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CASE STUDY:

SEXUAL & REPRODUCTIVE HEALTH HUBS IN VICTORIA

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A Sexual & Reproductive Health Strategy for the Southern Metropolitan Region

Case Study: Sexual and Reproductive Health Hubs in Victoria

WHISE

Who are we?

Women's Health in the South East (WHISE) is the regional women's health service for the Southern Metropolitan Region. WHISE is a not-for-profit organisation that focuses on empowering women. We work to improve the health and wellbeing of women in our region by providing health information and education to governments, organisations, education providers, and community groups. Our team of health promotion professionals work to promote gender equality, sexual and reproductive health and the prevention of violence against women.

Primary prevention

Primary prevention in health promotion is at the very core of what we do. It is a deliberate way of changing the underlying causes of poor health. Rather than treating disease, our work seeks to prevent disease. WHISE work aims to reduce incidence of poor health of women in our community. We train and raise understanding about gender equality because we know that this is the root cause of violence against women. We work in partnership with communities on sexual and reproductive health to support women to take control over their own health and wellbeing. Health promotion and primary prevention increases community wellbeing and most importantly for us, empowers women.

Where we work

We work across 10 local government areas. Our area of work is called the South Metropolitan Region of Melbourne and consists of approximately 1.3 million people, representing about one quarter of the state's total population. We cover the 10 local government areas of City of Port Phillip, City of Stonnington, Glen Eira City Council, Bayside City Council, City of Kingston, City of Greater Dandenong, City of Casey, Cardinia Shire Council, Frankston City Council and Mornington Peninsula Shire.

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Abbreviations

AusCAPPS	Abortion and Contraception for Primary Care Providers
CALD	Culturally and Linguistically Diverse
CERSH	Centre for Excellence in Rural Sexual Health
DoH	Department of Health
ED	Emergency department
EMA	Early medical abortion
EPPAS	Early Pregnancy and Post natal Assessment Service
IUD	Intrauterine device
LARC	Long-acting reversible contraception
MTOP	Medical Termination of Pregnancy
OB/GYN	Obstetrician gynaecologist
STOP	Surgical termination of pregnancy
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
VAGO	Victorian Auditor-General's Office
WHISE	Women's Health in the South East

Introduction

Purpose of case study

This report offers a case study of Sexual and Reproductive Health (SRH) Hubs across Victoria based on findings from interviews with Hub clinical staff. It highlights the important role of the SRH Hubs in providing accessible and affordable SRH services; their impact and the gaps they address; the challenges encountered by practitioners in establishing the SRH Hubs, and how these were overcome; and potential areas for strengthening in future.

The intention of this report is twofold: first, to support practitioners in existing or future SRH Hubs in their practice, by providing an outline of some of the critical processes, challenges and benefits of the Hubs. Second, the case study documents the work of the Hubs to support our collective advocacy to the Department of Health, particularly in advocating for long-term and sustainable funding for existing SRH Hubs and expanding into regions that currently do not have one. Additionally, the case study highlights the unique role of the Victorian Women's Health Services in supporting the SRH Hubs through advocacy and capacity-building for clinicians in areas such as early medical abortion.

The findings of the interviews will be presented after providing a brief background to the establishment of the SRH Hubs and research methods.

Background

Victoria's SRH Hubs were funded as part of Victoria's first SRH plan, *Women's sexual and reproductive health: Key priorities 2017–2020*, which aimed to address "barriers and service gaps that affect women's access to affordable healthcare, contraception and termination services across the state" (Department of Health, 2017, p. 1). The plan also aimed to support the SRH needs of Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds, people living in rural and regional Victoria, people with disability, women in same-sex relationships and gender-diverse people. In addition to the SRH Hubs, the Department funded Women's Health Victoria to establish 1800 My Options, the first Victoria-wide SRH service consisting of a phone line and website, and the Clinical Champions Project, a statewide program run by the Royal Women's Hospital which helps build capacity among the primary healthcare workforce for the provision of contraception and abortion services.

In 2017, the Department of Health allocated funding to establish eight SRH Hubs, followed by a further three regional SRH Hubs in 2021-22. As noted in the Victorian Auditor-General's Office (2023) report, "There is no standardised model of service delivery for hubs. Each organisation responds to its own geographic, cultural and structural context." To qualify for department funding, the SRH Hubs are mandated to:

- provide information for all forms of contraception and termination options.
- offer clinical services to women who opt for long-acting reversible contraception (LARC).
- offer clinical services for women who opt for medical termination.
- develop referral pathways for women who require surgical termination.

- provide sexual health testing, treatment and support.

In 2023, following the launch of the *Victorian Women's Sexual and Reproductive Health Plan 2022-30* (Department of Health, 2022), the Victorian State Government launched its $153.9 million package to address women's health, with the establishment of nine additional SRH Hubs planned in addition to the existing 11 (Department of Health, 2024). With the number of SRH Hubs set to almost double, this case study constitutes a timely resource to assist new Hubs in establishing their services, and for existing Hubs to learn from the practices of their peers.

Outline of consultation process and research methods

In late 2023, WHISE put out a call among SRH workers within the Victorian Women's Health Services Network requesting their participation in our SRH Hubs case study. We asked for their interest in reaching out to their local SRH Hubs and conducting an interview with Hub staff members (including nurse practitioners, nurses and doctors) on the model of care, services offered, and barriers to and enablers of their Hub's success. The WHISE Sexual and Reproductive Health team collaborated with the Evidence and Policy team to develop an outline for semi-structured interviews with SRH Hub staff across Victoria. In consultation with a Nurse Practitioner[1] at Peninsula Health, these questions were refined and finalised.

In January 2024, WHISE met with interested SRH staff from women's health services across Melbourne and regional Victoria to present a project briefing, giving an overview of the purpose and methods of the case study, and their requested involvement. We offered support in interviewing skills, shared a list of interview questions and asked that staff coordinate and hold these interviews, transcribe the recorded text and return to WHISE for analysis.

WHISE and three regional Women's Health Services (Gippsland Women's Health, Women's Health Barwon South West, and Women's Health Goulburn North-East) conducted interviews for this case study. Eight staff members from six different SRH Hubs were interviewed. The focus on regional SRH Hubs in our data is reflective of the current ratio of Hub locations across Victoria (four in metropolitan Melbourne and seven in regional Victoria). To maintain anonymity and readability, pseudonyms such as 'Metro Hub 1' and 'Regional Hub 1' have been employed throughout this paper for the Hubs.

SRH staff from the Women's Health Services completed the interviews and transcription in May 2024 and shared these with WHISE staff, who deidentified, collated and analysed the data using inductive and deductive methods. The data was segmented and analysed using NVivo software.

[1] "A Nurse Practitioner is a Registered Nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The Nurse Practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The Nurse Practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the Nurse Practitioner is determined by the context in which the Nurse Practitioner is authorised to practice" (Nursing and Midwifery Board of Australia).

Top-level codes were derived from the key themes of the interview questions, such as Model of care; Fee structure; and Challenges and how they were overcome. Sub-level codes reflected themes identified in interview data, such as the importance of nurse consultations, and the need for Medicare reforms.

Some key differences between SRH Hubs emerged in this process which presented challenges for the cross-comparison of Hubs. First, participants' Hubs offer different services due to differences in access to equipment and networks; clinical practice; resourcing; and local community need. Participants also reported different knowledge of how their services might be expanded or practitioners upskilled, for example, due to different understandings of legislation regarding medical termination of pregnancy (MTOP) provision regulations. Finally, participants expressed differing levels of confidence and willingness to implement practice, with some preferring to proceed without direction while others sought more consistent support and guidance from the Department of Health.

Overview of SRH Hub services and structure

Model of care and staffing profile

In the context of SRH, nurse-led models of care involve Nurse Practitioners and nursing staff, rather than doctors, leading the provision of services such as abortion, contraception and other SRH healthcare. The World Health Organisation (2015) recognises nurse-led care as optimal for women's reproductive healthcare, and this is reflected in a number of nations worldwide. Recent Australian research highlights nurse-led provision of abortion and contraception as safe, cost-effective, and increasing accessibility to SRH care, especially in rural areas (Botfield, Lacey, Fleming, McGeechan, & Bateson, 2020; Moulton, et al., 2024).

All but one of the SRH Hubs said they were either nurse-led or operated under 'hybrid' models of care, although not all had a Nurse Practitioner (NP) on staff. Metro Hub 1 described their Hub as nurse-led and advocated strongly for this model. This participant said that nurses at their Hub manage triage and intake and organise ultrasounds (dating scans) as well as pathology tests. However, they noted the importance of having the support of doctors and gynaecologists, especially for more complex cases. This participant noted, "I believe our current Model of Care, which is nurse-led and includes a Nurse Practitioner, is cost effective and efficient. Having established important referral pathways has optimised patient care. For example, those women experiencing a failed medical abortion, can be assessed in the Early Pregnancy Assessment Service [or EPPAS] by a specialist GP. The gynaecologists are incredibly supportive when care needs to be escalated." The Operations Director of Community Health decided at the outset, that the Hub could be led by our participant, who had been newly endorsed as a Nurse Practitioner. She was well supported by a Women's Health GP and together they completed training to provide intrauterine device (IUD) insertions.

Participants from regional SRH Hubs spoke often of the issues in retaining staff as shaping the model of care on offer. Regional Hub 1 noted that GPs are hard to retain in regional areas, with the clinic having reduced from six GPs to two. The Hub depended on these GPs for writing scripts and ordering ultrasounds, as well as IUD insertion as they do not currently have nurses with IUD qualifications. Regional Hub 3 found that after their Nurse Practitioner left, they were

reliant on GPs again as the remaining two nurses were not Nurse Practitioners. Regional Hub 4 described their model as a "hybrid, but primarily nurse led." They have a GP with an exclusive interest in sexual health who runs her appointments separately from the nurses.

Staffing capacity, and how staff were remunerated, varied considerably in accordance with funding streams and the financial governance of the community health centres or general practice clinics they were housed within. The most well-resourced SRH Hub in terms of staffing was Metro Hub 1, which had one full-time Nurse Practitioner, two nurses (total 1.0 EFT), an endorsed Nurse Practitioner in their colposcopy service (0.2 EFT), and a GP (0.2 EFT). This clinic operated 8:30-5:00 pm, Monday to Friday with these hours spread across four clinic sites and including a weekly outreach clinic. They also offered monthly Saturday clinics at their most accessible site. In contrast, Regional Hub 3 employed a 0.4 EFT GP, a 0.4 EFT sexual health nurse, and another nurse at 0.2 EFT, operating three days per week from one site.

Community health and accessibility

SRH Hubs are typically based in community health centres, equipping Hub staff with an on-site team to refer to for more complex cases. A further benefit of being located within community health is the accessibility of the service to diverse communities. Some SRH Hubs also operate across multiple sites.

When asked about the accessibility of their service to diverse communities, many participants spoke about the physical accessibility of their building, noting the provision of ramps or their clinic's location in a single level building.

Metro Hub 1 and Regional Hub 4 noted they provide staff training, for instance, on Aboriginal and Torres Strait Islander health, cultural safety and gender diversity inclusivity. They saw a reduction in geographic barriers to access with Hubs established across four regional sites, supported by their community health services employing social workers to facilitate access.

Several participants spoke about the accessibility of their SRH Hub to Aboriginal and Torres Strait Islander clients, noting that its integration within a community health organisation employing Aboriginal Health workers enhanced its effectiveness. Several Hubs spoke about working with interpreters onsite or by phone, with Metro Hub 1 also having Auslan interpreters available. Regional Hub 4 mentioned they employ multilingual staff and have a good relationship with the multicultural settlement team, with whom they have held outreach sessions and combined care events around issues such as cervical screening. Regional Hub 1 is based in a community health building which combines a refugee clinic, GP practice and the Hub, and said that this helps with privacy in a regional community context.

Patient criteria

In line with the SRH Hub funding objectives, all Hubs prioritised people with facing challenges in accessing health services, tailoring their criteria to address the specific needs of their local communities. Some of the priority criteria mentioned included healthcare card holders; asylum seekers; people with mental health issues or alcohol and other drug dependence; survivors of family violence or sexual assault; CALD people; First Nations people; people who had been incarcerated; and people with disabilities. Regional Hub 3 had their criteria listed on their website initially but found this was a barrier to people feeling confident in their eligibility, so now

they are open to anyone. Most SRH Hubs said they had no restrictions geographically, with one regional Hub taking clients from other regional areas who would prefer not to see their local provider.

Medicare was a key issue when discussing criteria for clients. Metro Hub 1 accepted international students without Medicare, as the fee could be waived in community health. Regional Hub 1 previously had a GP who waived fees for clients who did not have Medicare, however, their current GPs privately bill people without Medicare. In Regional Hub 1, clients without Medicare are required to pay out-of-pocket for their pathology and ultrasound services. Additionally, medication not covered by Medicare must also be paid for by clients.

Metro Hub 2 was the only SRH Hub with geographic restrictions for clients. However, they spoke about the impact of the recent closure of a private abortion clinic in Melbourne, which has led to many callers from other regions seeking surgical termination of pregnancy (STOP) and MTOP. Although staff refer callers to bulk billing GPs in their own areas, they are currently inundated with MTOP appointments.

How Department of Health funding enabled the provision or expansion of SRH services

The SRH Hubs were asked about their provision of the five key services that make them eligible for funding, and how funding supported the establishment or expansion of these services. These are 1) sexual health testing, treatment and support; 2) provision of information about contraception and termination of pregnancy; 3) provision of LARC; 4) provision of MTOP; and 5) referrals for STOP.

Overall, staffing was identified as a significant benefit of Hub funding that facilitated the establishment and expansion of SRH services. Several interviewees highlighted how the addition of extra staff enhanced their clinic services. This expansion allowed them to offer IUD insertions and MTOP, offer more detailed consultations, and, in some cases, extend their services into outreach work, including drop-in clinics and community education.

Importantly, their new status as SRH Hubs also enabled clinics to gain the support and trust of their communities. Regional Hub 4 noted that advertising as a Hub has made a difference in client rapport: “[Now] people are coming to us with the knowledge that they are seeing a sexual health specialist, and so are coming to us confident that they're going to receive quality care.”

The following sections outline how the funding enabled each of the five key services provided by SRH Hubs.

Sexual and health testing, treatment and support, and the provision of information about contraception and termination of pregnancy

All participants said that prior to Hub funding, their clinic was offering sexual health testing, treatment and support, as well as information about contraception and termination of pregnancy. However, this was inconsistent, and staffing enabled the provision of much more comprehensive care and information. All Hubs already offered or were working towards an

integrated approach, whereby sexual health tests are offered at LARC appointments, and contraception is discussed at sexual health screening appointments.

Staffing was a key outcome of funding for all Hubs' sexual health testing and treatment services. Regional Hub 2 commented that it allowed "quicker access to this service and more comprehensive results." Regional Hub 2 noted the benefits of GPs being able to refer clients for 45-minute nurse consultations, which allowed invaluable time for comprehensive sexual health discussions:

> *[Clients] now have a longer consult, more chances to ask questions, more information about the different STIs and how you treat them and more reassurance i.e. reducing stigma, letting clients know that STIs are common, that it is going to be okay, how we treat them et cetera. If a patient has tested positive to an STI they receive a phone call to return to the SRH Hub for treatment and support if they require it.*

The ability to offer testing and treatment in the same appointment is a significant benefit of Hub funding. For one of the regional Hub interviewees, being able to stock medication and treat clients at time of diagnosis for conditions such as gonorrhoea made this a distinctive service.

Provision of Long-Acting Reversible Contraception

All participants said they discussed LARC options with patients at all appointments, including sexually transmitted infection (STI) testing and MTOP. Prior to Hub funding, some services were offering Implanon insertion, but not IUD insertion, and funding enabled them to employ IUD-qualified staff or support existing staff to undertake training. For example, Regional Hub 2 did not initially offer IUD insertion due to "GP availability, training for IUD insertions, lack of time and financial incentives to provide IUDs." During this time, clients were referred to a specialist service with a 6-12 month wait time. After funding, new GPs were recruited who had obstetrics and gynaecology/women's health experience, including one with IUD insertion training. This helped the other GPs to feel more confident in offering IUDs, and now the clinic has two GPs with IUD qualifications, with another two planning to do training. This allowed nurses more time for patient discussion and education on how to prepare and what to expect, using trauma-informed practice. This regional Hub participant noted:

> *IUDs take time and GPs are not given financial incentives to provide this procedure. Having an SRH Hub means we can incorporate nurse-led discussions, which saves GPs time and makes it more appealing for them to provide this very important service.*

Provision of Medical Termination of Pregnancy

Hub funding enabled a number of SRH Hubs to offer MTOP for the first time. Prior to receiving funding, Regional Hub 2 only provided external referrals to GPs. Since the funding, however, the Hub has introduced nurse-led MTOP services with support from GPs. Clients are able to have a comprehensive discussion with the nurse in which they are given options and information on what to expect; briefed on pain management; and offered a phone check in and a follow-up appointment. This regional Hub participant noted,

Anecdotally, we are finding that we don't have many clients coming back worried about their bleeding or pain, as they have been well informed and supported initially and know what to expect. Having these 45-minute consults are well worthwhile and only available because of the nurse-led practice and SRH Hub funding.

She noted that SRH Hubs have allowed GPs to feel more supported in providing MTOPs:

I think there are reservations from GPs about providing MTOPs as it requires time to follow up. Previously they also had to complete the MS-2 Step provider course. The SRH Hub has meant that we can include nurse-led consults that enable more comprehensive care, time and follow up, which gives GPs the confidence to be involved.

Regional Hub 3 did not offer MTOP services prior to receiving Hub funding. The additional staffing made possible by the funding allowed them to initially hire a GP who collaborated with an external MTOP prescriber. Subsequently, the clinic employed their own GP MTOP prescriber. For Regional Hub 1, support and training from the Centre for Excellence in Rural Sexual Health (CERSH), Sexual Health Victoria and the Royal Women's Hospital's Clinical Champions Program enabled them to establish an MTOP service. Funding has enabled them to expand this service, but due to high demand in their region – with many clients travelling long distances for care – they have had to limit access to MTOP services.

Prior to funding, Metro Hub 1 did not have a medical abortion presecriber and there were only two MTOP providers in the region overall. Both the Nurse Practitioner and GP have completed appropriate training and, in collaboration with the hospital pharmacy, are able to provide this service. The Nurse Practitioner developed guidelines based on those already established by the Royal Women's Hospital and other Hubs, and with support from the Clinical Champions Project, were able to establish their service. They also coordinated with GPs, pharmacies, radiology services across the region to establish a robust service. The GP and nurses at this clinic collaborated with WHISE and the Royal Women's Hospital to deliver training to GPs in the sector on early medical abortion (EMA). They hired a nurse as a short-term project worker to set up systems (e.g., Clinical Practice Guidelines), develop consent forms, intake and referral processes, and to streamline the Hub's work. The Hub observed that since the opening of their termination service, more GPs in the region have begun prescribing MS-2 Step. They attribute this increase to the added comfort and support provided by a public organisation offering the service, which GPs can consult with for any questions or concerns. Referral pathways for escalation of care are well established at the Hub which is also reassuring for GPs working in the area.

Referrals for Surgical Termination of Pregnancy

Several regional SRH Hubs mentioned that prior to receiving Hub funding, they primarily provided STOP referrals to Melbourne, and sometimes to a regional service. For some Hubs, these referral pathways were established or expanded only after increased staffing from Hub funding.

For Regional Hub 1, the private STOP service was dependent on one gynaecologist who travelled regularly from Melbourne. However, this clinic stopped after the GP suffered an injury

and was unable to travel, demonstrating the vulnerability of regional health services to unpredictable and inconsistent levels of staffing.

Regional Hub 1's new Hub status and increased staffing from funding assisted them to convince their local public hospital to provide STOP, and to streamline the referral pathway process. Their advocacy led to their local public hospital offering STOP, which is where they now refer patients to. The Hub was handling referrals for the hospital for the first few years but having Hub status helped them to hand over this responsibility to the hospital, or risk diverting staff time from LARCs and MTOPs. The participant stated, "I think being a Hub just allowed us to be really clear about what we were funded to do and what we weren't, so that we could advocate to go, 'That's your job'." This also allowed for a more streamlined and effective referral pathway:

> *Over the last, I think two years, we've really pushed back at the hospital and say, 'This is your service. We will help you set up a referral pathway, but you need to be doing that all the pre-admission stuff.' Because what we were finding, especially because we were so busy, people would be wanting to access surgical termination, but not be able to get an appointment with us to then get a referral into the hospital. Whereas they'd be easily be able to get an appointment with their GP who should be able to refer in but wasn't able to. So, we've changed that pathway, so now that any GP can refer into the surgical termination.*

Regional Hub 2 said that Hubs offered the most direct pathway to STOP services due to the relationships Hub staff had built with allied health services. It also afforded clients additional time to discuss termination of pregnancy options:

> *GPs can still refer for a surgical termination, but I would just say that if they've come through the SRH hub, we can have a much lengthier discussion about the pros and cons of surgical or medical terminations. We utilise resources from the Royal Women's [Hospital] that look at the types of terminations and really take that time with the patient to work out what might be best for them. Our GPs can send patients who are unsure about what type of termination they want to me, and I can have a session with them to help work out what is best for them. If it is a surgical termination, great, we can complete the referral and for the patient and we can get them upstairs to the Women's Specialist Service … We have established a great working relationship, they are very supportive.*

Metro Hub 1 had already been referring STOP patients to two public hospitals and two private services. More recently, their community health centre had been given a directive to support establishment of a STOP service and subsequently began screening clients presenting for this reason. However, no extra funding was allocated for this, adding to Hub staff workload. Metro Hub 2 begins coordinating STOP referrals for clients during their dating scan, ensuring that if the gestational age exceeds the nine-week cutoff, they can quickly access STOP services. The participant noted that the Hub was able to refer clients, such as asylum seekers, who do not have Medicare cards, as they are required to obtain a GP referral to access STOP.

How the SRH Hubs function

Pathway of care for referrals or escalation

Several participants noted that clients prescribed MTOP were given a letter to take to the Emergency Department (ED) if they experienced pain or bleeding outside of Hub hours. Regional Hub 4 said their Hub had recently considered how to manage MTOP for clients who are fasting for Ramadan. In these cases, they have referred clients for STOP to ensure safety.

Metro Hub 1 reported having a reciprocal referral relationship with their local hospital's Early Pregnancy Assessment Service and with ED nurses, with whom they meet regularly. They also meet with nurses in the maternity ward, so staff feel comfortable referring to the Hub for postpartum contraception. If anything is out of scope they can refer to the inpatient gynaecologist.

Regional Hub 1 maintains a good relationship with the local obstetrician gynaecologist (OB/GYN) team, and if necessary, contact the hospital's obstetrics and gynaecology registrar to make client referrals. However, they note that their local hospital is one of few in Victoria without a public OB/GYN outpatient service, meaning clients may be charged for their care unless they are admitted via ED. The clinic maintains good connections with the Royal Women's Hospital via the Clinical Champions Program and with other SRH Hubs via the Abortion and Contraception for Primary Care Providers (AusCAPPS) network. Regional Hub 2 is supported by their Women's Specialist obstetrics and gynaecology service.

Promotion of SRH Hubs

Promoting the SRH Hubs was important to ensure that SRH services are accessible to community. Hubs were linked to 1800 My Options and spoke about promoting their Hubs via links with refugee clinics, migrant community councils, disability support and Aboriginal Health Services.

Two participants spoke about promoting their Hub via promotional cards and stickers with QR codes that linked to their website. Several Hub participants said they always accept opportunities to do TV, radio or local newspaper interviews, and viewed this as important in breaking down stigma regarding sexual health services.

Regional Hub 1 found that advertising their STOP services led to a rapid increase in demand, quickly reaching capacity and causing missed STI appointments, which proved unsustainable. To address this, they started scheduling termination appointments on days that aligned with their GP's availability.

One Hub promotes its services through the social media platforms of its community health organisation, while another operates its own Instagram account. Two regional services noted that although their Hub is listed on their organisation's website, it is difficult to find or does not appear readily in Google searches. They have raised these issues with their communications and marketing teams. Several Hubs spoke about their efforts to reach young people through school visits and presentations at universities and TAFEs. One Hub noted that engaging with

youth groups is particularly effective for reaching individuals who are not part of the school system.

Hub staff also reach out directly to local GPs by introducing the Hub through email and letters. Some staff members are especially proactive, delivering informational cards to GP clinics and speaking with nurses in person. One Hub prioritised building connections with GPs, as well as establishing a liaison with the local hospital ED, maternity ward, and Early Pregnancy Assessment Service to encourage word-of-mouth referrals from the start. Regional Hub 2, however, has faced significant challenges in recruiting GPs willing to support the service, citing difficulties in reaching individual GPs rather than clinic managers. They noted that local GPs often refer clients to Women's Specialist obstetrics and gynaecology services instead of the Hub, although the Hub occasionally receives overflow referrals from those clinics.

One Hub noted that while there were initial concerns from management about publicly promoting MTOP and fears of potential backlash against practitioners, staff advocated strongly for making the service publicly known. Another Hub highlighted the challenges of promoting SRH services in culturally and religiously diverse communities, especially concerning sensitive issues like abortion. Despite some community leaders expressing opposition, community members may still seek out these services. Several Hubs emphasised the importance of transparently advertising their abortion services to challenge stigma and promote acceptance.

Fee structures

Regional Hubs 3 and 4 said that they bulk bill, but overall, fee structures vary based on funding sources, clinic fees, and whether services are led by GPs or nurse practitioners.

For example, Metro Hub 1 operate two parallel services: an SRH clinic and an IUD service. The IUD service, located within a community health setting, charges a small fee based on the client's socioeconomic status. Fees for LARC services depend on Health Care Card or Medicare status and may be waived for clients at the clinician's discretion. For instance, for those clients who are homeless or Aboriginal and Torres Strait Islander. Clients without Medicare may face costs for pathology and ultrasound scans,[2] highlighting the need for Hubs to have their own ultrasound machines.

Regional Hub 1 charges only for IUD insertion, with GPs often bulk billing for Implanon insertions. They bulk bill clients under 16 and Aboriginal and Torres Strait Islander clients only pay for the cost of the script. Health Care Card and Pension Card holders pay $50 for IUD, while those without a concession card pay $155. Clients without Medicare face the full cost of services, though MTOP is free of charge. The Hub keeps some Mirenas and IUDs in stock for clients who cannot pay due to financial hardship or family violence. A funding increase would enable them to eventually waive all fees, as many people without Health Care Cards cannot afford services, and would also like to offer a salary to GPs to address appointment no-

[2] Pathology for STI screening can incur a cost of up to $100 even though Hub consult, scripts and procedure fees can be waived. Ultrasound scans can cost $200.

shows. Regional Hub 3 also bulk bills all clients but is concerned about the long-term sustainability of this approach.

Regional Hub 2 operates within a community health clinic but functions as a private clinic with GPs working on a split-fee system. Charges are determined by the GP unless the client holds a Health Care Card, in which case they are bulk billed. The clinic considers financial hardship for clients. Nurse appointments are free, but GPs handle pathology slips, STI testing, and medication, with charges set by the GPs.

Regional Hub 1 pointed to the way socioeconomic challenges impact clients in regional areas who may struggle to attend Hub appointments, especially when multiple services and consults are required:

> *I think when you're working with priority populations who have many challenges to get to appointments, there's competing priorities in their life that mean, we probably have the highest rates of failure to attend sometimes purely because of people's circumstances.*

> *I also think that the integration of the two streams of funding is a really good thing, and I think all Hubs should have that integrative model and get streams of funding from both places, because it allows them to be more integrated, and include partners and broader community in a bigger way, and, you know, localised services so people don't have to travel… I think that the other thing would be [to] have a sustainable nurse practitioner model … I think funding really needs to take into account like whilst you might have a smaller population, your service… takes you three hours of train travel, and if you missed that train, and you've got to go to two appointments like it, I think that you know, it's not just one data set that people need to be taking into account. It's a whole lot of things that, that I think funding needs to take into account.*

Regional Hub 2 highlighted some of the barriers to access faced by the large migrant worker population in their region, many of whom lack Medicare cards. This represents a huge financial outlay for pathology, ultrasounds and MS-2 Step: “We also have people that might be eligible for Health Care Cards, but there’s been reasons why they haven’t been able to access or go through the processes to get a healthcare card, so they’re still financially disadvantaged.”

Regional Hub 4 said that for people without a Medicare card, they try to manage their treatment without a GP or send them to the medical director GP who is salaried and can therefore waive fees. Regional Hub 2 also pointed out the lack of a standard fee structure for Hubs statewide:

> *We have a lot of migrant workers that work [locally], and they often don't have Medicare cards. This means they have to pay for pathology, ultrasounds and MS-2 Step - if they were accessing, say, medical termination, it’s just they often can't afford it. So it's a real barrier to how they receive their care. I think there is discrepancy between Hubs on how they charge people. It would be great if we had clear standards of practice and guidelines around how Hubs operate, fee structures, so we could work consistently across the state… it's not financially appealing for GPs to provide IUD insertions. Medicare rebates do not cover the costs associated with IUD insertions. This includes additional time, IUD kits and consumables, procedure rooms, and so on.*

Identified challenges and how Hubs overcame them

Establishing clinical practice guidelines

Metro Hub 1 said a key challenge was establishing clinical practice guidelines, including policies and procedures for each new service. With support from the Royal Women's Hospital, Melbourne Sexual Health clinic and other Hubs that shared their documentation, they transitioned to an electronic document system. This shift streamlined processes and improved communication between the Hubs and other services. However, setting up the new system required time and effort, diverting staff from clinical practice.

Sourcing MTOP providers and treatment space

Metro Hub 1 noted that a key challenge to setting up medical abortion access was securing a doctor to provide the service and finding a clinic room with free parking and public transport access. Hub funding allowed them to purchase a gynaecological couch for use at an accessible clinic site. However, the availability of rooms continues to be an issue, as they do not have a consistent number of rooms each day. Regional Hub 3 also faced similar challenges with room availability in their initial setup.

Establishing relationships with radiology, pathology and pharmacies

Metro Hub 1 noted that prior to the deregulation of MS-2 Step, they faced challenges finding accredited local pharmacists and ensuring a consistent stock of the medication. However, the hospital pharmacy was supportive in providing the medication from the outset, as several pharmacists were already training and familiar with this medication. The process has become much smoother now that Hub doctors and nurse practitioners can directly prescribe MS-2 Step.

Initially, the prohibitive cost of radiology for dating scans – ranging from $150 to $200 out of pocket – has been a significant barrier for clients. However, there are now some local radiology services willing to provide bulk billing arrangements to clients. Clinicians can organise these scans on behalf of clients to expedite access. Despite this improvement, clients in more remote areas of their region still lack access to nearby bulk billing radiology services.

Unclear expectations and insecure funding from Department of Health

Insecure funding from the Department of Health (DoH) was an issue for some Hubs. One participant noted that despite a significant increase in client numbers since the Hub's establishment, additional DoH funding has been limited, with equipment and staffing costs being covered by their community health organisation instead. Regional Hub 1 expressed frustration over the lack of secure funding to support long-term goals, such as community outreach, and to sustain and expand their services, noting that their appointments are typically fully booked. They also pointed out that Hub funding does not take account for increases in nurse wages.

Several of the regional Hub participants also noted a lack of a clear needs assessment process during the establishment of Hub funding and expressed a desire for more DoH support in setting up services and guiding clinical practice. Regional Hub 2 noted:

It would be a huge asset to have more guidance around what Hubs should look like, how they could operate, where to go if you need support, implementing regular meetings with other Hubs, regular check ins. I know we've got the Clinical Champions team and they do a wonderful job. But more DoH support regarding governance of the hubs would be really helpful.

While there is an existing SRH Hubs Community of Practice, this participant sought more centralised and structured guidance on the process of establishing their Hub.

Similarly, Regional Hub 1 identified "miscommunication" from the DoH as their biggest challenge. They would have preferred a data reporting tool and clear guidelines on how their funding should be used and what data to track from the outset. Instead, the processes initially seemed broad and flexible, only to become rigid with specific requirements later on. They described the difficulty of obtaining clear feedback from the DoH and the time-consuming nature of adapting to changing reporting guidelines, which diverted focus from clinical services:

They're asking us what we want to report… so I think we just kept clarifying, clarifying, clarifying and documenting because it kept changing. So for us, it was like we kept data on every MTOP we did. And we still do. So that we can, because often our medical records, and our community health data collection tools aren't ideal for the reporting that we need to be able to do. And the Department doesn't give us a proper reporting tool for us to use… And it's like, no you can do integrated reporting, doesn't matter - now it's like, we want you to separate them out. And just this feels like the goalposts change constantly. And I understand that as things become more streamlined or we work out things better, that often then becomes a better reporting tool, but that increases I think, administrative tasks of services and takes away from their service provision. And it's stressful.

Regional Hub 1 wanted to see a more streamlined Victorian service system, noting that unclear expectations create pressure on Hubs and prevent staff from focusing on service provision. In contrast, some other Hubs expressed a preference for less oversight or were satisfied with the consultation opportunities provided by the Department, such as the roundtable discussions held during the early stages.

Factors that supported the Hubs' development

Training opportunities and knowledge sharing

Four SRH Hubs highlighted the importance of the DoH-funded Clinical Champions Project, based at the Royal Women's Hospital. Regional Hub 2 noted that the program facilitated connections with the other Hubs. For Regional Hub 3, the Clinical Champions Project was instrumental in providing "support and confidence," helping to alleviate concerns about stigma and potential community backlash regarding abortion services. This was a recurring theme for some regional services, whose management had initially hesitated to promote their services due to fears of negative reactions. The Clinical Champions Project also enabled Regional Hub 3 to update GPs' skills for IUD insertions and enhance nurses' knowledge in contraception and STI management. The accessibility of this free, online education was highly valued by participants.

Additionally, some participants mentioned valuable training and support from Sexual Health Victoria, CERSH, local Women's Health Services, and 1800 My Options. Metro Hub 1 emphasised the critical role of training, noting that their staff have undertaken courses in Implanon insertion, STIs, endometriosis, and pursued postgraduate degrees in sexual health and health promotion. They also prioritise sharing their knowledge with other services to enhance collaboration, including working with local GPs, ED staff, and maternity ward midwives. The Hub Nurse Practitioners "provide training to clinicians from external services who have attended the theoretical component elsewhere, and we are wanting to become accredited in provision of cervical screening and LARC insertion."

Hub Community of Practice, managerial support and practitioner confidence

Clinic directors and obstetric directors were also recognised as helpful in establishing SRH Hubs. Metro Hub 1 particularly highlighted the crucial support from their Clinical Director, who had experience with nurse-led models from working in the UK. This director was instrumental in facilitating the participant's training in IUD insertion.

Beyond managerial support, connections with other Hubs in the Community of Practice played a significant role in providing Hub staff with insights into what could be achieved and fostering a sense of possibility. As a participant from Regional Hub 4 noted,

> *I think maybe a little bit, just not asking permission is a big part of it. And I had the confidence to do it that way because I knew that I had exec support … And I knew that I had, that other hubs are doing it well and doing it this way.*

A participant from Metro Hub 1 similarly noted that broad management support and trust in the nurse-led model enabled nursing staff to advance the Hub's services with minimal oversight:

> *We sort of went under the radar for a little while in terms of…the amount of autonomy we have. And now that we have come through the other side, I don't think that is going to change - it's definitely a nurse-led service. All the appointments and clinics are organised by us, and most of the services can be accomplished through nursing care. We have a collaborative arrangement with our GP and Clinical Director, and they are incredibly supportive. I think that we have demonstrated our worth. And from that perspective, it was an effective way to establish the service. Rather than having to check in with them all the time, we're able to just move ahead and be creative about how we designed the clinics and how we've… the special things that we've done within those services.*

Key achievements of Hubs and gaps they have filled

Providing financial and geographic accessibility

Many participants noted the benefits of waiving costs for MTOP or LARC services and prescriptions, offering bulk billing, and providing affordable SRH options for Health Care Card holders.

Geographic accessibility was also emphasised, with several participants noting that multiple Hub sites significantly improved service provision. Metro Hub 1 identified regional needs and established three Hubs to address them, including a Saturday clinic at the most accessible location by public transport. Regional Hub 2 stressed the importance of their services for clients travelling from other regions without local access to LARC and MTOP. Regional Hub 3 spoke about their central location, on-site pathology service, and strong partnership with a nearby ultrasound clinic offering same-day service, which enhances accessibility for clients travelling longer distances.

Building stakeholder relationships and collaborating with the Victorian Women's Health Services

A participant from Metro Hub 1 pointed to the critical role of establishing strong relationships with stakeholders, including other health practitioners and services. These connections were vital for supporting the nurse-led model of care and for engaging with the Victorian Women's Health Service in their region that facilitated access to local communities:

> *I think that we have developed more robust relationships with stakeholders. Having a collaborative approach improves care and outcomes for people attending for care.... we can make sure that there is a safety net for people if their condition is more complex and care needs to be escalated. By working in partnership, so much more can be achieved. An example of this, is the work we did with WHISE to deliver the menopause talks. We were able to reach a much broader community and educate them around the topic of menopause. So those relationships are imperative.*

For Regional Hub 1, a significant achievement was working with the local public hospital to encourage them to offer STOP and manage their own pre-admission clinic.

Metro Hub 1 noted that establishing the Hub increased accessibility to SRH care for Aboriginal clients. They collaborated with local Aboriginal community centres to deliver education on bowel and cervical screening and provided swabs for self-collection during sessions. Regional Hub 3 also developed new relationships with homelessness support organisations and services for young people in their region.

Destigmatising LARC, MTOP and STOP and expanding availability

Several participants highlighted a key achievement of their Hub was changing community attitudes toward SRH and initiating conversations around women's health issues. The provision of MTOP and referrals for STOP played a crucial role in destigmatising SRH services.

Additionally, several noted that their Hub's provision of MTOP and LARC, supported by their local public hospital, has increased comfort among other GPs and providers in offering these services. This has expanded access to MTOP and LARC beyond the Hub itself. Regional Hub 3, for instance, has streamlined access to STOP through their local community health organisation and a local GP provider.

Offering substantial consultation time

Participants spoke about the benefits of dedicated consultation time to discuss SRH and make informed choices. Regional Hub 3 participant said of the GP consultations on offer at their Hub:

> *Women have reported just being given the time to talk about their issues with a GP, who's had time and has been open to listen to what their concerns are, particularly around menopause and types of contraception. Some women have said, 'Oh, it's great. Now I understand' - you know, rather than just being [told], 'Oh, well, you need this', they've been able to come and be able to make an informed choice about what they want.*

The Regional Hub 2 participant noted that the provision of extended nurse consultation times has afforded:

> *More consult time for clients with complex needs, where they've got dual diagnosis or mental health issues, or have experienced family violence. I've got the ability to spend time building rapport with them to provide more comprehensive, trauma informed care.*

The participant also observed a reduction in presentations to the local hospital's ED, attributing this to the Hub's ability to manage post-termination bleeding effectively. Additionally, they highlighted that telehealth consultations have been instrumental in building trust and rapport within the community:

> *I have had one example where we had an Aboriginal student that didn't want to come down to the health service. However, we organised a telehealth consult with her from the school and we had a big chat first. We did two phone consults first, and so they'll probably 30-minute phone consults each, this enabled us enough time to build rapport for her to feel like she could come in. She was then confident in coming into the SRH Hub with her parent, it just took extra time and work initially… which wouldn't be possible without SRH Hub funding.*

Metro Hub 2 identified that a significant challenge was the time required for following up with clients after treatment. There is often reluctance to engage further with the service after the first step. The participant noted that explaining options and treatment processes, particularly when working with CALD women, is time-consuming and requires considerable effort. She described some recent feedback from a patient:

> *… she said to me, "Do you know you're the only person who has really taken time to explain to me so that I fully understand?" Because by the end of it, I asked her, "Do you have any questions? Is there anything you need clarification on, you know, for you to make a better informed choice?" … especially for us that with the women we deal with, yes, they might be able to speak English, but the level of understanding, I think it's something you have to sort of assess. And I think I'm just glad because I worked in refugee health, so I am big into checking in, 'Teach Back'.*

Establishing Penthrox pain relief for IUD insertion

Two SRH Hubs implemented Penthrox, also known as the 'Green Whistle', as an immediate pain relief option for IUD insertions, significantly reducing client waitlists for those who previously would have required general anaesthetic. Metro Hub 1 pioneered the use of Penthrox after observing that many women experienced pain during IUD insertions. Advocating for its use was challenging, as Penthrox had previously only been available only through the Acute Pain Services for outpatients. The approval process was lengthy and involved coordinating with pharmacists and training staff on the use of the Penthrox Inhaler, including potential side effects and aftercare. The participant expressed satisfaction with the outcome stating, "I'm so glad we persevered and were able to get approval because Penthrox is really well tolerated and clearly, the community are very appreciative that this from of analgesia is available to them," and suggested that Penthrox should be adopted as a standard of care statewide.

Expanding provision of LARC

Many clinics, including Metro Hub 1, were able to offer IUD insertions for the first time and significantly expand this service as their Hub developed. For example, Metro Hub 1 increased their IUD insertions from 2-3 per month to 10-15 per week. For more information, see the section on provision of Long-Acting Reversible Contraception under 'How Department of Health funding enabled the provision or expansion of SRH services'.

Undertaking training internally and externally

Metro Hub 1 emphasised the importance of staff education to ensure alignment with current and evidence-based practices. This education extends beyond internal staff to include colleagues, graduate midwives, and the broader educational community.

Regional Hub 1 provides health practitioners with the opportunity to shadow their service and actively participates in SRH conferences to share their expertise and experiences.

For more information on the importance of undertaking training, see the section on training opportunities and knowledge sharing under 'Factors that supported the Hubs' development'.

Offering integrated sexual and reproductive healthcare

Metro Hub 1 took pride in their development of comprehensive documentation and clinical practice guidelines for SRH Hub services. They also streamlined the triaging and referral process for scanning and bloodwork related to STOP, organising and packaging these materials for the patient's gynaecologist consult. Integrated care was an important focus, with this participant expressing pride in:

> *… the holistic approach that we have adopted, ensures that all women presenting at this service will be offered a cervical screening test and an STI check, and that they have had the opportunity to arrange adequate contraception, and any other care that they need.*

Areas that require further support or funding

Staffing

Insufficient staffing has significantly affected various aspects of service provision. SRH Hubs spoke about the need for locum doctors to cover staff leave and additional staff to support outreach programs, develop clinical practice guidelines for new services, and extend clinic hours and spaces.

Staff turnover in regional Hubs also poses challenges in promoting the Hubs to other service providers. Regional Hub 3 noted, "the lack of use of our services and the need to constantly to remind other service providers, GP clinics that we are here, that's probably surprised us a bit. But I guess with changes in doctors and locums, that makes it hard."

Equipment and in-house services

Participants indicated that funding for essential items such as vital signs monitors, gynaecological couches for speculum examinations and IUD insertions, and ultrasound machines would improve their services. In-house bloodwork could also streamline operations, saving both administrative time and costs for non-Medicare patients. Specifically, having ultrasound machines would alleviate financial burdens on clients, as most radiologists do not bulk bill and those that do often charge a partial fee of $50.

Collaboration with other community stakeholders

Regional Hub 1 noted that additional funding would enable them to connect with other organisations and visit local GPs to promote their Hub's services. Regional Hub 2 mentioned that sustained funding would facilitate collaboration with the disability sector, local Aboriginal Community Controlled Organisations, school nursing teams, and family violence experts. They plan to use expanded funding to increase service hours and enhance outreach to community groups:

> *Aboriginal women, women with disabilities, CALD clients, people that have experienced FV [family violence] or sexual assaults, or LGBTIQ community or [Health Care Card] all have a safe and welcoming space here at the SRH Hub. Ensuring these groups know about our service requires additional service promotion, which takes time. I am currently employed 20 hours a week and would benefit from additional hours to complete this service promotion work.*

Pointing to a more established clinic as an example, they noted:

> *New services always take time to become established, so my hope is that the hub continues to be funded as it would be such a shame to stop it in two years' time when we're finally starting to build momentum and get community word of mouth… we need to give SRH Hubs time and ongoing funding to be well utilised and supported within our communities.*

Funding for nurse practitioner training and staff professional development

Several regional Hubs stressed the importance of integrating Nurse Practitioners into their services and ensuring long-term funding for nurse-led models. Regional Hubs 1 and 3 said that

financial support for Nurse Practitioner training is vital to reduce dependency on GPs in the future.

Regional Hub 1 raised concerns that the high cost maintaining a nurse practitioner model could lead to service reductions and necessitate charging clients out-of-pocket fees. They explained,

> *[At the time the Hub was established] the Nurse Practitioner model wasn't really there and so that's what we went with, because we could have more reach, more flexibility, more integration, and more time with people rather than - but supported by GPs. And over time, we've increased our support of GPs and we would kind of pay them some time in terms of checking our results and all of that. If we lose our MTOP prescribers, yeah, we can't offer that service. Whereas nurse practitioners will be able to prescribe MTOP. But for us that sustainable model, it's not there...It's kind of a catch 22. Like we would have to put off staff to have a nurse practitioner, which decreases service availability for people. So [it's] this kind of weird dilemma. And I think until the Department of Health kind of really support nurse led models in a better way, we won't be going down that path.*

While this participant acknowledged the 2023 changes allowing Nurse Practitioners to prescribe MS-2 Step for early medical termination of pregnancy, she hesitated to pursue this option further due to concerns about the costs and lack of funding support for nurse practitioners.

Funded opportunities for the ongoing professional development of Hub staff were also seen as important to ensure, as Regional Hub 4 stated, "Hubs are the most progressive, most supportive, most up to date, places to go for this care":

> *The funding only funds the role, basically. And I've been lucky I had this additional funding that I secured. So, I've been able to do stuff that other Hub nurses probably can't. And I think that's a real problem... particularly in relation to education ... [if] my doctor and I hadn't been able to go to the sexual and reproductive health conference in Sydney last year, I don't think we would have started using Penthrox in IUD insertions, because I don't think that he would have been confident in doing that off the bat. The fact that he met a fellow GP there who was doing it, who had the evidence who supported that, is the reason why we started doing that.*

Legislative or policy changes

Regional Hub 2 wanted to see nurses "being able to order basic pathology, STI screening, ultrasound orders" and noted that Nurse Practitioners being able to prescribe MTOPs would improve Hub service. There was some inconsistency in Hub staff's knowledge about changes to MTOP regulation and what services Nurse Practitioners are able to provide.

Medicare reforms

Several participants discussed the need for a Medicare Benefits Scheme item for early medical abortion. For example, Regional Hub 1 said they would like to see:

Medicare changes to providing abortion care in primary care. So for general practice, having a better renumerated Medicare so that GPs can provide. Like at the moment, it's quite time consuming. And so our model - we're a funded nurse[-led service], we do the bulk of the appointment and GP pops in. We can do that. But in private practice, that's harder. And I think we might have more people take it up, if that was there.

Several Hubs discussed the need for Medicare reforms to better support nurse-led models of care by incentivising the training and hiring of Nurse Practitioners. This is supported by an Australian study by Botfield and colleagues (2020) who concluded that, "Enabling [Registered Nurse]-led LARC insertion is a cost-effective way of increasing accessibility to these contraceptive methods. The creation of Medicare Benefits Schedule item numbers for RNs appropriately trained in LARC insertion and removal would have benefits for both women and the Australian government" (p. 109). Regional Hub 2 spoke about the importance of Medicare Benefits Scheme items for services provided by nurses, such as MTOPs, cervical screening tests, and sexual history assessments. They expressed interest in pursuing Nurse Practitioner training but were deterred by the lack of job security, noting that Medicare billing for Nurse Practitioners is inadequate and does not guarantee a position within the Hub:

Certainly, improved rebates for sexual and reproductive health Medicare items. If you become a nurse practitioner... I wouldn't even make enough money to cover my hourly rate, which means my role wouldn't be viable in a GP clinic without Hub funding.

Regional Hub 1 similarly commented, "I just think being able to either have a really well funded Nurse Practitioner model, or a sustainable model, where you are paying GPs for their time, rather than them having to get Medicare billing, increases sustainability, in particular in regional areas." They added:

Let's say we can pay for two nurses to be on basically every day. But if we put a nurse practitioner on, that's going to drop the nurse hours as well. So it's kind of this catch-22 of potentially, we might not need a GP but the GP is able to bill so that actually doesn't - we pay one of our GPs who kind of oversees the sexual health clinic, we pay her a certain amount. But most of her money comes from billing, whereas now, the medical billing for nurse practitioners is not like, it doesn't cover the cost of them. Yeah. So it's about that ongoing kind of cost.

Regional Hub 3 highlighted the need for special considerations for migrant workers without Medicare cards. They suggested the implementation of temporary Medicare cards for these groups to improve access to essential services.

Expansion of SRH services to gender diverse communities and cis men

Metro Hub 1, who had recently met with a gender diverse Community Advisory Group, commented:

There's a bit of a gap in service provision to gender diverse clients. We want them to feel that they can come to our service, but we don't see biologically male clients. So I think that is a gap in service provision that doesn't really

make sense. So we're asking whether the service can be expanded, because our sexual health physician that's been doing some relief work would be happy to see men, or... people that identify as male. And I think that the two clinics should be run in parallel, because it's silly, somebody coming in for treatment for an STI and their partner can't come here because they're not biologically female.

A colleague from the same SRH Hub also noted the need for PrEP (Pre-exposure prophylaxis) and PEP (post exposure prophylaxis) HIV medications in their region and expressed a desire for their Hub to provide these services in future.

Discussion

This case study offers a critical summary of the key learnings gained from practitioners' experiences in establishing and maintaining SRH Hubs across Victorian metropolitan and regional areas. It aims to support both existing and prospective Hubs by sharing valuable lessons learned, while also highlighting strengths and identifying areas for improvement to inform policymakers. Several key themes are evident, that we wish to highlight.

Expansion of services

Funding for SRH Hubs has enabled the expansion of services, either by introducing new services or extending operating hours. This expansion has had positive effects on SRH service provision beyond the Hubs themselves, particularly in the area of abortion services. For instance, some Hubs observed that nearby clinics or GPs were more willing to prescribing MTOP, knowing that the Hubs were available to support their practices if needed. Additionally, the establishment of SRH Hubs, coupled with the provision of MTOP by highly qualified staff, has alleviated the burden on local hospitals by reducing the number of post-procedure presentations.

Sustained funding is essential to ensure organisations can continue providing these vital services. Participants noted that community access would be significantly improved by investing in medical equipment, such as ultrasound machines, which would enable continuous in-house care. Additionally, funding is crucial to support the retention and development of SRH Hub staff, particularly for regional Hubs. Currently, some Hubs must rely on supplementary funding from other sources to maintain the necessary clinic hours and services to meet community needs.

Participants also highlighted the need for Federal government reform of Medicare Benefits Schedule item numbers to support equitable access to SRH services through Hubs and to encourage nurse-led models. Such reforms could help establish a more consistent fee structure across all SRH Hubs, ensuring fair and accessible care for all communities.

Advantages of nurse-led models

Interviewees provided strong evidence highlighting the advantages of nurse-led models in SRH service provision. These models not only promote sustainable care but also enable regional Hubs to expand their service offerings. Some Hubs indicated that nurse-led models are more

cost-effective, though this view was not universally held among those interviewed. However, to function efficiently and effectively, nurse-led models require support through professional development and training, Communities of Practice, access to on-site equipment, and supportive policy environments. This includes necessary reforms to Medicare Benefits Scheme item numbers.

Benefits of community-based care

Community-based care was found to improve accessibility, particularly for groups experiencing disadvantage. However, the interviewees noted that strict eligibility requirements, particularly when detailed on websites, can cause confusion and potentially deter people from seeking care. To support the accessibility of Hubs, this case study supports recommendations made by the VAGO report, which highlight that a full understanding of service gaps and demand across the state is required to ensure optimal service accessibility and utilisation and to develop performance measures to monitor the Hubs' ability to improve service access.

References

Botfield, J. R., Lacey, S., Fleming, K., McGeechan, K., & Bateson, D. (2020). Increasing the accessibility of long-acting reversible contraceptives through nurse-led insertions: A cost-benefit analysis. *Collegian, 27*(1), 109-114. doi:10.1016/j.colegn.2019.05.001

Department of Health. (2017). *Women's sexual and reproductive health: Key priorities 2017-2020*. Melbourne: State of Victoria.

Department of Health. (2022). *Victorian Women's Sexual and Reproductive Health Plan 2022-2030*. Melbourne: State of Victoria. Retrieved August 8, 2024, from https://content.health.vic.gov.au/sites/default/files/2022-09/womens-sexual-and-reproductive-health-plan-2022-30-pdf.pdf

Department of Health. (2024, April 5). *About the Women's Health and Wellbeing Program*. Retrieved from Health.vic - Helping Victorians stay healthy and safe: https://www.health.vic.gov.au/womens-health-and-wellbeing-program/about-the-program

Moulton, J. E., Arefadib, N., Botfield, J. R., Freilich, K., Tomnay, J., Bateson, D., . . . Mazza, D. (2024). A nurse-led model of care to improve access to contraception and abortion in rural general practice: Co-design with consumers and providers. *Journal of Advanced Nursing, 00*, 1-19. doi:10.1111/jan.16299

Victorian Auditor-General's Office (VAGO). (2023, May 17). *Supporting Sexual and Reproductive Health*. Retrieved from Victorian Auditor-General's Office: https://www.audit.vic.gov.au/report/supporting-sexual-and-reproductive-health?section=

World Health Organization. (2015). *Health worker roles in providing safe abortion care and post abortion contraception: executive summary.* Geneva, Switzerland: World Health Organization.