		Ballarat	Creswick/Daylesford / Ballan		
Prevalence of chronic Hepatitis C^ (%)	0.65						0.82		0.69	0.7		0.65
Hepatitis C treatment uptake* (%)	63						67.7		48.3	75.9		55.2

Prevalence of chronic Hepatitis B#	0.44	0.42	0.47	0.43	0.96
Hepatitis B – care uptake+	11.5	< 6 receiving care	8.2	13.4	24.46
Hepatitis B – treatment uptake~	5.4	< 6 receiving care	3.8	6.7	11.02

^ based on published estimated of national prevalence and notifications from the NNDSS; * measured cumulatively as the total proportion of people treated of those living with Hepatitis C at the start of 2016, based on MBS and PBS records; # modelled prevalence based on census data and published seroprevalence; + based on receiving either MBS items 68482 and 69483 – viral load testing); ~based on PBS data

Table A1.7 Rate of PBS 10211K prescriptions for medical abortion, per 1000 population (Source: Women's Health Atlas Victoria, 2023)

	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victorian LGA average
Rate of PBS 10211K prescriptions by patient location	3.6	2.5	6.6	2.2	5.1	10.2	6.0	4.2	6.6	6.5	4.9	4.5
Rate of PBS 10211K prescriptions by prescriber location	0.0	0.0	5.3	0.0	1.1	0.0	0.0	5.6	1.4	0.8	0.0	4
Rate of PBS 10211K prescriptions by Pharmacy location	0.0	0.0	5.9	0.0	1.1	0.0	0.0	0.0	8.9	1.9	0.9	2.5

Table A1.8 Rate of long-term contraceptive insertion, per 1000, by Local Government Area (Source: Women's Health Atlas Victoria, 2023)

	West Wimmera	Hindmarsh	Horsham	Yarriambiack	Northern Grampians	Ararat	Pyrenees	Central Goldfields	Ballarat	Hepburn	Moorabool	Victorian LGA average
Rate of contraceptive implant insertion by patient location	9.0	6.7	7.5	10.2	8.1	9.5	10.6	10.0	9.3	6.7	8.0	8.2
Rate of contraceptive implant insertion by provider location	3.5	3.9	8.4	4.3	4.4	9.6	6.0	10.2	11.1	5.8	6.3	7.5
Rate of contraceptive IUD insertion by patient location	6.0	6.3	9.7	4.3	3.9	4.8	7.4	6.1	10.5	6.0	6.4	7.1
Rate of contraceptive IUD insertion by provider location	0.0	0.0	10.4	0.0	0.5	1.8	0.8	3.4	14.9	1.9	2.5	5.9

Data sources

Australian Bureau of Statistics. (2023). *Search Census Data.* https://www.abs.gov.au/census/find-census-data/search-by-area

Department of Health (Victoria). (2023) *Victoria, local public health areas and local government areas surveillance summary report.* https://www.health.vic.gov.au/infectious-diseases/local-government-areas-surveillance-report

Victorian Agency for Health Information (2020). The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: Findings from the Victorian Population Health Survey 2017. https://vahi.vic.gov.au/sites/default/files/2021-12/The-health-and-wellbeing-of-the-LGBTIQ-population-in-Victoria.pdf

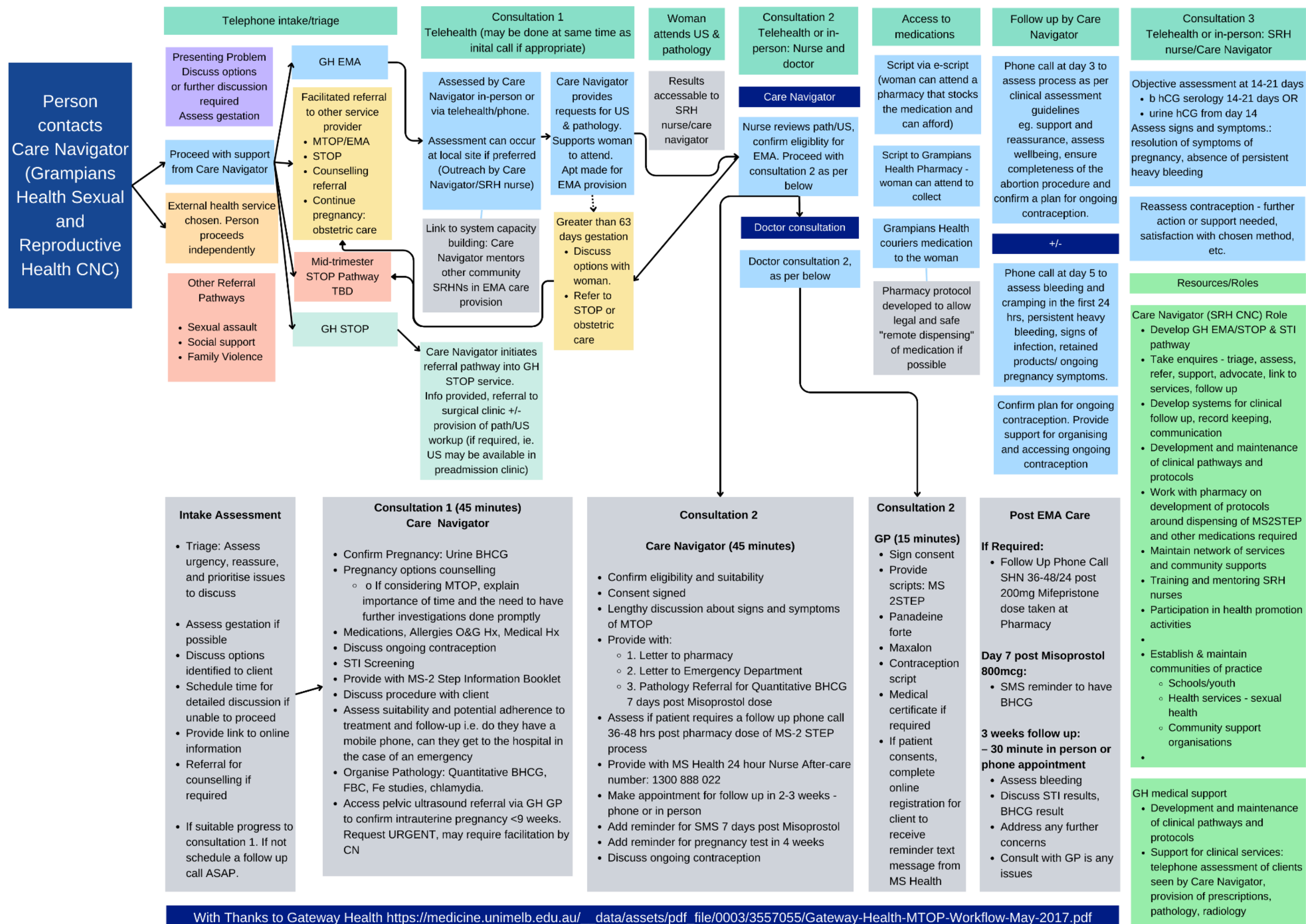
Women's Health Atlas Victoria. (2023). *Maps by priority health area.* https://victorianwomenshealthatlas.net.au/#!/

World Health Organization Collaborating Centre for Viral Hepatitis, The Doherty Institute (2021) *Viral Hepatitis Mapping Project: Online Portal* [database] https://ashm.org.au/vh-mapping-project/

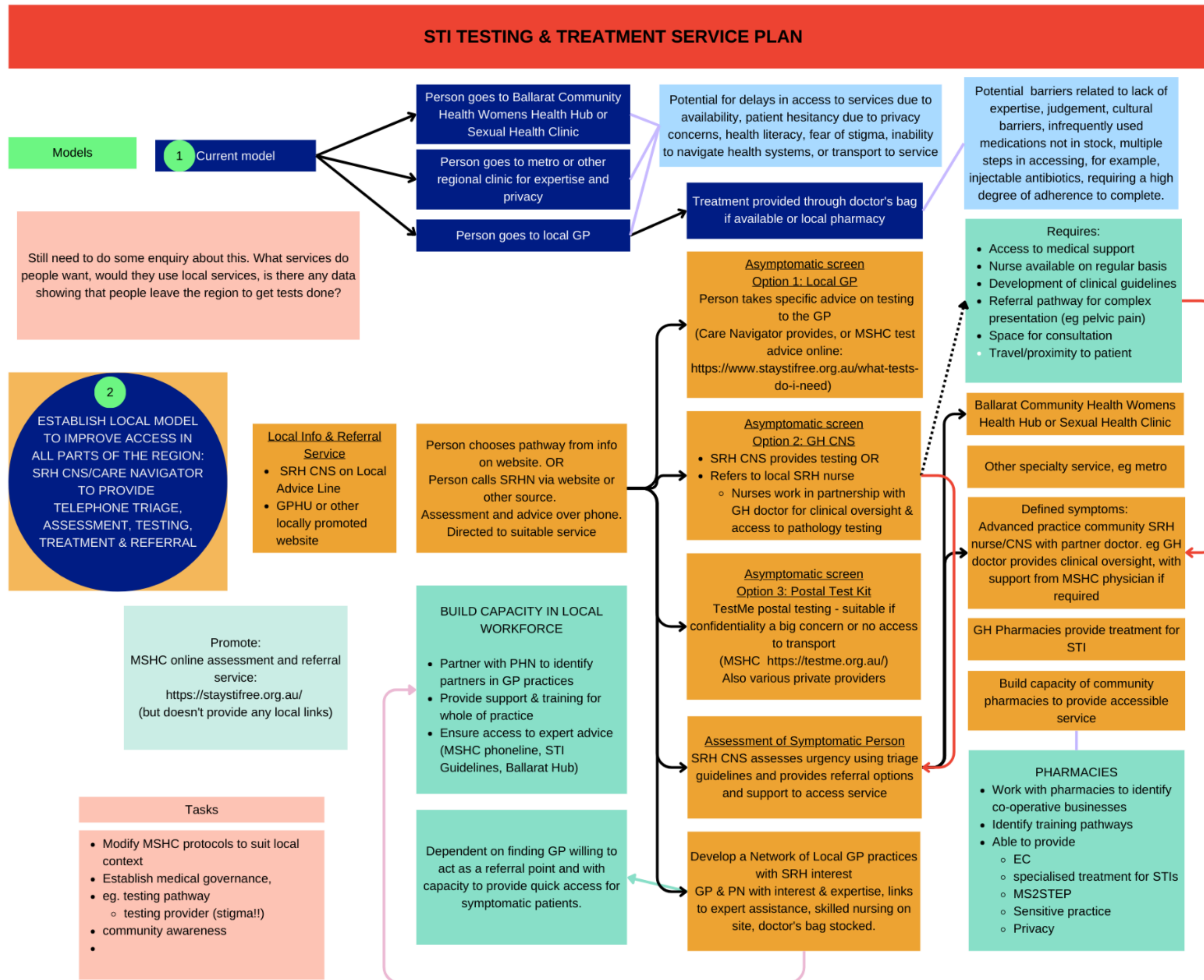
Appendix 2. Abortion access problem map

Patriarchal society
Training packages
- Partner with clinical champions, academics, First Nations organisations
Cultural /conservative values
Religious beliefs
Need to train/renew training every 3 years (GP)
Intimate partner violence
Conscientious objectors
Lack of knowledge/ training
Small rural community (everyone knows everyone else)
Stigma
Previous adverse encounters
Cultural acceptance of young motherhood
HCW knowledge/ attitudes and behaviours
Breach of confidentiality
Hub'n'spoke telehealth model of care
Expansion of nurse role – link to contraception and STI screening
Partner with Domestic Violence organisations, Women's Health Grampians
Fear
Dependent on single provider/ clinican
Pharmacy service access
Pathology service access
Radiology (ultrasound) service acess
GP service access
Waiting times
GP shortage
Problem: Prevention and timely access to abortion services in the Grampians region
Backup/ED distance
Coercive control
Geographical distance
Competing Priorities
Poor access to Contraception
Cost
Other immediate needs - e.g. food, shelter
Disability
Side effects
Access to transportation and accommodation
Integration of health and social care
Partner with 1800 My Options for better promotion
Cultural preferences
Community Education/ Knowledge - where to access services, how to naviage the system, urgency of the problem
Lack of advocacy
Socioeconomics
Poor promotion of health programs & health services
Funding models
Low health literacy
Gaps in school health program
Expansion/scale-up of achievement program in schools
Care Navigation role
Developmental vulnerability (e.g. adolescents)
Limited resources
SRH not prioritised by schools

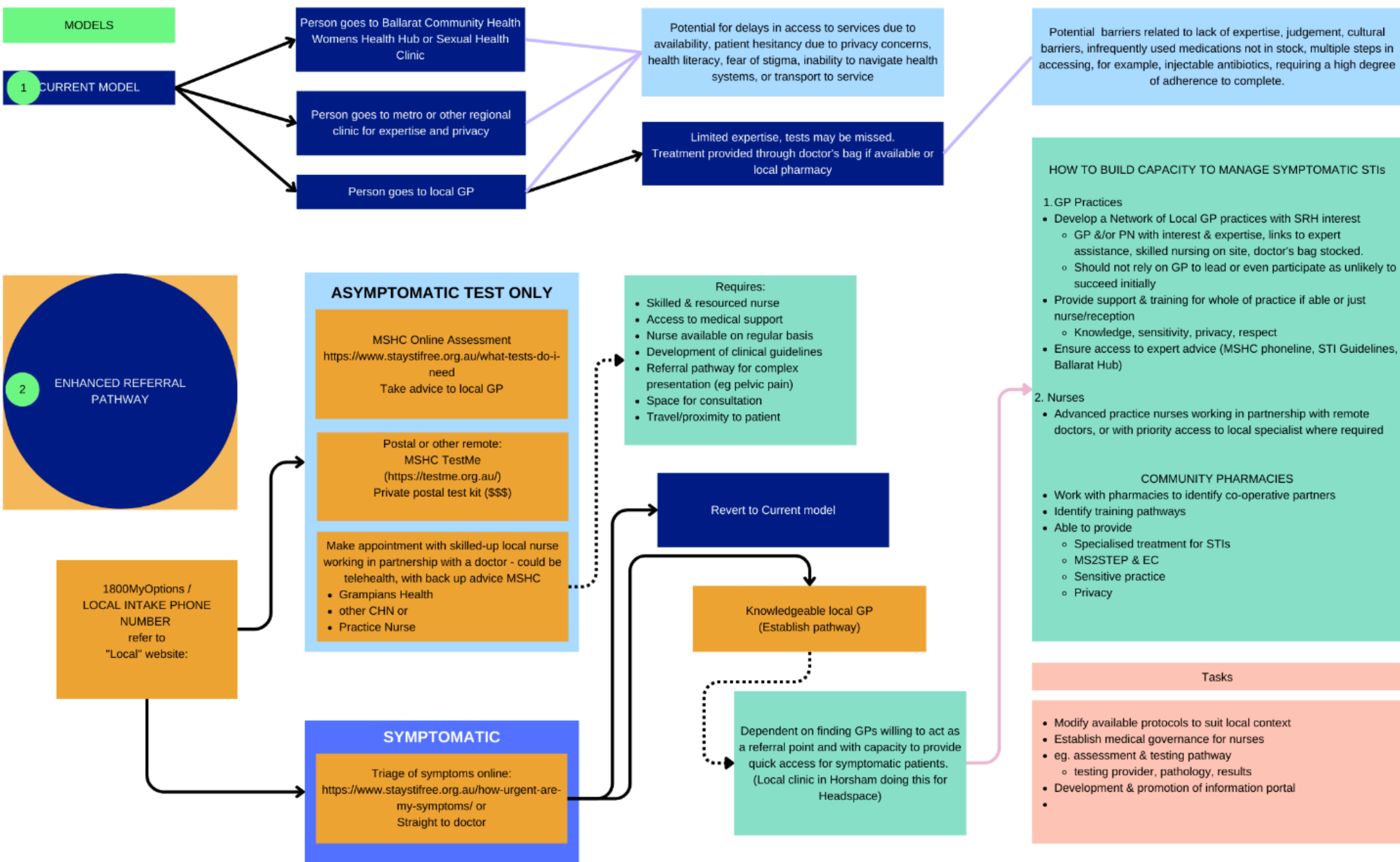
Appendix 3. Care Navigator supported pathway – abortion



Appendix 4. STI testing and treatment service plan with Care Navigator



Appendix 5. STI testing and treatment service plan without Care Navigator



Appendix 6. Health promotion plan detail

Target Group 1: Clinicians

Group	Proposed intervention	Who could do this?
GPs	Providing OR supporting early medical abortion, long-acting reversible contraception Develop a package for practices to use to support best practice care for women accessing seeking abortion: Can include local info/referral path, resources for GPs who are conscientious objectors. E.g. Meet your legal obligation to refer: what to say, what tests to do, where to refer	Royal Women's Hospital (RWH) Clinical Champions program Primary Health Network (PHN) Care navigator Sexual Health Victoria (SHV) Women's Health Grampians (WHG) Co-ordination by GPHU PPH team
Practice nurses / whole of practice interventions	Nurse participates in management of unplanned pregnancies and sexually transmitted infections ➢ Nurse upskilled ➢ Receptionist upskilled ➢ Timely access ➢ Sensitive care	PHN RWH SHV Ballarat Community Health (BCH) Care Navigator (targeted strategic approaches to individual practices) The Australian Primary Health Care Nurses Association (APNA)Co-ordination by GPHU PPH team
Community sexual health nurses	Nurse participates in management of unplanned pregnancies and sexually transmitted infections ➢ Nurse upskilled ➢ Receptionist upskilled ➢ Timely access ➢ Sensitive care	PHN RWH SHV BCH Care Navigator (targeted strategic approaches to individual practices) APNA Organisational support Co-ordination by GPHU PPH team
Pharmacies	Training in provision of sensitive and non-judgemental care and removing barriers to access to emergency contraception	Pharmacy peak bodies Care Navigator In-house professional development
Sonography	Staff trained to provide sensitive and non-judgemental care to women with unplanned pregnancy	Care navigator In-house professional development
Pathology	Staff trained to provide sensitive and non-judgemental care to women with unplanned pregnancy	Care navigator In-house professional development
MCHNs	Development of pathway and support to link women to contraception	Care navigator
All healthcare organisations	Change culture and attitudes towards patient privacy and confidentiality	Organisational support Co-ordinated by GPHU PPH Team

Target Group 2: Community health sector - people working with target populations:

Professional Group	Proposed Intervention	Who could do this? HP Team
Youth workers	Training in how to talk with young clients about sexual health	WHG SHV (free as per SHV website) Power to Kids | The MacKillop Institute
Alcohol and other drug support	Training in how to talk with clients about sexual health	WHG Care navigator SHV
Headspace	Training in how to talk with young clients about sexual health	WHG Care Navigator SHV
Family violence organisations	Training in how to talk with clients about sexual health	WHG Care navigator SHV
Secondary school nurses, teachers, wellbeing staff	Capacity building in sexual health assessment and local referral options	Care Navigator SHV

Target Group 3: Work with other community programs to assess potential for health promotion activities

Group/Program/Site	Proposed Intervention	Who could do this?
Local Councils	Engagement in accessible condom provision: vending or dispensing machines in accessible places	WHG GPHU PPH team
Headspace Uniting	Information visible on site	GPHU PPH team Care navigator
Council youth groups Other youth sites	Consumer consultation Information visible on site Peer education program	WHG GPHU PPH team Care navigator
Wimmera Development Association CALD support organisation	Consumer consultation Community education	WHG GPHU PPH team Multicultural Centre for Women's Health
Disability Organisations	Consumer consultation Community education	WHG GPHU PPH team Women with Disabilities Victoria (WDV)
LGBTIQ organisations	Consumer consultation	WHG GPHU PPH team
Women's Health Grampians	Strategic partnership	GPHU PPH team
Sporting clubs	Information visible Condoms available Community education Peer educators	WHG GPHU PPH team