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# EMR Sexual & Reproductive Health Needs Analysis: Findings and Recommendations

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Sexual and reproductive health (SRH) is one of the priority areas for Women’s Health East in our 2013-2017 Integrated Health Promotion Plan. In 2014 and 2015, a regional needs analysis was conducted in the Eastern Metropolitan Region (EMR) to identify barriers for women in achieving optimal SRH. The needs analysis included a literature review, data collection, and consultations with a range of organisations at the local, regional and state levels.

This document presents the findings of the needs analysis and details the processes that were undertaken to reach these findings. The EMR is home to women of all ages from a diverse range of backgrounds, including ethnicity, cultural and language background, Aboriginality, sexual and gender identity and ability. Additionally, these women live in a range of social and economic circumstances, have diverse abilities, levels of education and employment status.

Analysis of the evidence, demographic data and consultation findings revealed that within the EMR, women who were most likely to experience SRH inequities included young women, those from migrant, newly arrived and culturally diverse backgrounds, Aboriginal women, those who have experienced violence from men, women with disabilities and women of diverse sexual and gender identities.

The associated priority needs of these women were explored and recommendations were made regarding each of these priorities. These were endorsed by the Eastern SRH regional strategic reference group in November 2015 and are as follows:
1. Representation of SRH issues in Regional Policy and Planning

1.1 Promote the inclusion of SRH as a priority issue at local, regional and state government levels, and in community health, PCP, PHN and other relevant health plans.

2. Sexually Transmitted Infections

2.1 Improve access to STI information, education, prevention and screening for women, with a focus on those at greater risk.
2.2 Advocate for a National STI screening program.
2.3 Build workforce capacity to prevent Hepatitis B through education, immunisation, screening and treatment.

3. Reproductive Empowerment, Access and Rights

3.1 Strengthen women’s reproductive rights and capacity to make informed choices, through strategies that include education, advocacy and other means, and with a focus on those at greater risk.
3.2 Improve access to emergency contraception, medical abortion and surgical abortion.

4. Sexualisation and Objectification of Women

4.1 Promote gender equity by advocating for the non-sexualised portrayal of women in the public domain, e.g. the media, pornography and online gaming.

5. Sexual and Reproductive Health Literacy

5.1 Improve SRH literacy for all women.
5.2 Ensure access to responsive, culturally and linguistically inclusive healthcare for all women.

6. Female Genital Mutilation/Cutting

6.1 Advocate for a preventative and workforce capacity building response to FGM/C in the EMR.
INTRODUCTION

Sexual and reproductive health (SRH) is one of the priority areas for Women’s Health East in our 2014-2017 Integrated Health Promotion Plan. The objective for this work was to identify SRH priorities, target population groups, gaps and unmet need for women in the region. To achieve this, a regional needs analysis was undertaken in 2015 and 2016. The needs analysis included a literature review; collection of local, state and national SRH data and regional demographic data; and insights collected through consultations with relevant local, regional and state organisations.

Women’s Health East
Women’s Health East (WHE) is a regional women’s health promotion agency working across the municipalities of Manningham, Boroondara, Monash, Whitehorse, Knox, Maroondah and Yarra Ranges, that make up the Eastern Metropolitan Region (EMR) of Melbourne. Working within a feminist framework, Women’s Health East addresses the social, political and environmental factors that impact on the health, safety and wellbeing of women in the region. We build the capacity of services and programs in the region through leading, partnering, shaping, informing and delivering responses that optimally address issues affecting women.

Our health promotion priorities include:
- Sexual and Reproductive Health
- Prevention of Violence Against Women
- Gender Equity for Health Outcomes

Definitions of Sexual and Reproductive Health
There are a number of definitions associated with SRH that form the basis of discussions in this paper, including sexual health, reproductive health, reproductive rights and sexual health promotion. The following definitions are those used in the majority of current literature.

Sexual Health
“Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled”  

Reproductive Health
“Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so”

Reproductive Rights
“Reproductive rights … rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”

Sexual Health Promotion
Sexual health promotion focuses not only on individuals, but on communities and population groups. Its aim is to strengthen public policy that enables people to increase their capacity to achieve optimal SRH.

In addition to the above, good SRH is fundamental to a positive identity and the enjoyment of social relationships. Critically, evidence suggests that many sexual and reproductive health problems are preventable.
Policy and Environment
SRH strategies at the local level are informed by a number of individual state and national level policies. Overarching national or state SRH strategies that guide this broad area of work have not as yet been developed. However, policies for specific SRH issues include the 3rd National STI Strategy, the 4th National Aboriginal and Torres Strait Islander BBV and STI strategy, the 2nd National Hepatitis B Strategy, the Seventh National HIV Strategy 2014-2017, and the National Women’s Health Policy 2010.

At the state level, the Victorian Public Health and Wellbeing Plan 2015-2019 identifies priorities for health that include SRH. It is hoped that this inclusion will raise the profile of SRH as an important issue and encourage local governments, community health and other organisations to include it as one of their own priorities. The Women’s Health Association of Victoria (WHAV) has called for the development of a state women’s health policy and action platform for 2014–2018, suggesting five specific actions for government, including a state-wide sexual and reproductive health strategy.

One of the tasks for this document and associated work will be, in the absence of a state or national SRH strategy, to raise the profile of women’s SRH as a priority need in the EMR. It is anticipated that promotion of this issue will occur with local government, community health and other key organisations in the region.

Social Determinants of Sexual and Reproductive Health
According to the World Health Organisation (WHO), the social determinants of health are “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.” Further to this, the Australian Women’s Health Network (AWHN) suggests that these conditions are driven by higher level, structural factors that include gender, race, ethnicity, sexuality and ability. These structural drivers shape women’s everyday lives around social and economic factors, employment and work conditions, unequal pay, freedom from violence, education, care-giving roles and a number of other factors.

A social determinants approach to SRH focuses on population health and the disparities that occur within and between population groups, rather than a focus on individual behaviour change. This is an essential component for addressing SRH inequity. While individual behaviours contribute to health outcomes, there is evidence that addressing the broader determinants is just as critical.

The Women’s Health West (WHW) 2011 report “Social Determinants of Sexual and Reproductive Health” articulated the social determinants of SRH in the following way:

- Poverty and socio-economic status
- Violence and discrimination
- Gender norms
- Public policy and the law
- Cultural norms
- Access to affordable culturally appropriate health services

The Victorian Public Health and Wellbeing Plan 2015-2019 supports a social determinants approach to health, with its overarching aim to reduce inequalities in health and wellbeing, which includes SRH as one of its priorities.
Gender

Gender is a powerful, structural driver of women’s lives and health status. The AWHN explains the impact of the structural drivers on the lives of women as:

...the underpinning driver[s] of women’s socio-economic positioning. These are the deeply entrenched structural mechanisms that stratify society along gender lines, and produce and maintain gender hierarchies in relation to power, prestige and access to resources that are the key requisites for a healthy life.

Addressing the issues that have arisen from this regional needs analysis will be critical for women in the area. However, it is imperative in addressing health inequity that this work acknowledges gender as one of the structural determinants of health.

Intersectionality

The above mentioned determinants do not exist in isolation from one another. They can combine and compound in complex ways, leading to multiple forms of disadvantage and discrimination. This is known as intersectionality.

As a result, power, money and resources are distributed unequally within women as a group, leading to health inequities between women. Put simply; all women’s lives and health are impacted by their gender, however, the impact varies significantly according to the effects of other social determinants, such as ethnicity, sexuality and ability.
NEEDS ANALYSIS

SRH is one of WHE’s health promotion priority areas for 2013-2017. As the women’s health service in the EMR, a regional, strategic perspective has been taken throughout this work. As such, a regional needs analysis was undertaken to identify SRH priorities, gaps and unmet need in the region.

In this section of the paper, the needs analysis process, data sources and findings will be presented.

**Process**

The overarching goal of the needs analysis was to identify groups of women who are most likely to experience SRH inequities, to explore these issues and to generate a plan of action.

To inform the needs analysis, the following activities were undertaken:

1. Collection of EMR demographic data
2. Collection of regional, state and national SRH data
3. Literature review
4. Face to face and online consultations

These data were analysed and presented in a discussion paper that considered the barriers to good SRH for specific groups of women. Subsequently, consultations around this paper were conducted with key stakeholders that included WHE health promotion team, Family Planning Victoria (FPV), Multicultural Centre for Women’s Health (MCWH), Headspace Hawthorn, Yarra Valley Community Health, EACH Social and Community Health and Swinburne University (Croydon campus health service).

Following this, a number of draft SRH priority needs were identified for the region. In order to formalise these priorities and guide the progression of this work, the Eastern SRH regional strategic reference group was convened in July 2015. The strategic reference group currently comprises members from Family Planning Victoria (FPV), DHHS (Eastern), Secondary School Nursing Program (SSNP), Multicultural Centre for Women’s Health (MCWH), Deakin University, Manningham City Council, Yarra Valley Community Health (Eastern Health), EACH Social and Community Health, Headspace Hawthorn, Mullum Mullum Indigenous Gathering Place (MMIGP), and the Eastern Melbourne Primary Health Network (EMPHN). Jean Hailes also participated as members in 2015.
Recommendations for each of the priority issues were subsequently developed by the strategic reference group using a priority identification tool that was adapted from the Victorian Healthcare Association Population Health Planning Framework (Appendix 3) and used ideas from the Women’s Health Goulbourn North East IHP 2012-2016 priority setting process. The criteria used for prioritisation were:

- Prevalence of the issue
- Severity of the issue
- Selectivity (sub-groups who are inequitably affected) of the issue

Data
An overview of the data used in the analysis is given below. Although all attempts were made to access key data sources, this was not an exhaustive process.

EMR Demographic Data
Demographic data were collected from a variety of sources and are summarised below.

The Eastern Metropolitan Region (EMR) is an area covering almost 3,000 square kilometres that extends from Melbourne’s inner eastern suburbs to the rural fringe. The region contains the seven local government areas (LGAs) of Boroondara, Knox, Maroondah, Manningham, Monash, Whitehorse and Yarra Ranges. The region is home to people from a range of cultural and ethnic backgrounds, including Aboriginal communities, newly arrived migrants and refugees, as well as second or third generation migrant families.

The EMR as a region generally ranks higher than other Victorian regions on social, economic and health measurements. However, although the EMR constitutes areas of relative wealth and privilege, areas of significant disadvantage also exist, often alongside or within the more privileged areas. The needs of these communities can sometimes be masked and ignored through common perceptions about the socio-economic status of the EMR as a whole.

The EMR is home to 2,969 Aboriginal people that include traditional owners as well as people from other Aboriginal and Torres Strait Islander Communities. Aboriginal people reside predominantly in the outer east, particularly around Healesville in the Yarra Ranges, but also in Knox and Maroondah. Almost 1,000 of the Aboriginal people living in the EMR are under 14 years old; a significantly higher proportion than the general population.

Within the EMR, 26.7 per cent of people speak a language other than English at home and 31.5 per cent were born overseas. Cultural diversity however, differs significantly across LGAs with 44.4 per cent of the Monash population speaking a language other than English at home and 44.7 per cent born overseas. In contrast, six per cent of the Yarra Ranges population speak a language other than English at home and 16.3 per cent were born overseas. Additionally, 26,605 international students (on temporary student visas) attended the region’s three universities in 2014; Monash, Deakin and Swinburne.
Health indicators vary across LGAs. Life expectancy is ranked out of 79 for Victoria (1 being the longest life expectancy and 79 being the shortest). Examples of variation within the EMR are as follows:  

- Boroondara - 5 (women) and 3 (men)  
- Monash – 4 (women) and 6 (men)  
- Knox – 66 (women) and 25 (men)

Social indicators also vary between and within LGAs. For example, Boroondara is ranked number one in Victoria on the SEIFA index (least disadvantaged). However, within Boroondara there are 22 neighbourhoods out of 390 that are among the 20 per cent most disadvantaged in Victoria on either the Index of Relative Socio-Economic Disadvantage or the Index of Economic Resources.

Sexual Reproductive Health Prevalence and Incidence Data  
SRH data was collected predominantly from state and national sources, including the Australian Bureau of Statistics (ABS), National government policy and strategy documents, Australian Indigenous HealthInfoNet, Family Planning Victoria, Family Planning NSW, Infectious Diseases Surveillance Victoria, Better Health Channel, VicHealth and the Hepatitis B Mapping project.

Where available, regional and local government level data was used, however, this was limited to STI notification rates, cervical screening rates, Hepatitis B virus (HBV) prevalence and teenage pregnancy. Local demographic data was also used in conjunction with national and state level SRH data and evidence to extrapolate risk for women in the EMR. This data will be presented within the sections below, as relevant to each of the identified, priority needs.

Literature Review  
A literature review was conducted to explore current policy positions and frameworks and to ensure the needs analysis was grounded in up-to-date knowledge of women’s SRH and its determinants.

Evidence of good practice for health promotion, prevention and service delivery was reviewed to inform potential responses to recommendations. The literature included health reports, academic literature, discussion papers, web-site information, and government policy and strategies (state and national). Documents that were published between 2005 and 2015 were used primarily (except in a small number of cases where more recent information was not available).

The following sections provide an overview of SRH health status within the EMR and present the resulting key priorities for action arising from application of the priority identification tool.

Consultation Data  
Face-to-face consultations were held with 20 staff from 15 key local, regional and state organisations, which included community health, FPV, youth specific organisations, migrant and refugee services, Aboriginal organisations, secondary school nursing, family violence and sexual assault services. A consultation tool was developed for the consultations to identify gaps and unmet need in women’s SRH (Appendix 1).

An online consultation questionnaire was also sent to approximately 190 staff from 82 organisations (Appendix 2). There were 32 responses to the questionnaire; 21 of which were complete. The organisations included those listed above as well as local government, Department of Education & Training (DET), child and family services, tertiary education health services, Victoria Police, Primary Care Partnerships, Medicare Locals, Eastern Health, and disability organisations. The results of the questionnaire were used to further inform our understanding of women’s SRH, gaps and unmet need in the EMR.

The consultations were targeted to organisations in the EMR whose primary focus is women’s SRH,
as well as to organisations who may work in this space from time to time either through service delivery or health promotion. Feedback from the consultations provided the needs analysis with qualitative and contextual information that was used in conjunction with statistical and demographic data to identify SRH inequity in the region.

**Findings and Prioritisation**

The discussion paper that was developed from early findings of the needs analysis identified a number of population groups of women who were most likely to experience barriers to optimal SRH. They were:

- Young women
- Aboriginal women
- Women with disabilities
- Women who have experienced violence from men
- Women who are sexually and gender diverse
- Migrant, newly arrived and culturally diverse women

Following consultation with key stakeholders around the discussion paper, the following priority needs were established:

1. Representation of SRH issues in Regional Policy and Planning
2. Sexually transmitted infections
3. Reproductive empowerment, access and rights
4. Sexualisation and objectification of women
5. Sexual and reproductive health literacy
6. Female Genital Mutilation/Cutting

The following section will present and discuss each of these priority SRH needs in more detail, with particular focus on the groups of women who are likely to experience the greatest barriers around these issues.
EMR SEXUAL AND PREPRODUCTIVE HEALTH PRIORITIES

This section will focus on the six priority areas that were identified through the needs analysis. Relevant data and evidence of best practice will be discussed, followed by recommendations to address each priority.

Priority 1: Representation of SRH Issues in Regional Policy and Planning

Women’s SRH has not featured prominently in the strategic planning of organisations in the EMR. While some organisations are undertaking work relevant to SRH, very few have prioritised it in a way that is informed by analysis of the available data. One of the more immediate priorities identified through the needs analysis is the need to raise the profile of women’s SRH more broadly with a variety of organisations in the EMR, including local government (LG), community health, and a number of others. It is hoped that through this process, organisations will gain a better understanding of the SRH issues that women may face, leading to consideration of these in the development of their organisational plans.

The Victorian Public Health and Wellbeing Plan 2015-2019 identifies SRH as a priority area for action over the next four years. This is a positive factor, as local government, community health and other regional and local organisations use this plan to guide development of their priorities for action. At present, a gap exists around a more comprehensive, state or national level SRH strategy. It is hoped that the Victorian Government will develop such a strategy in the near future, and that this will provide guiding principles and evidence of good practice for SRH health promotion and planning that is readily available to local organisations.

Recommendation for priority 1:

Promote the inclusion of sexual and reproductive health as a priority issue at local, regional and state government levels, and in community health, Primary Care Partnership, Primary Health Network and other relevant health plans.
**Priority 2: Sexually Transmitted Infections**

Sexually transmitted infections (STIs) are a significant issue in Australia, Victoria and the EMR. Women have higher notification rates than men for some STIs, including chlamydia. Some groups of women are at higher risk of STI infection than others and this is likely to be attributable not only to biological factors, but also a number of social and environmental factors. Women from lower socioeconomic background, due to a number of factors associated with knowledge, education and health literacy, are likely to be at higher risk for STIs. Additionally, young women, culturally diverse women, Aboriginal women, lesbian and bisexual women, women with disabilities and those with experience of family violence are all at higher risk. The factors for these groups of women will be discussed in more detail later in this section.

STIs of particular concern include chlamydia, gonorrhoea, syphilis, human papilloma virus/genital warts (HPV), genital herpes, HIV and hepatitis B. Chlamydia is the most common STI in Australia and notification rates have risen significantly over the past couple of decades. Rates of gonorrhoea have also risen in recent years, while that of HIV and syphilis have remained relatively stable.

Chlamydia is the most commonly diagnosed bacterial STI in Australia. In 2014, 90 per cent of the 12,607 STI notifications among Victorian 15–24 year olds were for chlamydia. Chlamydia is diagnosed in significantly more women than men, with notifications increasing over recent years:

- National notification rates increased between 2002 and 2011 from 24,400 to approximately 80,800: a more than threefold increase
- Notification rates for women in Victoria approximately doubled between 2006 and 2010

The factors that have contributed to the rise in chlamydia notifications in recent time are not clear cut. Chlamydia has likely increased in prevalence; however, the rise may also be attributed to greater public health awareness, increased levels of knowledge about STI transmission and better access to healthcare. The combined effect of these factors may have resulted in higher STI screening rates.

Chlamydia is asymptomatic in up to 90 per cent of cases and current testing rates are thought to be as low as 10 per cent of the population. Diagnosis may rely on opportunistic testing of those who present for non-SRH matters and consequently, the majority of chlamydia cases remain undiagnosed, unreported and untreated, leading to higher risk of long term, negative health consequences. These can be serious and include pelvic inflammatory disease, infertility and increased susceptibility to other STIs, particularly HIV.

HIV rates remain relatively stable for Victoria with approximately 306 new diagnoses in 2013 and 280 in 2011. The majority of these infections occurred through anal sex between men. At the end of 2011 an estimated 2,401 women in Australia were living with HIV, approximately ten per cent of people with HIV. Most women are infected with HIV through heterosexual contact and although this mode of transmission accounts for the minority of overall infections, it is slowly increasing. Heterosexual transmission is commonly due to being from or having sex with someone from a country with high HIV prevalence.
Young Women
Sexually active women between the ages of 15 and 29 years old are at significantly higher risk of chlamydia than others. This is thought to be due to biological factors, but also to behavioural factors that include the use of condoms, number of sexual partners and barriers to preventative healthcare and others.29

Table 1 shows a comparison between the chlamydia notification rates for Eastern LGAs and averages for the EMR and Victoria. LGAs that have higher than average rates include Knox, Whitehorse, Maroondah and Yarra Ranges. Maroondah and Yarra Ranges in particular have significantly higher rates than the EMR and state averages (46.17 and 45.57 respectively compared to 35.70 for the EMR and 38.72 for Victoria).

Some interesting paradoxes between this and other data exist. Although Manningham has lower notification rates of chlamydia than other areas (Table 1), in 2009 68.6 per cent of adolescents in the area said they did not practice safe sex by using a condom, compared to 41.9 per cent in Victoria.31 This finding may relate to education, sexual behaviour and rates of testing in Manningham, but certainly bears further scrutiny.

Table 1: Chlamydia notification rates by LGA (Data source: Family Planning Victoria 2013, Eastern Region sexual and reproductive health indicators)
Figure 3 indicates the number of chlamydia notifications for each LGA in the EMR for 2014. The graph illustrates the significantly higher notification rates for females compared to males. However, it is difficult to establish whether this is a reflection of actual prevalence or due to different testing patterns and notification rates between the sexes.

There is evidence to show that routine, opportunistic chlamydia testing for 15 to 25 year olds would improve rates of diagnosis and treatment and ultimately result in a decline in the prevalence of the infection. A recent study cited in the Medical Journal of Australia found that increasing annual chlamydia testing rates to 20 per cent of young people under 30 years could halve the prevalence in four years. Unlike many other developed countries in the world, Australia does not have a national STI screening program, which could address the testing rates referred to above. The Third National STI Strategy suggests that a screening program may be considered when final results from the Australian Chlamydia Control Effectiveness Pilot (ACCEPt trial) are available. The ACCEPt trial is currently in the data collection phase, although early findings indicate that routine testing of young people in general practice increases the rate of detection significantly.

The Royal Australian College of General Practitioners recommends 12 monthly screening for high-risk, asymptomatic, sexually active young people aged 15–29 years, particularly if they are under 20 years of age, Aboriginal or Torres Strait Islander, have inconsistent or no condom usage or recent change in sexual partner. They suggest that routine testing for women at the time of Pap screening is reasonable; however, it is difficult to determine how many GPs follow these recommendations. Furthermore, the current two yearly cervical screening program will be replaced within the next few years by a five yearly program for most women, making this recommendation obsolete.

Migrant Women
Migrant women tend to have lower overall rates of STI infection than women in general. Cultural, social, economic factors and age may all be contributing factors. However, women from a number of ethnic backgrounds, particularly China and Vietnam are significantly more likely to be infected with the Hepatitis B virus (HBV). The inner east area of Melbourne (Manningham, Whitehorse, Boroondara & Monash) is ranked seventh highest for HBV prevalence, out of 61 areas in Australia.

HBV can be transmitted in a number of ways. The virus can be transmitted sexually, although is commonly transmitted as a blood borne virus (BBV), particularly during childbirth. Some people who become infected with HBV will go on to develop chronic HBV and those people will be at risk of liver damage, cancer and death. Some important statistics include:
Two in five people are symptomless and unaware they have chronic HBV.

Only five per cent of people with HBV in Australia are getting treatment.

Approximately two thirds of Australians living with chronic HBV were either born overseas or are Aboriginal and Torres Strait Islander people.

Women aged 20-35 have a higher incidence of notifications of chronic HBV (possibly due to antenatal testing).

Without access to appropriate care, around 15-25 per cent of people living with chronic HBV will die from their condition and this is increasing.

Liver cancer is preventable through HBV vaccination and treatment of chronic HBV.

90 per cent of babies who are exposed to HBV at birth will develop chronic (lifelong) HBV, however breastfeeding is considered safe.

Australia’s Second National Hepatitis B Strategy and the Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy outline the targets and interventions that aim to reduce the morbidity and mortality from HBV.

International Students
Female international students are a specific cohort of migrant women who are at higher risk for STIs than other university students. Three universities are located in the EMR, giving rise to a significant number of international students who live, work or study in the region. The rates of STIs are higher for these young women, due to factors such as poor SRH literacy, access to health services, financial issues and separation from family and community.

Women who have experienced Violence from Men
Forty to forty-five per cent of women who experience intimate partner violence (IPV) also experience forced sex and/or sexual violence and these women are more likely to suffer negative SRH impacts. STIs have been found to be more common for women who have a history of violence from men, however, statistical data relating to this is difficult to obtain.

Same Sex Attracted Women
Women who have sex with women may be at higher risk of some STI infections than women in general, due to a number of factors. Knowledge of STIs and their transmission between women may not be well understood by these women or some healthcare providers. Perceived and actual difficulties in mainstream healthcare access may also contribute to higher risk and lead to lower STI screening rates for this group of women.

Women who have both male and female sexual partners have been found to be at even higher risk for STIs than those who have sex exclusively with men or with women. This risk appears to be related to earlier sexual initiation, substance abuse and risky sexual behaviour by same sex attracted (SSA) women.
The most common STIs to be transmitted between women are the HPV, candida, herpes simplex virus and bacterial vaginosis. Prevention of infection includes the use of condoms, gloves and dams that form a barrier to transmission, as well as routine STI screening. Transmission of the most common strains of HPV can also be prevented through vaccination, which is now included in the schools immunisation program for all girls and boys.

**Aboriginal Women**

The health and life expectancy of Aboriginal people remains considerably poorer than that of non-Aboriginal Australians and is closely associated with socio-economic disadvantage, dispossession and disempowerment. Consistent with this, is the significant gap between SRH outcomes for Aboriginal and non-Aboriginal Australians. SRH disparities include higher rates of STIs, BBVs and HIV. Indigenous Australians represents roughly two per cent of the overall national population, but roughly ten per cent of the chronic HBV burden.

Young Aboriginal women in particular, have significantly higher rates of STIs than non-Aboriginal women, and higher rates than young Aboriginal men. As noted previously, serious long-term consequences of STIs include female and male infertility, chronic pelvic pain, adverse pregnancy outcomes, development of cancers and increased susceptibility to HIV infection.

**Recommendations for priority 2:**

1. **Improve access to STI information, education, prevention and screening for women, with a focus on those at greater risk**

2. **Advocate for a National STI screening program**

3. **Build workforce capacity to prevent Hepatitis B through education, immunisation, screening and treatment**
**Priority 3: Reproductive Empowerment, Access and Rights**

Reproductive health refers to the basic right of all people to have a responsible, satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when and how often to do so. It includes the right to make decisions regarding reproduction free from discrimination, coercion and violence.

However, despite some progress, stigma is still associated with women’s reproductive health choices and this can cause shame, embarrassment and inability to pursue personal choice. Women’s reproductive choices that still carry stigma include abortion, unplanned and teenage pregnancy, lesbian parenting, sexual intimacy and parenting by women with disabilities, and the choice to not have children.

To have true reproductive freedom, women must:

1. Have the right to decide on all matters concerning their own reproductive health, including decisions regarding pregnancy and child-bearing
2. Feel empowered and able to act on these decisions
3. Have access to the required information in order to make these decisions, as well as access to the services and options of their choice

To make and act on these choices about their reproductive lives, women must be free from discrimination and coercion, and have access to information and services regarding:

- Contraception, including condoms, contraceptive pill, long-acting reversible contraception (implants and intrauterine device [IUD]) and emergency contraception
- Abortion (surgical and medical termination of pregnancy)
- Assisted reproductive technology

It is important to note that as well as access to pregnancy prevention measures, women must also have the freedom and choice to choose pregnancy and parenthood. Those who are sometimes denied this right include women with disabilities and women who are lesbian, gay, bisexual or trans (LGBT).

**Young Women**

Young women are at higher risk of violations of their reproductive rights than women from other age groups. Young women are more likely to face barriers to information and education, access to appropriate SRH care, and are more likely to experience sexual assault and sexual violence.

Unplanned pregnancy, particularly for teenagers can have far reaching effects for the woman, her child and other family members. Teenage pregnancy rates are higher amongst young women from backgrounds that include lower socio-economic factors, violence, family conflict, disengagement from school, living in a rural or remote area and being from Aboriginal or Torres Strait islander background. Family Planning Victoria derived birth rates (ABS data) indicate that the LGAs of Maroondah and Yarra Ranges have higher rates of teenage pregnancy than other LGAs in the region. However, these rates are slightly lower than the Victorian average (Table 2).
These figures must be viewed with some caution however, as not all teenage pregnancies are unplanned and not all unplanned pregnancies are unwanted. Nevertheless, there is evidence to suggest that the economic impacts of teenage pregnancy can be significant, both in the short and long term.

<table>
<thead>
<tr>
<th>Geographical area</th>
<th>Number of births per 1000 population (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Births to mothers under 20 years</td>
</tr>
<tr>
<td>Boroondara</td>
<td>1.1</td>
</tr>
<tr>
<td>Knox</td>
<td>4.0</td>
</tr>
<tr>
<td>Manningham</td>
<td>0.8</td>
</tr>
<tr>
<td>Maroondah</td>
<td>7.1</td>
</tr>
<tr>
<td>Monash</td>
<td>2.8</td>
</tr>
<tr>
<td>Whitehorse</td>
<td>2.2</td>
</tr>
<tr>
<td>Yarra Ranges</td>
<td>6.9</td>
</tr>
<tr>
<td>EMR</td>
<td>3.4</td>
</tr>
<tr>
<td>Victoria</td>
<td>9.13</td>
</tr>
</tbody>
</table>

Table 2: Births to young women in the EMR by LGA

Within the EMR, data shows that for sexually active females of all ages in 2009, 33.3 per cent in Monash and 27.9 per cent in Knox did not use contraception, compared to 21.1 per cent in Victoria. Further exploration of these figures is warranted.

Prevention of unplanned pregnancy in sexually active women relies primarily on information, education, access to healthcare and use of contraception. Access to abortion is also a critical option for women in the early stages of pregnancy who would prefer termination of that pregnancy. The following section will consider some of the barriers for women in accessing contraception and abortion.

**Long Acting Reversible Contraception**

Long acting reversible contraception (LARC) is commonly cited as a preferable contraceptive option for young women and is associated with a 20-fold reduction in unplanned pregnancies. However, uptake of LARC by young women remains low compared to other contraceptive methods, particularly the oral contraceptive pill. This may be attributable in part to lack of routine recommendation by health providers. It is also linked to young women’s knowledge about contraceptive options and their ability to request it from healthcare providers. Additionally, the initial cost of LARC may be a barrier for some young women, although the long term costs are generally lower. For example, the cost of an implant in the arm is around $30 (can be more) and the cost of an IUD varies but is generally more than $100.

**Emergency Contraception**

Unintended pregnancy can be prevented through the use of emergency contraception (EC) up to three days after sexual intercourse where contraception was not used. EC is available to women through pharmacies as an over the counter medication. Pharmacists however, are still within their rights to refuse to dispense this product if they have a conscientious objection, although they
must offer an alternative supplier if they do so. In these cases, for young women in particular, obtaining EC may be difficult. Furthermore, many women report that they are not given adequate information in a private and confidential manner when they do request EC. 48

Pharmacists can also refuse to dispense EC to young women on the grounds that they are under the age of medical consent (18 years). However, the law in Victoria has flexibility that allows health professionals to assess the competence of a minor to make a decision about their own healthcare. 49 This recognises that many adolescents are capable of making appropriate decisions about contraception. However, it is thought that some pharmacists refuse to dispense EC to young women despite this provision.

EC is sometimes confused with medication termination of pregnancy (MTOP) by members of the community and this may cause a reluctance to use it by those who do not want an abortion. However the action of EC is to prevent the implantation of an embryo (if one has developed) before pregnancy occurs. 50 Greater public information and education about EC may be warranted.

Abortion
Abortion is a legal procedure in Victoria and in most states and territories of Australia. However, access to both surgical and medical abortion remains limited. Young women in particular may face misinformation and judgement from sectors of the community, including pro-life campaigners. The cost of both surgical and medical abortion is prohibitive for many women due to limited public hospital access for these procedures.

Surgical abortion or surgical termination of pregnancy is available through the public health system at the Royal Women’s Hospital at no cost. However, as these waiting lists are generally lengthy, the service is prioritised for those deemed most in need. Surgical abortion is not available at any of the Eastern Health public hospitals, including Box Hill and Maroondah. It is available in the EMR only through the private system locally at Dr Marie (Marie Stopes) in Croydon, at a cost of around $350 in 2014. Out of region options include the Fertility Control Clinic in East Melbourne.

MTOP using Mifepristone was legalised in Australia in 2012 and is available to women who are nine weeks pregnant or less. Availability of MTOP remains very limited and clinics that do offer this option rarely promote the service. Doctors who wish to prescribe Mifepristone and pharmacists who wish to dispense it must undertake training through Marie Stopes; however, the uptake of this training has been slow. FPV, which is located in Box Hill is currently piloting a community-based MTOP service model, which will be used to support, educate and train healthcare practitioners in the wider community. The majority of women are being privately billed for this service, with an out of pocket cost of around $215. However, a limited number of appointments are being reserved each week for health care card holders. Dr Marie offers MTOP at a cost of around $500 before rebate. MTOP is also available at the Fertility Control Clinic in East Melbourne.

Availability of MTOP remains very limited and clinics that do offer this option rarely promote the service

It is difficult to ascertain why private health services charge up to $500 for MTOP; significantly more than that for the surgical alternative, which requires surgery and anaesthesia. Required ultrasound before administration of Mifepristone may be one factor, but is unlikely to account for the total cost. The Australian Research Centre in Sex, Health and Society is currently conducting research which is investigating factors that may
influence the low rates of MTOP, particularly the barriers for women.

On a positive note, access to abortion may have improved as a consequence of recent legal changes. ‘Exclusion zones’ have been created around services that provide abortion through the Public Health and Wellbeing Amendment [Safe Access] Bill 2015. The Bill supports women’s reproductive health choices by ensuring that all women can access health services that provide abortions without fear, intimidation, harassment or obstruction.\(^{51}\)

**Migrant Women**

Migrant and newly arrived women may face a range of barriers regarding access to modern contraceptive options. This may be due to limited knowledge of contraceptive options because of poor or no education in their country of origin. Migrant women may also find the Australian health system difficult to navigate, including avenues for obtaining contraception.\(^{52}\) Additionally, cultural factors may influence and limit contraceptive options for this group of women. Furthermore, health information in Australia is often provided only in English, making access to health information less freely available for those who are not literate or fluent in English.

**International Students**

International students are a group of migrant women who have been noted to be at higher risk of unintended pregnancy and abortion than women in general. The risk factors are thought to be similar to those listed above for STIs.\(^{40}\) Abortion services for international students are not covered by compulsory health insurance for the first 12 months in Australia and access to the private system may not be affordable.

**Women who have experienced Violence from Men**

Women who experience violence from men are more likely to have their sexual and reproductive rights denied. They may experience non-consensual sex and sexual violence, as well as having limited access to contraception, abortion and healthcare. As a consequence, they are more likely to have poorer sexual and reproductive health outcomes.\(^{53}\) Complications of pregnancy are more common and include inadequate foetal weight gain, infections during pregnancy, miscarriage, haemorrhage and low birth weight.\(^{54}\) This group of women also have a higher rate of abortion than women in general.\(^{54}\)

Statistics show that women who are pregnant are more likely to experience violence from an intimate partner and this can lead to adverse effects on the unborn child.\(^{41}\) This risk is a critical consideration for antenatal care providers.

**Women with Disabilities**

Women with disabilities are more likely than other women to experience discrimination and denial of their sexual and reproductive rights.\(^{55}\) This plays out in practices such as “forced and/or coerced sterilisation, forced contraception and/or limited or no contraceptive choices ... menstrual and sexual suppression, poorly managed pregnancy and birth, forced or coerced abortion, termination of parental rights”.\(^{55}\) Additionally, women with disabilities commonly face assumptions about their sexuality, their capacity to engage in intimate relationships and their parenting ability. As a consequence, they may have limited opportunities for relationships, intimacy and sexual pleasure.

Women with disabilities experience even higher rates of men’s violence and sexual assault than women in general. More than 70 per cent of women with disabilities have been a victim of sexual violence\(^{55}\) and this figure is likely to be
More than 70 per cent of women with disabilities have been a victim of sexual violence. Higher for those with an intellectual or cognitive impairment.

Within the EMR, there are a number of health services that cater specifically for people with disabilities. FPV in Box Hill provides one-to-one counselling to people with cognitive impairments, including those with intellectual disabilities, learning disorders, acquired brain injury and autism. Counselling is provided in relation to sexuality, human relations and sexual and reproductive health. They also provide secondary consultations to parents, carers and staff, as well as group education for adults with a cognitive impairment. EACH also provides services for people with disabilities.

Aboriginal Women
Aboriginal and Torres Strait Islander women are more likely to have children at a younger age. 52 per cent of the Aboriginal women giving birth in 2010 were aged less than 25 years, and 20 per cent were less than 20 years, compared with 16 per cent and 3 per cent, respectively, for the broader community. In Australia, teenage pregnancy rates for young Aboriginal women (including young teenagers) are significantly higher than for young women in general, with 18 per cent of all babies born to Aboriginal women from teenage mothers, compared with only 3.4 per cent of those born to all mothers.

However, consultations in the EMR revealed that teenage pregnancy within the Aboriginal community does not attract the same stigma as that within the general community. Babies are welcomed and are often viewed as a positive addition to the community. Rates of abortion also tend to be lower for Aboriginal women than for other women.

Despite the reduced stigma, adverse pregnancy outcomes are still more common for young Aboriginal women, with risk to their own health as well as the long term outcomes for their children. Aboriginal women remain twice as likely to die in childbirth as non-Aboriginal mothers, and are significantly more likely to experience pregnancy complications. Very young mothers may also be at higher risk of child protection intervention, including removal of the child to care.

Recommendations for priority 3:

1. Strengthen women’s reproductive rights and capacity to make informed choices, through strategies that include education, advocacy and other means, and with a focus on those at greater risk

2. Improve access to emergency contraception, medical abortion and surgical abortion
Priority 4: Sexualisation and Objectification of Women

Perceptions and portrayals of femininity and masculinity have varied over time and have different meaning according to culture, geography and a number of other factors. However, in Western cultures, femininity can be associated with women as sexual beings and objects of desire, with appearance being a key factor in determining the value of women.

Sexualisation is defined as the valuation of a person based on their sexual appeal to the exclusion of other characteristics and physical appearance is equated with sex appeal. Similarly, objectification occurs when women are seen as an object of physical desire for another’s use, rather than as an independent person with decision-making capacity.

The sexualisation and objectification of women is apparent in the media and pop culture, through television, video games, the internet, film, advertising, clothing, animated cartoons, magazines and news. The availability and nature of pornography is also believed to contribute to the sexualisation and objectification of women. Young women in particular, report that young men may have unrealistic expectations of sexual relationships based on pornography they have viewed, rather than on respectful relationships.

The sexualisation and objectification of women are linked to gender stereotyping and sexist attitudes that are constantly reinforced through this media depiction of women. It is now well accepted that these sexist attitudes are linked to gender inequality and are key determinants of violence against women.

Objectification can have a significant impact on the self-esteem and body image of women, leading to health and wellbeing issues that include eating disorders. Rates of eating disorders are high in some eastern LGAs compared to Victoria. For example, in Boroondara 16.7 per cent of adolescents have an eating disorder compared to only 2.5 per cent for Victoria.

Objectification of women may also be a contributor to higher rates of cosmetic surgery, which is increasing in popularity in Australia. Additionally, young women and men who view pornography may have unrealistic expectations of what a ‘normal’ labia looks like and this may also be a factor in the rates of cosmetic surgery. The most common genital cosmetic procedures are labioplasty and vulvoplasty.

Recommendation for priority 4:

Promote gender equity by advocating for the non-sexualised portrayal of women in the public domain, e.g. the media, pornography and online gaming.
Health literacy refers to the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply health information to make effective decisions about health and take appropriate action. Health literacy is also reliant on systemic and environmental factors that include health infrastructure, policies, processes, materials, people and relationships that make up the health system. These factors impact on the way that people understand, appraise and apply health-related information, as well as the way they access healthcare.

Health literacy is influenced in a number of ways, by factors such as attitudes, beliefs, education background, general literacy, cultural norms, and prior knowledge. There is evidence to suggest that improving health literacy leads to improved health outcomes. The National Statement on Health Literacy states “there is the potential to not only improve the safety and quality of health care, but also to reduce health disparities and increase equity”.

Health providers are often seen as the ‘gatekeepers’ of health services and have considerable power in determining who and in what way, medical information and/or support is obtained. Judgement and assumptions around individual behaviour, lifestyle or background can lead to discrimination and lack of access to healthcare, particularly for vulnerable people. Additionally, health providers may lack the confidence to have sensitive conversations about SRH and as a consequence, this subject may never be raised.

One aspect of individual health literacy relates to knowledge of and adherence to screening recommendations. SRH screening includes regular Pap Screens (cervical screening), which at present is recommended every two years for sexually active women (other than those with particular risk). Pap screen rates for the EMR are on average, slightly higher than the Victorian average (Table 3).

<table>
<thead>
<tr>
<th>LGA</th>
<th>2011-2012 (%)</th>
<th>2012-2013 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boroondara</td>
<td>67.4</td>
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</tr>
<tr>
<td>Knox</td>
<td>62.7</td>
<td>62.9</td>
</tr>
<tr>
<td>Manningham</td>
<td>66.0</td>
<td>66.4</td>
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<tr>
<td>Maroondah</td>
<td>60.6</td>
<td>61.6</td>
</tr>
<tr>
<td>Monash</td>
<td>57.9</td>
<td>58.1</td>
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<tr>
<td>Whitehorse</td>
<td>61.0</td>
<td>61.0</td>
</tr>
<tr>
<td>Yarra Ranges</td>
<td>63.4</td>
<td>65.0</td>
</tr>
<tr>
<td>Eastern Metro</td>
<td>62.6</td>
<td>63.0</td>
</tr>
</tbody>
</table>

Table 3: Pap Screen rates EMR by LGA

Women’s Health Victoria (WHV), Family Planning Victoria (FPV) and The Royal Women’s Hospital are currently undertaking a review of the capacity of the Victorian health sector to provide contraception, pregnancy advice and abortion services. This project will hopefully identify some of the systemic and environmental barriers that women may face in accessing SRH care, as well as informing a future strategy for women’s SRH.
**Migrant Women**

Migrant and refugee women in Australia can experience substantial barriers to obtaining health information through mainstream sources. Furthermore, the strong relationship between culture, health beliefs and practice may add another level of complexity to health literacy. Accessing health services may also be difficult due to the nature of employment and hours of work, residential instability and poor English proficiency.

Further barriers to health literacy include the complexity of the Australian health system, the role of primary health providers and access to culturally appropriate health promotion messages. Women in particular may face barriers to SRH care, due to cultural and gender expectations that include taboos around open SRH discussion. Needs analysis consultations revealed that older migrants sometimes rely on their younger, more literate children to interpret and advise on health matters and this may also be a barrier to SRH literacy.

**International Students**

Female international students are a sub-group of migrant women who may face particular challenges to health literacy, particularly regarding SRH. These factors have been discussed in above sections. However, as well as factors such as poor SRH literacy, access to health services, financial issues and cultural factors, these young women may also experience barriers to good SRH due to lack of immediate support from family and friends.

**Women who have experienced Violence from Men**

Women who have experienced IPV may face complex barriers to SRH care, including financial factors, fear of retaliation and fear of not being believed. As a result, sexual violence may go undisclosed. Health professionals require skills that allow them to screen for signs of intimate partner sexual violence and to effectively support these women. Women who have experienced sexual assault have lower rates of Pap screening. This is due to a number of factors including feelings of vulnerability, helplessness or shame, memories or flashbacks, embarrassment, fear, pain and/or anxiety, and/or physical and emotional discomfort. PapScreen Victoria and CASA Forum (Centres Against Sexual Assault) have developed guidelines for nurse Pap screen providers, including how to ask about sexual assault, how to provide a comfortable environment, and how to ensure women feel comfortable and in control. It is unclear whether doctors also have access to these or other guidelines.

Family violence workers in the EMR participated in a needs analysis consultation. They reported that women who have experienced family violence may have difficulty in disclosing sexual violence to a family doctor, particularly where the partner/perpetrator is a patient of the same doctor. Furthermore, the partner/perpetrator may insist on attending medical consultations with the woman, preventing her from disclosing the abuse and any SRH issues that have resulted.
**Women with Disabilities**

Women with disabilities are often unable to access healthcare easily. Health literacy may be a factor (particularly for women with an intellectual disability), ability to travel to and attend appointments may be limited and services may not be accessible or appropriate to the needs of women with disabilities. There may also be a reliance on carers and supporters to negotiate healthcare, and this may present a number of barriers, particularly around SRH.

Women with disabilities are less likely than women in general to have regular Pap screens. The barriers that these women encounter include transport issues, access to information and services, assumptions about sexuality, pain due to physical disability, as well as time provision for examination and privacy issues.

**Sexually and Gender Diverse Women**

Women who are sexually and gender identity diverse may face a number of barriers in mainstream healthcare access, including perceived and real attitudes of healthcare providers. SSA women have the same need as other women for SRH screening, including for STIs and Pap screening. One study reported that nearly 34 per cent of LGBT people ‘usually or occasionally’ hid their sexuality or gender identity from healthcare providers. This may have serious implications for the way in which this group of women access SRH care.

Gay and Lesbian Health Victoria (GLHV) in conjunction with Quality Innovation Performance (QIP) has developed Rainbow Tick; a program consisting of six standards which identify LBGTI inclusive practice. When working towards a Rainbow Tick, organisations are supported to understand and implement LBGTI inclusive service delivery. The Rainbow Tick reassures LBGTI consumers and staff that those organisations are aware of, and responsive to their needs.

Organisations can choose to be formally accredited against these standards by QIP, however this is not a mandatory requirement for any service.

Through consultation, Headspace Hawthorn reported that 20 per cent of their 2014 consultations with young people included those who identified as same sex attracted. This figure suggests that the service provides a safe space for same sex attracted young people to access and talk about their sexuality. This may warrant further investigation around enablers and barriers to service access for young women who are same sex attracted and may highlight the need for more youth specific services.

**Aboriginal Women**

Cultural factors play an important part in the health of Aboriginal people and interpretations of health literacy may be less relevant to many in these communities. Aboriginal health does not just involve the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community. Many Aboriginal people prefer to seek healthcare from an Aboriginal Community controlled health service (ACCHS), which are initiated and operated by the local Aboriginal community. Where these services are not available, it is possible that Aboriginal people are less likely to seek healthcare. Health promotion also needs to be culturally appropriate and there are many examples of materials and programs that have been designed by and for Aboriginal communities.
There are a number of Aboriginal health and other services in the EMR, but at present there is no ACCHS. Consultations revealed that many Aboriginal people travel to Fitzroy to access the Victorian Aboriginal Health Service there. In particular, maternity services that employ Aboriginal health workers have shown improvements in maternal and child health in other areas of Australia, but these programs have not been trialled in the EMR.

Regional Aboriginal services include Mullum Mullum Indigenous Gathering Place, which runs a variety of programs for the local Aboriginal community, including occasional health check days. Boorndawan Willam provides services that address the impacts of family violence affecting Aboriginal communities. Eastern Health also provides an Aboriginal health service through Yarra Valley Community Health, employing both a male and female Aboriginal health worker. Healesville Indigenous Community Services Association (HICSA) provides a point of contact for information on available services and programs. All of these organisations may have a role in women’s SRH as it arises.

Recommendations for priority 5:

1. Improve SRH literacy for all women

2. Ensure access to responsive, culturally & linguistically inclusive healthcare for all women
Priority 6: Female Genital Mutilation/Cutting (FGM/C)

Female genital mutilation/cutting (FGM/C) is a “harmful traditional practice that affects the health and wellbeing of girls and women all over the world”. It is defined by the World Health Organisation as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”. FGM/C has no health benefits, is a violation of the human rights of women and girls and is associated with a number of serious physical and psychological complications.

The prevalence of FGM/C practice is concentrated in 29 countries around the world, predominantly in Africa. The WHO has estimated FGM/C prevalence in a number of countries, categorising them into those with universal, high, moderate or low prevalence. There are several other countries where FGM/C is known to occur, but the prevalence cannot be estimated.

FGM/C Types I to IV involve a variety of practice with more or less severe alteration to the female genitalia. Type III is generally considered to be the most extreme form of FGM/C, involving narrowing of the vagina, cutting and re-positioning of the labia and excision of the clitoris. Population data shows that the EMR is home to a significant number of people who were born in countries where FGM/C is known to occur; including those with and without an estimated prevalence. This includes a small number of people from Somalia, where Type III FGM/C is almost universally practiced, as well as people from Ethiopia, Kenya, Sudan, Egypt and Liberia, where FGM/C prevalence estimates are moderate to high (Appendix 4).

Type IV is often considered to be the least harmful of FGM/C practice, involving pricking, piercing, incising, scraping and cauterising in the genital area. Little research or evidence exists however, to substantiate the claim that this is less harmful. Type IV FGM/C is associated with specific Indonesian and Malaysian ethnic communities, of whom there are sizeable populations in this region. Prevalence within these communities is not known. It is critical that engagement and determination of the needs of these communities is carried out in the EMR, and that a service response is established to address both prevention and education regarding this health and human rights issue.

Country of birth data should be used with caution however, as it provides limited information about ethnicity and cultural background, which are more accurate predictors of the practice. Generalisations should be avoided as they can be harmful to women, leading to stigma and marginalisation. In addition, this data does not account for the complex factors that influence the continuation or abandonment of FGM/C in countries of settlement (see Appendix 5 for country specific information). Nevertheless, country of birth data provides a compelling argument for further investigation of need in the EMR.
A successful approach to the reduction and elimination of FGM/C involves a holistic framework that focuses on community engagement and encourages community ownership of the issue. Of vital importance is the empowerment of women and girls, the involvement of men, and the use of a human rights and sexual and reproductive rights agenda.\textsuperscript{71}

The EMR is the only region of Melbourne that has not previously been funded to undertake FGM/C prevention and education. Other regions have been funded through the Family and Reproductive Rights Program (FARREP) since its inception almost 17 years ago. Over the past year, WHE have advocated both regionally and at state level for funding to be allocated to this region.

\textbf{Recommendation for priority 6:}

\textit{Advocate for a preventative and workforce capacity building response to FGM/C in the EMR}
SRH is an important health issue for women as it contributes to the burden of disease and affects population groups of women inequitably. Many of the causes of poor SRH are preventable. During 2014 and 2015, WHE conducted a regional SRH needs analysis to identify SRH priorities, gaps and unmet need for women in the region and to identify some priorities for action. Data for the analysis was collected from a variety of sources and led to some important findings around the SRH of women in the EMR.

A regional SRH strategic working group was convened in July 2015 and progress has since been made around formalising both priority needs and recommendations for the region. The task for the group this year is to identify and undertake actions that address these recommendations both in the short and longer term. The development of new partnerships and formalising of existing ones will be crucial to progressing this work.

We welcome the opportunity to engage with our partners in this work in the coming years. We look forward to contributing to the health and wellbeing of women in the EMR, through enhancement of their sexual and reproductive choice, freedom and control.
## APPENDIX 1: Sexual & Reproductive Health Consultation Tool

**Direct service delivery / Health Promotion program**

<table>
<thead>
<tr>
<th>Name of program/service</th>
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<tbody>
<tr>
<td>Outline &amp; aims of program</td>
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<tr>
<td>Geographic coverage</td>
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<td>Target group/s</td>
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<tr>
<td>Aspects of SRH health being</td>
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<tr>
<td>Accessibility of service/program</td>
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<tr>
<td>Program/service timeframes &amp; sustainability (resourcing,</td>
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<tr>
<td>Barriers to access (age,</td>
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<tr>
<td>Pathways into service/program</td>
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<tr>
<td>Referral to other services if</td>
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<tr>
<td>Program achievements</td>
<td></td>
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<tr>
<td>Other SRH need unable to</td>
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<tr>
<td>Other services provided by</td>
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<tr>
<td>Partnerships</td>
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<tr>
<td>Regional /other gaps – strategic</td>
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<tr>
<td>Identified vulnerable groups of</td>
<td></td>
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<tr>
<td>Follow up /potential contacts</td>
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</tbody>
</table>
APPENDIX 2: Online Consultation Tool

1. What is the name of your organisation?
2. What is your name and your position at the organisation?
3. What is the name of your program/service?
4. Is the goal of your program / service to improve the sexual & reproductive health of women in the EMR?
   Yes  No
   If yes, please go to question 5. If no, please go to question 12.
5. What type of service/program do you provide? (please tick all that apply)
   - Counselling service
   - Maternal child health
   - General health clinic
   - Sexual health clinic
   - Women’s health clinic
   - Education program
   - Sexual & reproductive health screening
   - Group program
   - Sexual & reproductive health awareness campaign
   - Prevention program
   - Research
   - Other (please specify)
6. Please give a short description of the aims and outline of the service/program
7. What is the geographic coverage of program /service?
8. Who is the program targeted to?
   - Young people (25 and under)
   - Women
   - GLBTQI people
   - Migrant or refugee women/men
   - Aboriginal or Torres Strait Islander women/men
   - Women with a disability
   - Other (please specify)
9. Please add any further information regarding the details of this target group
10. How do people access the service/program e.g. referral, appointment, drop-in, application to program?
11. What factors might make it difficult for people to attend this service/program?
12. Do any other programs/services run by your organisation have a sexual and reproductive health component or are they likely to address this topic in any way? If so, please give a brief outline of these programs.

13. How is sexual and reproductive health, exploring sexuality and/or developing intimate relationships incorporated into this program?

14. What aspects of sexual & reproductive health might be addressed directly or indirectly through programs/services at your organisation?
   - Sexual health education
   - Contraception, including implants and emergency contraception
   - Sexually transmitted infections – testing and treatment
   - Cervical screening
   - Pregnancy options counselling
   - Termination of pregnancy
   - Fertility

15. Does the program/service involve partnerships with other organisations?
   Yes
   No
   If no, please go to question 18

16. Which organisations do you partner with?

17. Will the partnerships be long term?
   Yes
   No

18. What are the sexual and reproductive health gaps or unmet need for women in your service area?

19. How might this need be addressed?

20. Which groups of women do you feel are likely to have the poorest outcomes for sexual reproductive health?

21. Do you have any other comments that you feel might be relevant to this survey?

22. Are you happy to be contacted for further information if required?
   Yes
   No

23. If you answered 'yes' to this question, please enter your contact details below.
APPENDIX 3: Needs Analysis Priority-Setting Tool

### SEXUAL & REPRODUCTIVE HEALTH ISSUES

**Vision** - Women in the Eastern Metropolitan Region will have choice, freedom and control regarding their sexual and reproductive health & wellbeing. They will have access to quality, relevant information about sexual and reproductive health and will be respected for their lifestyle choices.

<table>
<thead>
<tr>
<th>Priority Criteria</th>
<th>Sexually transmitted infections (STIs)</th>
<th>Reproductive choice, access and rights</th>
<th>Sexualisation &amp; objectification of women</th>
<th>Poor sexual &amp; reproductive health literacy</th>
<th>Poor access to appropriate sexual &amp; reproductive healthcare</th>
<th>Female genital mutilation/cutting (FGM/C)</th>
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<tbody>
<tr>
<td><strong>Prevalence</strong> (how widespread)</td>
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<td><strong>Severity</strong> (costs for life expectancy/quality of life)</td>
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<tr>
<td><strong>Selectivity / sub-groups (are specific groups affected inequitably?)</strong></td>
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<tr>
<td>Young women</td>
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<td>Newly arrived/migrant women</td>
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<tr>
<td>Aboriginal women</td>
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<td>International students</td>
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<td>Women experiencing VAW/sexual assault</td>
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<tr>
<td><strong>Selectivity / sub-groups (are specific groups affected inequitably?)</strong></td>
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<tr>
<td>Women with disabilities</td>
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<tr>
<td>GLBTQI women</td>
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<td>Older women</td>
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Women’s Health East

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APPENDIX 4: EMR Country of birth data

<table>
<thead>
<tr>
<th>Estimated FGM/C prevalence</th>
<th>EMR population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>97.9%</td>
</tr>
<tr>
<td>Egypt</td>
<td>95.8%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>74.3%</td>
</tr>
<tr>
<td>Sudan</td>
<td>90%</td>
</tr>
<tr>
<td>Liberia</td>
<td>45.0%</td>
</tr>
<tr>
<td>Kenya</td>
<td>32.2%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>19.0%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>14.6%</td>
</tr>
<tr>
<td>Iraq</td>
<td>8.0%</td>
</tr>
<tr>
<td>Ghana</td>
<td>3.8%</td>
</tr>
<tr>
<td>Uganda</td>
<td>0.6%</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
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</table>

EMR residents born in countries where FGM/C has been documented and the prevalence estimated.\textsuperscript{75}
### APPENDIX 5: Overview of FGM/C practice in countries of origin for people living in the EMR

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>FGM/C Practice</th>
</tr>
</thead>
</table>
| Somalia          | - Over 80% of Somalian women have undergone Type III FGM/C (the most severe type)  
                  - There is little evidence of change in the Somalian community regarding FGM/C practice  
                  - There is little ethnic variation within Somalia leading to almost universal practice  
                  - The rates of FGM/C for people of Somalian origin tend to be almost universal, regardless of which country they live in.  
| Egypt            | - Although a high prevalence country, there are signs that change may be taking place, particularly in the younger age groups. There is suggested rapid abandonment of the practice in Australia  
                  - A high number of Egyptian people who live in Australia are Christians, who do not traditionally practice FGM/C  
                  - Transit country for refugees since the 1980s. Many refugee children born in Egypt, have parents from high prevalence countries such as Somalia, Ethiopia and Eritrea |
| Kenya            | - There are large variations in the prevalence of FGM/C depending on ethnicity and area (rates range from 4% in the west to 99% in the north-east)  
                  - There is high prevalence amongst ethnic Somalis and Ethiopians living in Kenya, including refugees  
                  - Many children of parents from Somalia and Ethiopia have been born in Kenyan refugee camps, hence their country of origin is recorded as Kenya. |
| Sudan            | - FGM/C is almost exclusively practiced in North Sudan (now known as Sudan). These figures were published before the country of Sudan became those of Sudan and South Sudan. Refugees from these countries have been predominantly from the south, which is Christian and has low levels of FGM/C  
                  - 13% of Sudanese people in Victoria identify as Islamic, suggesting that they are more likely to be from the north of Sudan and more likely to be affected by FGM/C, particularly Type III |
| India            | - There is only one rural community in the west of India (pop approx. 1,000,000) who are known to practice FGM/C. There is no information regarding the settlement of people from this community in Australia |
| Malaysia and Indonesia | - FGM/C practice in these countries is predominantly of Types I and IV. Type IV ‘pricking’ or removal of a small piece of flesh is the most common practice.  
                  - Education programs in Australia have focussed on the more severe Type III, however it is recognised that type IV may also cause significant psychological harm  
                  - There are a large number of people from Asian countries living in the EMR, particularly from Malaysia where Type IV FGM/C is practiced |
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