Women's Health East
Investing in Equality and Wellbeing for Women

A Strategy for Equality: **Sexual and reproductive health in Melbourne's East 2026-2031**

Acknowledgment of Country

Women's Health East acknowledges the Wurundjeri Woi-wurrung people, the Traditional Custodians of the land on which we work. We pay our respects to Elders past, present and future.

We recognise the deep knowledge, strength, and sovereignty of First Nations women, who have practiced bodily autonomy, family planning and sexual and reproductive healthcare on these lands for tens of thousands of years.

We acknowledge that colonisation disrupted these practices and continues to contribute to health inequities experienced by First Nations women today, including in access to sexual and reproductive health care.

We commit to listening, learning, and working towards a future where all women – including Aboriginal and Torres Strait Islander women – have access to culturally safe, respectful, and self-determined sexual and reproductive health services.

A note on language

In this strategy, 'women and gender-diverse people' refers to cisgender women, transgender women, non-binary people, and others who may use sexual and reproductive health services such as abortion, contraception, maternity care, and assisted reproductive technology.

When citing research, we use the term 'women' unless otherwise specified, as most available data does not differentiate or define gender identity. We acknowledge that this is a limitation and that such language may exclude non-binary and gender-diverse people, who often face additional barriers to accessing reproductive healthcare and support.

We also note that when data refers to 'Australian-born' populations, it does not always include Aboriginal and Torres Strait Islander peoples, who experience disproportionate health inequities, including in SRH. We recognise the importance of naming these exclusions and working to ensure greater visibility and inclusion in both data and practice.

Suggested citation

Women's Health East 2026, A Strategy for Equality: sexual and reproductive health in Melbourne's East 2026 - 2031, WHE, Melbourne.

Collective effort

A Strategy for Equality: Sexual and Reproductive Health in Melbourne's East 2026-2031 was developed in consultation with stakeholders including members of the Sexual and Reproductive Health in Melbourne's East (SRHME) partnership. The partnership includes representatives from local government, community health organisations and other service providers committed to improving the health and wellbeing of women in the region. The Sexual and Reproductive Health in Melbourne's East partners include:

- Centre for Culture, Ethnicity and Health
- City of Boroondara
- City of Monash
- Deakin University
- Department of Education
- EACH
- Eastern Health
- Eastern Melbourne Primary Health Network
- FVREE
- Headspace Knox
- Inspiro
- Jean Hailes for Women's Health
- Knox City Council
- La Trobe University
- LiverWell
- Monash Health
- Monash University
- MSI Australia
- North Eastern Public Health Unit
- Refuge Australia
- Sexual Health Victoria
- St Vincent's Hospital Melbourne
- Whitehorse City Council

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CEO message

Leading on sexual and reproductive health (SRH) means recognising it as essential to the overall health and wellbeing of our communities. Without it, true gender equality cannot be realised.

The Eastern Metropolitan Region has a strong record of good health outcomes and partnerships. But this masks a more complex reality: persistent and entrenched inequalities leave too many women and gender-diverse people across the region with inadequate access to essential health services and poor sexual and reproductive health outcomes. This is why improving access to services remains a key priority in A Strategy for Equality.

Since launching our first strategy in 2020, Women's Health East and our Sexual and Reproductive Health in Melbourne's East partners have worked tirelessly to shift this picture. We have expanded access to safe and publicly funded abortion care; centred the voices of women; amplified lived experience; and strengthened the workforce to better meet the needs of marginalised communities.

This work has happened against a backdrop of promising state and federal investment and reform. The Victorian Government launched the Women's Health and Wellbeing Program and the state's first Sexual and Reproductive Health Plan, alongside legislative changes such as the decriminalisation of sex work and the introduction of affirmative consent laws. At the federal level, new commitments to women's health represent an important step forward.

Sexual and reproductive health is not a side issue. It is central to gender equality, public health, and social progress. This strategy is our collective commitment to building a future where the rights of every woman and gender-diverse person in the EMR are respected, protected, and realised.

Kate Phillips

Kate Phillips
Chief Executive Officer

A Strategy for Equality 2026-2031

Vision

The right to optimal sexual and reproductive health and wellbeing is realised for all women and girls, non-binary and gender-diverse people in the Eastern Metropolitan Region without exception.

Purpose

To drive coordinated action to address the sexual and reproductive health and rights of women and girls, non-binary and gender-diverse people in the Eastern Metropolitan Region

Priority 1: Equity

Advance the SRH of all women and gender-diverse people in the Eastern Metropolitan Region by addressing systemic health inequities and upholding the rights of those most impacted by poor outcomes.

Objective 1: Increase SRH literacy among priority populations through the delivery of sex-positive, intersectional, culturally safe SRH promotion programs.

Objective 2: Normalise SRH through community-led, culturally safe education and engagement initiatives that challenge stigma and cultural taboos.

Priority 2: Capability

Strengthen the knowledge, confidence, and accountability of the workforce to provide high-quality, inclusive, and rights-based SRH care.

Objective 3: Increase awareness of the impacts of reproductive coercion, sexual violence, and systemic violence — including racism and ableism — among the SRH workforce.

Objective 4: Improve capacity of healthcare and community services professionals to provide inclusive, culturally responsive, gender-affirming and disability-accessible SRH care through ongoing, practical training and tools

Objective 5: Improve knowledge base through the strengthened collection, sharing and use of quantitative and qualitative SRH data, with a focus on intersectionality, lived experience, and equity in health outcomes.

Priority 3: Access

SRH services are more available, affordable, culturally appropriate, and easy to navigate for all who need them — when and where they need them.

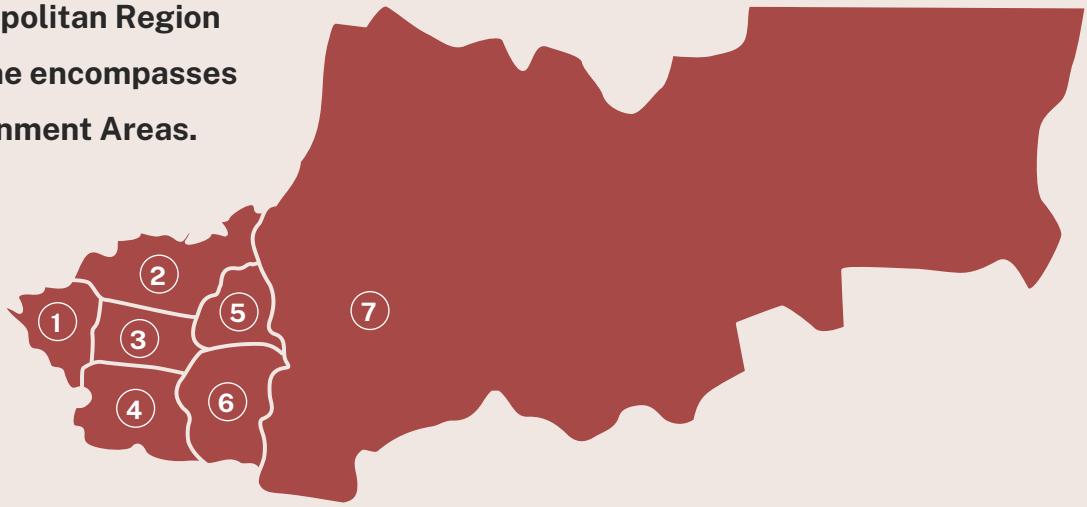
Objective 6: Increase cross-sector collaboration and partnership to identify and remove financial, social, cultural, geographic, and digital barriers to SRH care.

Objective 7: Improve access to specialist SRH services through clear, inclusive, and culturally relevant information and referral pathways across healthcare, education and community settings.

EMR Snapshot

The Eastern Metropolitan Region (EMR) of Melbourne encompasses seven Local Government Areas.

1. Boroondara
2. Manningham
3. Whitehorse
4. Monash
5. Maroondah
6. Knox
7. Yarra Ranges



554k+

As of the 2021 Census, the EMR had a combined female population of approximately 554, 139.[1, 2]

37%

37% of residents in the EMR were born overseas. The City of Monash has the highest proportion of overseas born residents at 50.4%.[1, 2, 3]

7.7%

7.7% of residents in the EMR experienced food insecurity in 2023, meaning they need to prioritise survival over their sexual and reproductive health.[5]

71.5

The rate of reported incidents of family violence among women in the EMR was 71.5/10,000 in 2023.[6]

2x

The rate of hepatitis B notifications in 2023 was double in the EMR compared to the state average (1.3 vs 0.7/10,000).[8]

5.4

Contraceptive implant use is lower in the EMR (5.4/1,000 females in 2022) compared to the Victorian average (7.5/1,000 females in 2022). Manningham has the lowest rate at 4.16/1,000 females.[10]

Guiding documents

A Strategy for Equality: Sexual and Reproductive Health in Melbourne's East 2026 – 2031 **sits within a broader state, national and global policy context in relation to SRH. Our framework aligns with the principles, approaches and opportunities identified within these documents.**

- Victorian women's sexual and reproductive health plan 2022–30
- Victorian Aboriginal Sexual and Reproductive Health Plan 2022-2030
- Strategy Overview and System Enabler Plan 2022-2030
- Theory of Change in Sexual and Reproductive Health for Victorian Women
- Victorian Public Health and Wellbeing Plan 2023–2027
- Australian Government Department of Health and Aged Care: National Women's Health Strategy 2020–2030
- Ottawa Charter for Health Promotion (1986)
- Convention on the Elimination of All Forms of Discrimination against Women, 1979
- Framing Sexual and Reproductive Health: Message Guide, 2025

Evaluation of A Strategy for Equality 2020-2025

Key achievements

27 professional development workshops with **42** partner organisations, reaching **853** participants, to strengthen culturally safe sexual and reproductive health services for priority groups.

Strengthened regional collaboration and coordinated response through **18** partnership meetings with members from **28** organisations.

Delivery of **35** tailored education sessions with migrant and refugee communities, engaging **703** participants to build health literacy, reduce stigma, and normalise sexual and reproductive health discussions.

22 editions of the Eastern Melbourne Sexual & Reproductive Health e-Bulletin, published since April 2023, building workforce knowledge and community awareness.

Considerations

Uneven engagement with priority populations throughout the strategy period.

Initial planning considered the needs of disadvantaged groups, but uneven implementation left some communities underrepresented. Limited capacity, differing priorities, and alignment challenges made relationships harder to sustain. Long-term engagement will require continued investment in shared priorities and trust.

Professional development initiatives were well-received, and new knowledge needs to be embedded into routine practice.

Capacity-building initiatives require follow-up tools and supports to embed learning. Some objectives remained unimplemented, highlighting the need for further investment to turn strategy into lasting organisational and systemic change.

Stronger, systemic collaboration is needed in future strategies.

Progress was made to align the SRH and family violence sectors but work on reproductive coercion and sexual violence remained project-based, limiting sustainability.

Consultations

Women's Health East consulted community members and professionals across Melbourne's east to shape the next five-year SRH strategy. Participants included women from diverse cultural backgrounds (Chinese and Hakha Chin), young women, LGBTIQA+ communities, women with disability, Aboriginal and Torres Strait Islander women, and those working in healthcare, local government, education and community services.

These conversations revealed insights into what works, what must change, and how to collaborate for better sexual and reproductive health outcomes. Across the consultations, several critical themes emerged consistently — themes that now form the foundation of this strategy.

Access to services

Access challenges were a key theme, especially in outer suburbs and rural areas. Barriers included:

- location
- cost
- transport
- long waits
- no bulk billing
- limited access to services such as LARC, medical abortion, and menopause support.

Young people and migrants often lacked awareness of available services, faced confusion with referrals, or feared being judged or disrespected.

"By the time you figure out where to go and how much it will cost, it's already too late."

Community member

"We need more services closer to where people actually live, not just in the city."

Community health worker

"Training is great — but we need time and support to put it into practice. It can't just be a one-off workshop."

Community health worker

Workforce capability and support

Health and community sector workers described a passionate but overstretched workforce, calling for more training in trauma-informed care, consent, abortion referrals, and culturally safe practice, along with tools, resources, and leadership to embed SRH in daily practice.

Some noted that SRH is not always seen as 'core business,' making it hard to prioritise particularly in time-poor or crisis-focused settings.

"Staff really want to do the right thing, but they just don't always know how."

University student health services

System gaps and collaboration

Workforce participants highlighted frustration with a fragmented SRH system, marked by services operating in isolation, limited shared referral pathways, and insufficient data sharing. They called for stronger regional coordination, clearer client pathways, and more opportunities for collaboration and shared learning.

"It feels like everyone's doing bits and pieces. We need a joined-up system."

Health promotion coordinator

Stigma and shame

Stigma remains a major barrier to SRH access and conversations, with topics like periods, abortion, sexual pleasure, menopause, and contraception still taboo in many communities — preventing people from seeking help, accessing timely care, or recognising health issues.

Participants supported creative and culturally appropriate ways to challenge stigma — such as art projects, storytelling or peer-led programs. The Framing Sexual and Reproductive Health Messaging Guide reinforces the importance of strengths-based, inclusive, and non-stigmatising language in shifting public attitudes and normalising SRH conversations, especially in communities where shame and taboo remain strong.

"People are too ashamed to even ask the question."

Community member

Health literacy and education

Participants called for more community education and accessible information, noting widespread uncertainty about SRH rights, services, and topics such as contraception, menopause, period pain, and talking to kids about consent and relationships.

Schools, families, local councils, and community organisations were identified as key partners in building SRH literacy and breaking down shame.

"We need information in plain language, and in lots of languages, not just English."

Community member

"There's so much I wish I'd been told earlier."

Community member

“You shouldn’t have to explain your whole identity just to get care.”

Community member

“It’s not just about having a rainbow sticker. It’s about what happens once you walk in the door.”

Community member

Equity and inclusion

Barriers to care are not experienced equally. People with disability, migrant and refugee communities, LGBTIQA+ people, and Aboriginal and Torres Strait Islander communities face added challenges such as stigma, poor cultural safety, inaccessible services, and service provider assumptions.

Participants stressed the importance of listening to lived experience, ensuring services are welcoming to everyone, and building trust over time.

Violence is a pervasive issue

Violence – including family, sexual and institutional violence such as racism and ableism – was a recurring theme. Participants stressed the need for greater awareness of reproductive coercion and the need for trauma-informed responses. A First Nations participant highlighted the intergenerational impacts of colonisation, from the destruction of women’s spaces and birthing trees to ongoing cultural loss affecting health and identity.

“I’m a mum of seven. Everyone else’s needs were met. My own health was not seen as important. My partner didn’t care.”

Community member

Strategic framework

Equity

Goal: Advance the SRH of all women and gender-diverse people in the Eastern Metropolitan Region by addressing systemic health inequities and upholding the rights of those most impacted by poor outcomes.

Objectives	Actions	Success indicators
1 Increase SRH literacy among priority populations through the delivery of sex-positive, intersectional, culturally safe SRH promotion programs.	Develop and deliver tailored SRH promotion and prevention information to enhance and promote good SRH across the life course. Partner with trusted local organisations to co-design and deliver SRH education tailored to specific communities.	Number of tailored SRH initiatives co-designed with, and delivered to, priority communities experiencing stigma and exclusion (e.g. migrant women, LGBTIQA+ people, women with disabilities). Increased diversity of communities represented in initiative leadership or participation.
2 Normalise SRH through community-led, culturally safe education and engagement initiatives that challenge stigma and cultural taboos.	Support community-led initiatives that centre lived experience and address stigma in culturally relevant ways. Use the Framing Sexual and Reproductive Health: Messaging Guide to develop SRH messages.	Increased confidence among participants to talk openly about sexual and reproductive health with family and friends. Increased dissemination and promotion of evidence-based SRH information across diverse communities.

Capability

Goal: Strengthen the knowledge, confidence, and accountability of the workforce to provide high-quality, inclusive, and rights-based SRH care.

Objectives	Actions	Success indicators
3 Increase awareness of the impacts of reproductive coercion, sexual violence, and systemic violence — including racism and ableism — among the SRH workforce.	Embed lived experience voices into training design and delivery, ensuring practitioners hear directly from people impacted by violence and coercion. Collaborate with the regional family violence prevention partnership (TFER) to build cross-sectoral understanding and referral networks.	Increase in the number of health workers reporting improved understanding of violence and its impacts on women's health and wellbeing. Improved self-reported ability to identify and respond to reproductive coercion, systemic discrimination, and cultural or gender-specific health needs.
4 Improve capacity of healthcare and community professionals to provide inclusive, culturally responsive, gender-affirming and disability-accessible SRH care through ongoing, practical training and tools.	Provide professional SRH education so that primary health professionals gain skills and maintain contemporary evidence-based knowledge, particularly in the provision of early medical abortion. Deliver professional education to primary care professionals to improve their capacity to deliver trauma-informed, culturally safe, inclusive care that is free from discrimination and gender bias, in line with the Victorian Women's Pain Inquiry.	Health and community professionals report increased understanding of the SRH needs of priority populations. Health and community professionals report increased confidence to provide inclusive, culturally responsive, gender-affirming, and disability-accessible SRH care. Increased number of early medical abortion providers in the EMR.
5 Improve knowledge base through the strengthened collection, sharing and use of quantitative and qualitative SRH data, with a focus on intersectionality, lived experience, and equity in health outcomes.	Partner with community organisations to collect and embed lived experience and qualitative data through consultations, storytelling, interviews, and co-designed evaluation methods. Regularly publish and share findings with partners and community in accessible formats to ensure transparency and encourage data-informed action.	Increased number of disaggregated SRH data by priority population (e.g. by gender, age, disability, cultural background, sexuality, etc.). More regular and coordinated data sharing among partners, including public health, community health, and women's health organisations.

Access

Goal: SRH services are more available, affordable, culturally appropriate, and easy to navigate for all who need them — when and where they need them.

Objectives	Actions	Success indicators
6 Increase cross-sector collaboration and partnership to identify and remove financial, social, cultural, geographic, and digital barriers to SRH care.	Integrate health promotion activities with service delivery in primary health and community settings. Maintain and grow the Sexual Health in Melbourne's East (SRHME) partnership to provide opportunities for collaboration and shared learning.	Increase in the number of organisations and range of sectors engaged in the SRHME Partnership. Increased number of joint initiatives or partnerships established to address SRH access barriers. Stakeholders report improved collaboration and alignment across sectors.
7 Improve access to specialist SRH services through clear, inclusive, and culturally relevant information and referral pathways across healthcare, education and community settings	Develop and deliver education promoting the availability of services such as 1800 My Options, SRH Hubs and women's health clinics, among priority populations. Work with trusted partner organisations to create opportunities for community members to connect with services.	Community members report improved awareness of, and access to, services. Community members report increased confidence to access SRH services. Number of community members who undergo health screening as a result of participating in a health promotion program.

Implementation, Governance and Accountability

Achieving the goals of *A Strategy for Equality* requires sustained collaboration, strong governance, and shared accountability across the Eastern Metropolitan Region.

Guided by Women's Health East, implementation will be supported by the SRHME partnership, recognising that no single organisation can address the complex, systemic barriers to SRH equity alone. By working together, partners can coordinate action, share resources and knowledge, leverage collective influence, and ensure the strategy remains responsive to community needs.

Throughout the life of the strategy, two to three-year action plans will be developed to translate priorities into concrete, time-bound initiatives that respond to emerging opportunities and challenges.

An accompanying evaluation framework will track progress toward objectives, measure outcomes across priority populations, and assess impact over time using quantitative and qualitative measures from local data, partner reporting, and community feedback. Evaluation findings will be shared transparently and used to inform continuous learning, future planning, and advocacy.

Appendices and Further Reading

Priority Populations

Aboriginal and Torres Strait Islander women

For over 60,000 years, Aboriginal and Torres Strait Islander Peoples sustained powerful knowledge systems to support reproductive health and Country. Colonisation — through forced child removal, suppression of cultural knowledge, displacement, and denial of bodily autonomy — created a legacy of harm that continues today. Aboriginal and Torres Strait Islander women experience significantly poorer SRH outcomes: cervical cancer incidence is 2.9 times higher and mortality 6.5 times higher than non-Indigenous women;[8] gonorrhoea and infectious syphilis rates are 2.5 and 21 times higher respectively;[9,10] and hepatitis C rates are 17 times higher.[10] These inequities reflect ongoing systemic injustice, including intergenerational trauma, racism, and culturally unsafe health systems.[11] Despite these barriers, Aboriginal and Torres Strait Islander women demonstrate strength, leadership and resilience. As recognised in the Victorian Aboriginal Sexual and Reproductive Health Plan 2022–2030,[12] improving outcomes requires systems that uphold Aboriginal women's rights and enable their communities to lead.

Culturally and linguistically diverse women

Culturally and linguistically diverse (CALD) women — including migrant and refugee women from diverse ethnic, cultural, linguistic, and religious backgrounds — face significant barriers to SRH care. Health systems frequently fail to provide culturally appropriate services, language access, or community-led design. Evidence shows poorer outcomes for women born overseas, including overrepresentation in stillbirth statistics and higher rates of pre-eclampsia, gestational diabetes, and chronic hepatitis B.[13,14] CALD women are less likely to use contraception15 or participate in screening programs due to language barriers, cost, unfamiliarity with the health system, and limited culturally safe options.[8,16] International students face particularly acute challenges including high rates of unplanned pregnancy, STIs, and abortion, driven by poor SRH literacy, cultural stigma, and service inaccessibility.[17] Structural reform and community-led solutions are essential to ensure CALD women can safely access their SRH rights.

Gender and sexually diverse people

Sexually and gender diverse people, including those who identify as lesbian, gay, bisexual, transgender, queer, intersex, asexual and other identities, face significant barriers due to systemic exclusion, stigma, and lack of appropriate services. Mainstream SRH services remain predominantly heteronormative and gender binary in design, leaving many feeling unwelcome or invisible. Over half of trans and gender diverse people report insensitive SRH care, and many avoid or delay care due to fear of judgment.[18] School-based sex education fails LGBTQIA+ people, with only 2.4% of trans and gender diverse people rating it as 'excellent'.[18] Exclusion from prevention programs has real impacts: LGBTQIA+ women experience higher rates of STIs, unplanned pregnancies, and abortion than heterosexual women,[19,20] while trans men and asexual people are far less likely to be offered cervical screening.[21,22] Sexually and gender diverse people deserve services that reflect their identities, affirm their experiences, and respond to their unique SRH needs.

Women with disabilities

Women with disabilities are denied their sexual and reproductive health and rights due to systemic ableism, discrimination, and exclusion from health systems and decision-making. Poorer outcomes result not from disability itself, but from stigma, social injustice and barriers to care. Women with disabilities are often perceived as asexual or incapable - assumptions that lead to harmful practices including involuntary contraception, sterilisation and pregnancy termination, which remain legal in some Australian jurisdictions.[23] SRH education is often denied, creating vulnerability to coercion, exploitation and violence.[24] Women with disabilities experience higher rates of STIs and unintended pregnancies, lower contraceptive use,[25] and are twice as likely to experience sexual violence compared to women without disabilities.[26,27] Inaccessible facilities, limited communication support, and discriminatory attitudes from health workers prevent access to care.[28] Achieving reproductive justice requires recognising women with disabilities as autonomous, rights-holding individuals and designing inclusive, accessible services led by people with lived experience.

Older women

Older women (aged 65+) are routinely overlooked in SRH policy and service delivery despite many continuing sexual relationships throughout their lives. Exclusion from SRH education, prevention campaigns and clinical care reinforces the dangerous myth that aging diminishes sexual health needs.[29] This neglect has real consequences: older women face rising STI rates due to biological vulnerabilities, lower condom use, and limited access to testing, while postmenopausal hormonal changes lead to complex physical and mental health needs that services often fail to address.[30,31] Stigma, ageism and lack of provider capability act as structural barriers, leaving many older women feeling embarrassed or dismissed when seeking care. Older women deserve SRH care that respects their autonomy, affirms their experiences, and adapts to their changing health needs across the life course.

Women with experience of violence

Violence against women has well-documented, long-lasting impacts on physical, mental, sexual and reproductive health. Intimate partner violence contributes significantly to disease burden in women of reproductive age, accounting for an estimated 8-9% of total disease burden.[32] Women who have experienced violence are significantly more likely to contract infections including HIV, and face higher rates of unintended pregnancy, abortion, miscarriage, and pregnancy complications[33] — including a two-fold increase in abortion, 16% increase in low birth weight, and 43% increase in preterm births.[33] Violence often begins or escalates during pregnancy.[34] Mental health impacts include increased risk of PTSD, sleep and eating disorders, anxiety, and depression, compounded by institutional violence when systems fail to respond appropriately.[35] Reproductive coercion — behavior that interferes with reproductive autonomy through threats, pressure, or violence — is increasingly recognised as a form of family violence.[36,37] Addressing the SRH needs of survivors requires trauma-informed, integrated care that restores choice and control.

Appendix 2

Guiding Principles

1. Sexual and reproductive rights-based

This strategy is grounded in sexual and reproductive rights and the framework of reproductive justice — which recognises the right of all people to decide if and when they have children. We acknowledge that structural inequality, discrimination, and colonisation have denied these rights to many, particularly Aboriginal and Torres Strait Islander people. Our strategy works to ensure all women and gender-diverse people can access information and services free from stigma, coercion, or violence, and that care upholds their dignity, autonomy, and rights in every aspect of sexual and reproductive health.

2. Intersectional and inclusive

We recognise that people's experiences of health and access to care are shaped by intersecting factors such as gender, culture, disability, income, age, sexuality, and migration status. An intersectional and inclusive approach ensures that programs address power imbalances and reflect the real, diverse experiences of our communities. Our strategy commits to culturally safe, gender-affirming, and accessible approaches that centre lived experience and ensure everyone feels welcome, respected, and understood in sexual and reproductive health care.

3. Evidence-based

This strategy is informed by the best available evidence, including research, population data, practice insights, and lived experience. We use data to guide decisions, identify gaps, and measure progress, while recognising that mainstream data often overlooks some communities. Our goal is to ensure that actions are not based on assumptions but grounded in real-world needs, emerging knowledge, and continuous learning, so that sexual and reproductive health work in the region is both impactful and accountable.

4. Environmental co-benefits

We recognise the connection between human and environmental health, and the growing impact of climate change on health equity. Our strategy will seek environmental co-benefits — supporting actions that are good for both people and the planet. This includes promoting local, accessible services that reduce travel, advocating for climate-resilient reproductive health systems, and using digital solutions where appropriate. We will align our work with broader public health and sustainability efforts, ensuring our strategy supports a just transition to a healthier, more sustainable future for all.

5. Innovation

We are committed to innovation that responds to the complex and evolving community needs. This includes new approaches to service delivery, communication, and community engagement, and challenging outdated systems that no longer meet people's needs. We will use creative methods to tackle stigma, reach priority groups, and expand access. We will be open to learning, adapting, and working with community members and partners to test new ideas. Doing this, we aim to create smarter, more effective ways to improve SRH for everyone.

6. Collaboration and partnerships

Collaboration is essential to achieving long-term change in SRH. This strategy is built on partnerships across sectors. We value the strengths and insights that each partner brings and commit to working together with trust, respect, and shared purpose. Collaboration helps avoid duplication, ensures services are better connected, and supports more holistic, coordinated responses. Through genuine partnerships, we can amplify impact, create lasting systems change, and ensure that care reflects the needs and voices of our communities.

7. Guided by the Ottawa Charter for Health Promotion

This strategy is guided by the principles of the Ottawa Charter for Health Promotion, which emphasises enabling people to increase control over their health and its determinants. We are committed to strengthening community action, building healthy public policy, creating supportive environments, developing personal skills, and reorienting health services toward prevention and equity. These principles support a whole-of-system approach that goes beyond individual behaviour change. By embedding the Ottawa Charter into our work, we ensure that SRH promotion addresses the broader conditions that shape people's health, wellbeing, and rights.

8. Self-determination and agency

This strategy recognises racism and the ongoing impacts of colonisation as key drivers of SRH inequities. We are committed to supporting self-determination by ensuring Aboriginal and Torres Strait Islander communities, and others historically excluded, have the power to lead solutions that affect them. Organisations must go beyond acknowledging intersectional drivers — they must take responsibility for learning about and acting on issues of racism, power, and privilege. Promoting agency means listening to lived experience, shifting power to communities, and creating systems that are inclusive, culturally safe, and grounded in justice.

Appendix 3

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