family planning victoria
Sexual & Reproductive Health
Care. Education. Advocacy.

Consultation response

Victorian Women's Health and Wellbeing Strategy 2010-2014

Submission to: diversity@health.vic.gov.au

or sent by post to:

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Family Planning Victoria agrees to the following information being cited in the Victorian Women's Health and Wellbeing Strategy 2010-2014

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Family Planning Victoria (FPV) is funded by the State Government to provide education, training, counselling and clinical services throughout Victoria, focussing on sexuality, sexual and reproductive health.

FPV is an independent, not-for-profit organisation established in 1969. It has led the provision of sexual and reproductive health and education services in Victoria for almost 40 years. FPV has a voluntary Board of Management with paid managers and staff. We have Australian Taxation Office-approved Public Benevolent Institution status. Most importantly, FPV considers healthy sexuality and relationships vital to individuals, families, the community and society.

FPV is a member of the national Sexual Health & Family Planning Australia (SH&FPA) body and the International Planned Parenthood Federation (IPPF).

We work particularly with young people aged under 25 whose lifestyle or life situation may place their sexual health at risk.

Our Vision
Our vision is sexual and Reproductive Health for all Victorians.

Our Mission
Our mission is to provide a leadership role in sexual and reproductive health public policy, advocacy, education and clinical care.

Our Target Groups:

- education and health care providers
- young people under 25
- parents and carers
- people in their reproductive years
- agencies working with vulnerable populations.

FPV works in both metropolitan and rural settings. Our professional and community education, clinical and research services both inform professionals and benefit the wider community. FPV also works closely with other agencies throughout Victoria to build a better understanding of the importance of good sexual health. In short, FPV encourages the development of skilled sexual health practitioners, appropriately timed sexual education, access to reliable information and high quality confidential health care.

FPV operates from two main sites: Box Hill and the Melbourne CBD Action Centre. FPV also has outreach services in Hoppers Crossing and Cranbourne community health centres.

1. Are the suggested four priority areas (chronic illness and injury; violence against women; mental health; and sexual and reproductive health), the right ones for the Strategy to focus our efforts on for the next four years?

The Victorian Women's Health and Wellbeing Strategy 2010-2014 consultation paper provides evidence to back the State Government's decision to name chronic illness and injury, violence against women, mental health, and sexual and reproductive health key health priorities for Victorian women.

Family Planning Victoria (FPV) **endorses women's sexual and reproductive health** as one of the health and wellbeing strategy's four priorities. We recognise that significant inroads have been made to improve the health of all Victorian women across the four priorities.

FPV advocates a whole of government approach to address structural barriers to health equity and wellbeing for Victorian women, with a specific formalised collaboration between the Department of Health (DH) and the Department of Early Education and Childhood Development (DEECD).

Addressing sexual and reproductive health requires **integrated interventions at individual, family, community and health system levels within a legal, policy and regulatory environment protecting the sexual rights of all people**.[1]

The consultation paper's snapshot of women in Victoria section (p 25) did not discuss addressing issues such as the over-representation of women in acute health services, whether the selected priority areas should focus on prevention/early intervention and treatment, or if these health priorities covered all women in all age groups.

Social Inclusion

Social and economic disadvantage must be addressed to reduce avoidable health inequalities. **Adverse social and economic circumstances** cause high levels of stress and unhealthy behaviours that can lead to high disease and injury rates.[2]

A State Government focus on social inclusion would be a powerful step in reducing health inequalities by addressing the social exclusion of disadvantaged Victorians, placing them at the centre of their own health management.

The Victorian Women's Health and Wellbeing Strategy 2010-2014 should form part of a whole of government social inclusion agenda by addressing the health inequalities which exist between different groups of women. Social exclusion is associated with high levels of risk behaviours, such as obesity, smoking and much worse health outcomes. Good health enables women to be socially included and fully participate in community life.[3]

Evidence shows, for example, that the impact of discrimination, social exclusion and stigma on same-sex attracted or bisexual women:

- reduces their access to and effective use of health services, including screening programs
- prevents the delivery of culturally sensitive and appropriate sex education
- predisposes them to high levels of drug, tobacco and alcohol abuse

- increases their risk of homelessness, which further increases their vulnerability to sexual risk taking and violence
- creates high levels of depression, anxiety, self-harm and suicide (these women also describe a disproportionately high experience of child sexual abuse compared to heterosexual women)
- increases their risk of physical and verbal abuse and sexual violence
- increases their risk of sexually transmissible infections (STIs), blood borne viruses (BBVs) and unintended pregnancy.

Diversity of Victorian women

FPV wants a Victorian Women's Health and Wellbeing Strategy 2010-2014 that, **firstly, addresses the diversity of all Victorian women and, secondly, provides health services tailored for and responsive to the needs of Victoria's marginalised and disadvantaged women.**

The 2010-2014 strategy must continue to address the diversity of all Victorian women. Sexuality and sexual orientation, life stage, relationship status, disability status, gender identity, cultural and linguistic background, Aboriginal or Torres Strait Islander identity, reproductive status and reproductive ambitions are all critical factors affecting how women (and men) experience health and health services.

The Victorian women's health and wellbeing consultation paper raises the issue of siloing the women deemed most at risk and the proposed 2010-2014 strategy priority areas. From a social determinants perspective, there are considerable overlaps within and between these groupings which must be considered for any strategy to be effective. Diversity inclusion needs to be integrated into every proposed program and policy.

Sexual orientation and gender identity need to be recognised as social determinants of health. Certain sub-populations of gay, lesbian, bisexual and transgendered or intersex people are particularly vulnerable to sexual and reproductive health problems. To promote health equity in this respect it is important to design strategies which include people with diverse sexuality or gender orientation, do not presume heterosexuality, and recognise that people in same-sex relationships may be or plan to become parents.

Having 'Men's Health' and 'Women's Health' policy frameworks raises several problems; foremost is that sexual and reproductive health is about relationships and relationships occur between men and women (whether heterosexual or not). This then impacts upon sexual and reproductive health. Working with men and boys in a sexual rights framework is critical to improve the sexual and reproductive health of women, because changing the attitudes of men is needed to reduce and prevent violence against women.[4]

The other problem with separate men's and women's health policies is transgendered and intersex people, who are already marginalised and stigmatized, are displaced on an assumption that the population divides neatly into two halves. Although transgendered and intersex people are a minority, they are a vulnerable population with a right to health equity.

Linking priorities

For the purposes of this consultation response we will focus on sexual and reproductive health and highlight its links with the other three priorities.

Sexual and reproductive health encompasses the obvious problems of HIV and STIs, unintended pregnancy and abortion. But it also includes issues as diverse as infertility, genital organ cancers, which sometimes result from STIs, sexual dysfunction, mental and physical disabilities, acute and chronic illnesses and domestic and sexual violence. Same-sex attracted young people are a particularly overlooked group with poor sexual and reproductive health outcomes.[5] In short, good sexual health is integral to good general health.

It is important to highlight the links between the four selected priorities as poor health status in one area, such as mental health or violence against women, is often related to poor health status in another.

The link between mental health and sexual and reproductive health is demonstrated by:

- perinatal depression and suicide, the mental and psychological consequences of miscarriage, abortion or pregnancy and childbirth complications, lack of post-childbirth support, gender-based violence (GBV) and HIV/AIDS[6]
- a decreased ability to make rational choices and increase the probability of risky sexual behaviour and substance abuse. This can lead to unintended pregnancies, STIs - including HIV - and a higher risk of being either the victim or perpetrator, of GBV
- depression during pregnancy or after childbirth, which are experienced by 10-15 per cent of women
- post-traumatic stress disorder in rape victims, which one third experience
- the fact that up to 40 per cent of people living with HIV suffer from depression[7]
- young people dropping out of school with special and complex needs having extremely high rates of sexual behaviour, mental health problems and drug abuse[8]
- mental health problems associated with sexual and reproductive health issues, including homophobia and suicide in same sex attracted young women and men.[9]

Links between STIs and chronic illness and the impact on women's health and wellbeing include:

- The high economic and social costs of sexual ill-health; STIs cause unnecessary morbidity and mortality which can be prevented by access to education, positive social attitudes to sexuality, early diagnosis and treatment.
- From 2000-2007 Chlamydia notification rates rose by 307 per cent.[10]
- Chlamydia, whilst largely asymptomatic,[11] causes Pelvic Inflammatory Disease (PID), ectopic pregnancy and chronic pelvic pain.[12]
- Chronic pelvic pain caused by PID is associated with a lowered level of general health, vitality, social functioning and mental health compared to age-matched women who have not had PID.[13]
- Low socio-economic status teenage mothers are more likely to continue their pregnancy than others for a range of reasons, but their children are more likely to grow up in poverty, abuse drugs and alcohol, turn to crime and become young parents themselves.[14]
- Obesity reduces the ability to conceive spontaneously and affects pregnancy outcomes.[15]

- Obesity in pregnant women [is] also linked to higher intensive care nursery admission rates, birth defects, prematurity and respiratory distress syndrome among infants.[1617]
- Up to 10 per cent of women and 30 per cent of obese women[18]have Polycistic Ovary Syndrome, which is associated with an increased risk of diabetes, cardiovascular disease [19] and mental health issues.
- Maternal alcohol use during pregnancy contributes to a range of infant problems, including hyperactivity and attention problems, learning and memory deficits and social and emotional development problems. Fetal Alcohol Syndrome (FAS)[20] is the most serious possible consequence.

Women who have experienced violence are more likely to suffer mental health problems including depression, anxiety, post-traumatic stress disorder, self-harm tendencies and suicidal thoughts.[21] Violence against women is also associated with ongoing physical conditions including chronic diseases, disabilities, irritable bowl syndrome, smoking and substance misuse.[22]

Links between violence against women and sexual and reproductive health include:

- In Australia, 33 per cent of women have experienced physical violence and 19 per cent sexual violence since turning 15 (ABS, 2005). Even higher rates were reported in 2004 (IVAWS), with 57 per cent experiencing physical violence in their lifetime and 34 per cent experiencing sexual violence.
- Sexual assault in Australia is most likely to occur in the home. The ABS reports that in 2006 the rate was 66 per cent for Australia and 64 per cent in Victoria. Most sexual assault victims had some form of relationship with the offender (78 per cent).
- A 2007 VicHealth report found Victorian women more than five times more likely than men to be killed by a partner, providing some insight into why reporting rates are so low. Women are much less likely to report violence by a partner or family member than violence[23]
- Almost 90 percent of reported rape and 76 percent of reported sexual assault victims are women.[24]

Social Determinants of Health

FPV endorses the State Government's continued focus on the social determinants of health framework to analyse and explain the state of women's health.

These social factors including poverty, power inequalities, social/cultural attitudes, sexuality and gender identity, social isolation, discrimination and lack of access to information and education all affect the health of Victorian women. Aboriginal women in particular face multiple disadvantage that translates into poor health outcomes, due to Australia's history of dispossession and disenfranchisement of Aboriginal people.

For example:

- Social exclusion also results from racism, discrimination, stigmatisation, hostility and unemployment.[25] The longer that people live in disadvantaged circumstances, the more likely they are to suffer from a range of health problems including mental health and sexual and reproductive ill health.

- Sexual and reproductive ill health disproportionately affect vulnerable population groups such as young people, homeless young people, people with disabilities, lesbian, gay, bisexual, transgender (LGBT) people, Indigenous people and people from culturally and linguistically diverse backgrounds.

Good sexual and reproductive health for men and for women goes beyond the absence of disease to include social, intellectual and emotional dimensions. This includes respecting the sexual health rights of others, the ability to make and participate in decisions that affect sexual and reproductive health and the ability to negotiate sexual practice with intimate others.

Our health and wellbeing is affected by our start in life and our everyday life experiences from pre-birth.[26] Our capacity to make positive health choices and to manage our own health and wellbeing are linked to social factors, including our position on the 'social ladder'.[27]

The higher the level an individual's or group's power or status in society, the more resources and opportunities they will have to control their sexual and reproductive lives and to enjoy their sexuality.

2. The paper describes how women experience a range of serious illnesses such as cancer and diabetes. What should we do differently for women to reduce the numbers of chronic illnesses and injuries they experience?

Whole of government approach

Responses are needed at every level of Government.
The 'Health in all Policies' model South Australian Thinker in Residence Ilona Kickbusch proposed in 2007 is an excellent overview of how coherent policy, consistent with a health equity goal across all government departments, is essential to ensure a quality health system responsive to community needs. This represents a policy paradigm shift that considers the social determinants of health and does not focus on ill health.

The World Health Organisation says that health ministers, supported by their ministries, should play a stewardship role within government to improve the politicians' understanding of the social determinants of health. This would help to prepare the political ground for such change and increase their understanding that many aspects of health are created outside the health care system.

Evidence Base

Regular five-yearly monitoring of the population's health, including sexual and reproductive, would provide the evidence base required for stronger interventions to reduce health inequities.

A clear picture of where we've come from and how we might progress requires regular monitoring. As the population ages, the growing disease burden will increasingly impact on health resources. An evidence-based approach will help maximise the effectiveness of policies and programs and facilitate resource allocation to cost-effective interventions. Comprehensive gender-relevant evidence is needed, plus more knowledge about how women and health professionals can best address women's health issues and behavioural risk factors.[28]

Monitoring the general population's wellbeing, including young people's sexual behaviour, would provide a stronger basis for planning interventions to reduce unplanned pregnancy and abortions. It would also allow targeted interventions in communities and populations at greatest risk, and facilitate appropriate service planning. This information should be compiled in a single report circulated annually to relevant communities, agencies and health professionals.

The information would inform men's and women's health strategies, as sexual and reproductive health data could be cross-referenced with wider health and wellbeing indicators such as mental health, drug and alcohol use, school attendance and homelessness.

Chronic disease and STIs

It is essential that all agencies, including core funded HIV, Hepatitis C and sexual health services including Family Planning Victoria), be required to monitor and report STI screening levels.

A population screening program should be established to determine actual chlamydia rates in Victorian young people.[29]

An annual sexual health literacy and diversity program should also be funded to focus on both primary prevention and raising the awareness of symptoms and the need for testing in high risk populations.

If left untreated, STIs generate secondary chronic health conditions which carry high economic and social costs. STIs cause unnecessary morbidity and mortality which can be prevented by access to education, positive social attitudes to sexuality, early diagnosis and treatment. Unwanted pregnancy also has a significant life-changing impact on individuals.

Chlamydia

Chlamydia infection reduction strategies are necessarily multifaceted. Encouraging condom use alone is not enough as correct use is just as important in decreasing risk.[30] Screening for chlamydia, treating cases and contact tracing all decrease the infective pool. Many international studies have found an increased risk of chlamydia infection with lower socio-economic status.[31] [32] [33] [34] However in Victoria the chances of being diagnosed with chlamydia are higher in those living in more affluent suburbs, probably due to more testing.[35] FPV, which is involved in comprehensive school education and medical practitioner education, is in an ideal position to lead in the prevention of this condition with serious chronic disease sequelae.

Syphilis

Although syphilis is uncommon in Victorian women its incidence is highest during the child bearing years, with the median age 28 years in 2006.[36] Congenital syphilis rates tend to parallel the rate of syphilis in women.[37] Congenital syphilis incidence rose in 2001 and levels have since been consistently higher than the 1990s. Condoms decrease the risk of syphilis transmission,[38] but do not give complete protection.

Genital Herpes

An estimated 12 per cent of Australian adults have the herpes simplex type 2 virus, the major cause of genital herpes. It is more common in women than men; 20 per cent of women aged 35-44 have the virus.[39] Genital herpes infections are associated with an increased risk of HIV,[40] and a risk of neonatal transmission. It may also be a co-factor for cervical cancer, and may be associated with long term psycho-social morbidity.[41]

Primary prevention

A comprehensive national strategy is needed for hepatitis B (HBV) prevention and management.

Preventing STIs through vaccination is becoming easier with new human papillomavirus (HPV) vaccines and HBV immunisation.

Making HPV vaccines more widely available through PBS subsidies to young women outside the school system should be considered. Evidence is already strong that they can impact significantly on the incidence of HPV in women and heterosexual men.[42]

The HPV vaccine strategy has been proven effective in reducing HPV related cancer in adolescent women. We recommend building upon the current vaccination strategy.

Rates of newly acquired HBV infection have fallen among young people in recent years. Most people living with chronic HBV in Australia are immigrants from high prevalence countries, while Indigenous Australians and injecting drug users are also disproportionately affected.[43] Novel vaccine delivery approaches such as accelerated schedules, free vaccine, high outreach levels for both recruitment and vaccination delivery also appear to help universal immunization.[44]

3. What practical things could the Department of Health focus on to improve women's health outcomes? Where can we make the most difference within these areas?

Health promotion priorities

To reiterate, FPV advocates a whole of government approach **to addressing structural health equity and wellbeing barriers for Victorian women.**

It is essential that the strategy's four priority health areas are embedded and identifiable in the Victorian Health Promotion priorities 2007-12. Aligning a gendered women's and men's health and wellbeing approach to State Government priorities will ensure that primary care partnerships and key agencies develop community-based health promotion strategies that recognise gender as a health determinant.

Practical activities:

1. Implementing incentive programs.
To encourage agencies working on the more difficult priorities, such as sexual and reproductive health, the State Government should offer key organisations a health-funded incentive. This funding could be matched to key result areas and ensure that no priorities are consistently 'left behind' due to lack of funding and/or political will. Incentive programs could boost sexual and reproductive service availability at the local community level, like Papscreen Victoria's incentive scheme does. This model could, for example, include the provision of youth clinics, STI screening programs and emergency contraception (EC).

2. Conduct a regular population-based survey, including sexual and reproductive health, and distribute a user-friendly report to relevant communities, agencies and health professionals.

3. Provide the evidence base for the four priority groups, with preventative measures, to all primary care partnerships, incorporating the measures into member agency Integrated Health Promotion planning.
Monitoring should include a range of sexual and reproductive health outcomes of interest, including STI notification rates, birth rates and abortion rates. Monitoring should also cover other important sexual health indicators, such as contraception use, frequency and method, including emergency contraception.

This information would be most useful if sexual and reproductive health data could be cross-referenced with wider health and wellbeing indicators such as mental health, drug and alcohol use, school attendance and homelessness.[45]

Regular monitoring of abortion and general wellbeing, including young people's sexual behaviour, every five to ten years would help develop interventions to reduce unplanned pregnancy and abortions, allow targeted intervention in communities at greatest risk, and facilitate appropriate service planning.

For example there is no formal abortion monitoring in Victoria or nationally,[46] [47] nor

a regular survey of the health and wellbeing of young Victorians that includes sexual behaviour.[48]

The State Government should support the continuation of this monitoring

The Department of Health and the Women's should work together on a pilot project to voluntarily monitor abortions like authorities do in South Australia and the United Kingdom. About one-sixth of Victoria's abortions are performed at the Women's. They are not representative of the whole state due to the high proportion of public patients and the hospital's focus on the socially disadvantaged. But such a pilot would establish the feasibility of such data collection and provide a base to develop more comprehensive state-wide monitoring.[49]

4. Increase availability of contraception by:

4.1 Installing condom vending machines in all public government health facilities.

Young people living in regional or rural areas have an increased risk of untreated STIs due to a shortage of medical services. This has implications for the entire community.[50]

When the only GP is their family doctor, young people often feel uncomfortable or too concerned about confidentiality to seek information, testing or treatment about sexual health, including contraception.[51]

4.2 Auspice and fund an annual sexual health and diversity campaign promoting STI and blood borne virus (BBV) prevention and testing, and support greater access to sexual health resources in youth communities.

Chlamydia notifications rose considerably during 2007-08 in four of the five Victorian rural and regional areas, including Gippsland, Hume, Loddon Mallee and the Grampians. Syphilis and gonorrhoea notifications also increased in the Loddon Mallee and Gippsland areas.

Data also shows that STI testing and notification are much lower in rural areas than metropolitan regions; rural areas also have poorer access to health and community support services.

4.3 Funding a campaign to promote more effective contraception methods is essential for the sexual and reproductive health and wellbeing of Victorian women.

Widespread use of emergency contraception should reduce the overall risk of unplanned pregnancy. The risk to an individual is cut by 85 per cent if taken at the appropriate time after unprotected sex.[52] Despite improved access increasing its use, emergency contraception has failed to decrease pregnancy termination rates.[53] Possible reasons include women having repeated unprotected sex and not using emergency contraception each time[54] [55] or using no contraception or less effective methods.[56] Women more likely to use emergency contraception also have a lower risk of unplanned pregnancy.[57]

Australian women have limited knowledge of emergency contraception use and availability.[58] [59] [60] Although this knowledge has risen over the years in women considering pregnancy termination, their use of it has not.[61] Studies show women who know about emergency contraception may experience considerable barriers to its use, including cost and the embarrassment of asking a pharmacist for it.[62]

The Health Department could help by promoting emergency contraception use, but only in the context of also using other more effective contraception and safe sex methods to prevent STIs. A careful campaign is needed to highlight the need for women to use EC after unprotected sex, while also emphasising that protection before the event is much more effective.

4.4 State government to develop a program to subside the cost of emergency contraception (EC).

EC costs up to $40, whether or not the woman has a health care card (HCC). This compares to $5.30 for four months of some oral contraceptive pill brands and three years of the contraceptive implant for health care card holders. The department could help by funding family planning clinics with subsidised EC.

Pharmacies are the main stockists of EC. FPV has heard many first hand reports of young women refused EC for being aged under 16. There is no legal age restriction and the assessment should be competency based. This initial refusal may make a subsequent attempt to obtain EC more difficult.

Two Australian studies have highlighted some difficulties for women which could act as potential EC barriers. One study found more than 20 per cent of women would not attend a pharmacy if they thought they could be recognized.[63] Another found lack of privacy an issue for some. The same study showed some women were surprised by questions the pharmacist is required asked about contraception use and STIs and felt it inappropriate.[64] (9)

We recommend developing a web-based knowledge bank that includes publicly accessible data bases of youth-friendly GPs and pharmacies who stock the morning after contraceptive pill.

5. The DH to fund new GP services within schools - especially in rural settings. (See Question 6, Satellite Community Health Service in a School).

Education and Sexual Health Literacy

6. The DH to fund:

1. **DH and DEECD to implement the checklist for effective sexual health literacy programs and supporting resources** (see Examples of good practice for an overview of the checklist p 31)

2. **DH to fund a scholarship fund for current teacher professional development.**

Health promotion programs and specialised service delivery aimed at key population groups must be underpinned by a universal and comprehensive sexuality and relationship education campaign for children growing into adolescents.

Universal and comprehensive age and stage-appropriate sexual health literacy programs and sexuality and relationship education promote positive sexual and reproductive health. They are essential in reducing domestic violence, sexual assault and negative mental and psychological outcomes. As children grow into adolescents, a positive relationship and healthy understanding of their own bodies, sexuality and sexual and reproductive health helps them to access more information and services. It also helps in developing positive relationships with others, heterosexual or otherwise.

International evidence shows effective sexual health literacy programs share many characteristics with effective literacy programs.

Like English literacy, sexual health literacy is built up over time. It requires an ongoing, sequential learning program delivered by teachers who are skilled, knowledgeable and comfortable with the subject matter.

As with any effective learning program, the focus needs to be on the student, the needs and assets they bring and the outcomes they achieve.

We have developed a practical checklist for building sexual health literacy, based on the effective literacy teaching checklist developed by the DEECD's Eastern Metropolitan Region.

Principals and schools implementing this checklist would ensure:

- the sexuality education curriculum is implemented as planned
- teachers have access to ongoing support and professional development
- the program is adapted with sexuality education developments and in line with student needs and assets.

At present, the value placed on comprehensive sexuality education in Victoria largely depends on individual schools, and private schools are exempt. This means a wide variation between schools' approach to sex education, teacher confidence and priorities.[65]

To ensure we teach young people to make informed decisions about sexuality and safe sexual and reproductive health choices, we must implement comprehensive sexuality literacy and education programs in all Victorian schools.

We recommend:

1. an audit of all Victorian primary and secondary schools to identify what is taught in sexual and reproductive health education
2. a measurable and bi-annually reported survey of teachers' knowledge, competency and comfort teaching sexual and reproductive education
3. setting minimum standards for teachers running comprehensive sexual and reproductive health education programs
4. including information about successful existing programs and pilots in the proposed annual report of young people's sexual and reproductive health.[66]

7. DH to undertake/fund a mapping exercise on the availability and range of sexual and reproductive health services in all Victorian regions.
Some of this work has been done with maternity services, stand-alone sexual health services and tertiary education providers. Bendigo Loddon Primary Care Partnership (Sexual Health Services Mapping Tool) is a successful model and process that could be used state-wide.

We know clients have limited access to sexual and reproductive health services in regional and rural Victoria, as our client data reveals that many are forced to use urban services.

8. Department of Health to provide Division of General Practice incentive programs to increase their sexual and reproductive health activity.
Nearly 90 per cent of women and 70 per cent of men aged 15–24 visit a GP at least once a year.[67] Increased general practice screening for chlamydia and other STIs is an effective way to increase population coverage. However, studies show that despite such STI screening being very acceptable to young people, general practice testing rates remain very low, between six and 10 per cent.[68]

This highlights the importance of practitioner education at university and continuing medical education programs. A financial incentive such as a specific Medicare benefit might also promote further testing.

There is also a need to examine the attitudes of medical practitioners and pharmacists. Anecdotally there appears to be much moralising among them, making it harder for young people seeking effective information, testing, screening and access to contraception and abortion services. Cultural competency/humility training helps GPs to deliver effective and sensitive services to marginalised groups.

9. The DH fully funds accredited agency-provided workforce development programs for nurses and GPs, including online clinical education modules.
Models such as the UK's National Health Service (UK NHS) e-Health program, which provides online clinical education modules for health practitioners, should be considered here to provide more uniform service delivery, screening and treatments.

10. The DH fund a pilot program working with Victoria's top eight tertiary institutions to develop pre-service training for teachers, health and human services and teaching professionals.
Lack of regional and rural access to services and competent health workers is an ongoing, national infrastructure and funding crisis. We must build the capacity of our health and education workforce to meet the demands of vulnerable population groups.

Such a program could be run by agencies like FPV and the Centre for Excellence in Rural Sexual Health. Or the State Government could provide scholarships to ensure practitioners access existing courses.

FPV is a leader in education, medical and nurse practitioner workforce development. It is ideally placed to work with the DH to lead preventative health strategies with key stakeholders addressing a range of sexually transmitted infections, diversity literacy and unplanned pregnancy.

11. Funding to be provided to:

1. ensure key women's health priorities align with State Government health promotion priorities across all Victorian regions
2. conduct an analysis of women's health issues across all Victorian regions
3. resource mainstream services to adopt a gender equity approach to health outcomes
4. fund the translation of women's sexual and reproductive health research into practice and disseminate findings on topics including the link between violence against women and STI rates, abortion, cervical cancer and pregnancy.
5. fund a sexual and reproductive health population and place mapping exercise for Victorians.

12. DH to fund a review of the Victorian Family and Reproductive Rights Education Program (FARREP).

The FARREP program works to prevent female genital mutilation (FGM) through health promotion activities aimed at affected communities. FARREP works with communities that practice FGM in order to:

- strengthen their knowledge about FGM to help change their attitudes about the practice and prevent it
- increase access to timely and appropriate sexual and reproductive health services by women and girls from communities that could practice FGM
- build the capacity and expertise of mainstream and specialist sexual and reproductive health services to deal with women and girls affected by or at risk of FGM.

Program funding is based on a decentralised model and directed at 11 service providers who employ about 20 FARREP workers. FPV facilitates the FARREP program.

13. Fund and develop new media strategies to promote positive sexual and reproductive health messages for Victorians.

New media targeting high-risk populations should be used to help prevent STIs. The immediacy and interactivity of vehicles such as Twitter deserve more exploration.

It is widely recognised that pleasure can motivate unsafe sex, but there has been limited exploration of its potential to motivate safe sex. Evidence suggests that positive incentives are the most effective way to promote safer sex practices.[69]

Social marketing via new media to drive community education campaigns could play a role in promoting positive sexual and reproductive health messages to combat stigma and discrimination.

4. In what ways can health service providers ensure that they better understand and meet the health needs of women?

Gender Equity

The Department of Health should fund and adopt a gender equity approach using tools such as a gender responsiveness framework, DH Gender and Diversity Lens and legislating gender equity requirements.

Publicly funded Victorian services, including health services, should plan for and report on gender and diversity. This includes a commitment to **gender-based health outcome analysis**, to enable effective interventions development and their evaluation.[70]

Gender equity gives women and men equal opportunity to realise good health, and recognises that gender is a health determinant.[71] A gender equity approach recognises the different challenges women and men face managing their health, including different health requirements and service access barriers.

There is substantial evidence that some groups of Victorian women have not benefited from overall health improvements experienced by most women. The needs of women at higher risk of a range of health problems should be addressed through new interventions which are culturally appropriate and designed to target areas of health inequity.

Abortion Law Reform

We need more active management from health care providers for women who have undergone one or more abortions.[72]

Access to safe abortion services is a necessary part of any comprehensive reproductive health service system. Although abortion is now lawful in Victoria, women's to access services is still an issue due to geographical and financial considerations. Limited training and development opportunities for health professionals working in the field and ongoing anti-choice protests also pose problems. Stigma and myths surrounding abortion compound all of these issues.

Abortion services must be complemented by a broader strategy to prevent unintended pregnancy. Victoria's law changes must be accompanied by measures to improve termination service access and increase awareness about women's options. Initiatives must also address unintended pregnancy and the importance of shared responsibility by both men and women. Unbiased, relevant and accurate information and support for women is also imperative.[73]

5. Are the suggested population groups of women under each priority area the right ones?

Involvement of Young Women

The Victorian Women's Health and Wellbeing Strategy 2010-2014 should identify young women aged under 25 as a separate priority population.

Young Australians, especially young women, carry the greatest burden of sexually related disease in our community. Culturally and linguistically diverse, same-sex attracted and gender diverse and indigenous youth are also at increased risk, However, this disease burden cannot be considered in isolation. Sexual health is intimately connected by a complex web of social attitudes and behavioural factors influencing young people's sexual and reproductive health.

Young people are not identified as a specific priority population within the strategy, and are considered with older women and sole mothers. Sexually active young people are generally at greater risk of STIs, so it should be a priority within the strategy.

Affected people and communities must be integral to the strategy both in principle and practice. The participation of young women, both in and out of the school system, is imperative for successful STI prevention and reproductive health literacy. It is important to acknowledge the contexts in which young women (and men) receive and produce information, and peer networks' importance in informing young people's ideas about sex. FPV strongly supports the DH and the DEECD sectors working together to improve the understanding of issues and barriers to reaching young people with key sexual and reproductive health prevention messages.

We need to acknowledge the broader range of social determinants that intersect with STI transmission and reproductive health. When combined they create a sense of urgency within the Victorian community about young people and sexual and reproductive health issues. As such, it would be useful for the final strategy to define the wide range of health matters and links that can affect sexually and reproductive health such as fertility, homophobia, mental health, violence, chronic illnesses such as obesity and alcohol and other drug use. Mapping policy and program responses in those areas could help the 2010-2014 strategy achieve its aims.

Young people make up around 20 percent of the population. Effective interventions can produce long-term benefits for their health and wellbeing and for society's, build their resilience and significantly reduce the long term economic burden on government.

As stated in the WHO report, Department of Reproductive Health and Research (RHR), 'Adolescents have sexual and reproductive health needs that differ from those of adults in important ways, and which remain poorly understood or served in much of the world. Neglect of this population has major implications for the future, since sexual and reproductive behaviours during adolescence have far-reaching consequences for people's lives as they develop into adulthood.'[74]

Positive, supportive non-judgmental service provision can strengthen young people's capacity to advocate for themselves.

We believe youth is a critical time for establishing and reinforcing good health behaviours, and avoiding significant health problems later in life. Specific health interventions and approaches that target young people are imperative to deal with risk behaviours during this stage. Helping young people make decisions and develop habits that will positively influence their future health and prospects is a challenge for communities, governments and public health organisations.

6. What approaches are most effective for responding to the health issues faced by particular groups of women under the priority areas, such as Aboriginal women, refugee women and young or older women?

Specialised Health Services

Prioritise improved access to youth-friendly health services.

Non-traditional STI screening and education sites such as sporting clubs have proven particularly effective and provide the opportunity to target another sub-group of young people.

Prioritising improved access to 'youth friendly' health services would help. The 4th National Health Survey of Australian Secondary Students found that although doctors were the most trusted sexual health information source, young people did not often use them. Workforce development and using primary healthcare settings to improve sexual health service access must both be a priority in the 2010-2014 strategy.

The Action Centre is Family Planning Victoria's youth specific service in Melbourne's CBD. Located in Elizabeth Street, it offers young people aged under 25 a broad range of sexual and reproductive health services. Young people are also the primary users of our main Box Hill clinic and our Cranbourne and Hoppers Crossing outreach services. All our services welcome same sex-attracted and gender-nonconforming young people.

Our Hoppers Crossing outreach service in the City of Wyndham's Youth Resource Centre provides sexual and reproductive health services for young people. We recommend it to government as a model for providing specialised services to priority populations.

Specialised health services, such as youth health services for homeless young people, family planning clinics, sexual health clinics, Aboriginal medical services and emergency departments, achieve higher STI screening rates than general pratice (50-90 per cent).[75] Such services should be adequately funded for clinical, education and health promotions targeting specific populations of young people who may not access general practice.

For example the cost of contraceptives is not subsidised. A very effective method such as Implanon costs more than $200, compared to $5.40 for Health Care Card holders and around $33 for others. Overseas students also have to pay for STI tests unless they go to Melbourne Sexual Health Service.

Services targeted to specific issues: Antenatal care for young mothers

Multidisciplinary age-specific antenatal services have been associated with improved outcomes for young women, including reduced infant prematurity rates.[76] [77]

Positive, supportive non-judgmental services can strengthen young people's capacity to advocate for themselves and their children. They can also improve short and long-term outcomes for mothers and children. Teenage-specific antenatal services have detected higher health risk rates than those in general antenatal clinics [99], such as unstable housing, drug dependency and domestic violence placing the child at risk of abuse and neglect.

The detection of these factors and the ability to offer young mothers greater support and coping strategies has been positively correlated with better postnatal outcomes for the mother and child.

Satellite Community Health Service in a School

A rural secondary college, local community health service, medical group and the then Department of Human Services secondary school nursing program combined to set up a community health service at the school. The School Council was involved and parents consulted and engaged. They were able to opt their children out of the service if they wished.

The school already had a student wellbeing coordinator, two counsellors, a chaplain, psychologist, social worker and a school nurse. They now form a youth clinic in the school, with a multi-disciplinary team including a community health nurse, secondary school nurse and a GP from a local medical group.

The community health centre administered the facility and the Department of Human Services secondary school nurse coordinated student access, provided services and referred to school or external services as required. The main goal was to augment the school's health education and provide more complete primary health care. In this rural region, access to health services is limited by lack of providers and bulk billing. The 'Youth Clinic' service has been well used, including by young people seeking contraception, pap smears, STI screens and pregnancy tests. Young people are also presenting with general issues such as mental health concerns.[78]

Safer Sex in the Sticks

Given young people outside school face an elevated STI risk, it is necessary to prioritise community broad interventions to ensure that these adolescents can also easily access sexual health education and relevant clinical services.

The 'Safer Sex in the Sticks' project is one example of a successful community-wide approach to STI prevention. It aimed to reduce chlamydia transmission in young people across Victoria's Swan Hill region. The project's success was largely due to local community involvement in its development and implementation.

Sexual Health and Diversity Enterprise (SHADE)

This project promotes STI and BBV prevention and testing and support greater access to sexual health care in these communities.

SHADE raises awareness of STIs and blood borne viruses (BBVs) in both Indigenous and non-Indigenous young gay, lesbian, bisexual, intersex, transgender and queer people (GLBTIQ) and their social networks.

It also engages the wider community by encouraging public discussion and debate on sexual health issues relevant to young people. The campaign spans each month of February and includes community grants, workforce development and a social marketing campaign involving resource distribution.

Why do we need SHADE?
Chlamydia notifications rose considerably in 2007-08 in four of the five rural and regional Victorian areas, including Gippsland, Hume, Loddon Mallee and the Grampians. Syphilis and gonorrhoea notifications also rose in the Loddon Mallee and Gippsland areas.

Data also shows that STI testing and notification are much lower in rural areas than metropolitan regions, with rural areas also having poorer access to health and community support services.

Who does SHADE reach?
SHADE reaches a different part of regional and rural Victoria each year, targeting key communication messages and tailoring strategies to meet local community needs. Following the success of the 2010 SHADE Gippsland campaign, 2011 is set to target the Hume region.

What does the SHADE Workforce Development Program involve?
Health care professionals in the SHADE region receive workforce development training to raise awareness of diversity and improve management of the health and social issues facing GLBTIQ youth. Participants work together to challenge misconceptions and develop communication skills they can then apply to a broad range of situations.

FPV strongly recommends the funding and development of SHADE as an annual regional and rural campaign run simultaneously across all five DH areas in the month of February by FPV, women's health services, the Victorian Aboriginal Community Controlled Health Organisation and local governement authorities.

New South Wales Aboriginal Sexual Health Workers

A network of Aboriginal sexual heath workers liaises between Aboriginal and Torres Strait Islander communities and health services around sexual health-related issues.

Workers are based in both the public and community-controlled health sectors throughout NSW. They are either based in Aboriginal Community Controlled Health Organisations or government funded health promotion services.

Gippsland Women's Health Service

The Gippsland Women's Health Service is facilitating the development of a Sexual and Reproductive Health Strategy. The strategy is a comprehensive, evidence-based plan that will direct and inform the promotion of sexual and reproductive health in targeted populations across the Gippsland region. The strategy's goals are:

1. To reduce the incidence of chlamydia throughout Gippsland.

2. To reduce the teenage pregnancy rate throughout Gippsland.

DH could fund all Victorian Women's Health services to undertake this model leadership role to build their capacity to address sexual and reproductive health.

Bendigo Loddon Primary Care Partnership

Sexual health services mapping is clearly a successful model and process that could be used across the State.

Goal

- To increase access to responsive sexual health services for people with diverse needs in the Bendigo Loddon PCP catchment.

Objectives

- collect detailed information about sexual health services provided by agencies to identify gaps in the delivery of sexual health services.
- identify opportunities to build the capacity of agencies to meet the sexual health needs of our communities.
- enhance opportunities for collaboration and integrated service planning between sexual health service providers.
- develop sexual health services directory for the Bendigo Loddon communities.

Examples of good practice: FPV workforce development

For nurses: Certificate in Sexual and Reproductive Health

These courses can be undertaken separately but to receive the Certificate in Sexual and Reproductive Health (Nursing), a participant must successfully complete both. If they want the full certificate, FPV recommends doing the Comprehensive Sexual and Reproductive Health course first to minimise workload and the number of clinical placements.

1. Comprehensive Sexual and Reproductive Health (Nursing) course
This is a theory-based course providing up-to-date, evidence-based information on broader issues in sexual and reproductive health.

2. Pap test and Introduction to Sexual Health (Nursing) course
This course will enable you to develop the clinical knowledge and skills required to become a Pap test provider.

Pregnancy Choices Course For other professionals

This workshop is for nurses, psychologists, social workers, general practitioners and other professionals who support clients presenting with an unplanned pregnancy.

For Medical Practitioners:

The Sexual Health and Family Planning Australia Certificate in Sexual and Reproductive Health for Medical Practitioners

An intensive and comprehensive course for general practitioners, accredited nationally by Sexual Health & Family Planning Australia (SH&FPA), Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM). The course provides training for excellence in the delivery of sexual and reproductive health in primary care.

Doctors not wishing to attend the full theory course may choose to attend individual days. This is an excellent opportunity for GPs wanting a refresher in specific areas of sexual and reproductive health. There is no examination requirement.

Examples of noteworthy or good practice in Education

Drawing on Victorian and international evidence and our practice experience, we have developed a model to build the capacity of schools to deliver effective sexual health literacy programs.

Using expert providers and facilitating local health and education services working together at a network level, forging strong links between schools and local health services to resource and support sexuality education and open service pathways for students.

Through school and community partnerships; local data collection; local program development; resource development; professional development (including train-the-trainer); peer mentoring; and supported classroom program delivery, the model equips school leaders and teachers with the skills and support resources required to implement ongoing and sustainable sexual health literacy programs from Year 5-10. It provides:

- a school and community liaison worker to act as a central resource and support base for schools to increase collaboration between the health and education sectors and build support for ongoing programs
- school leader training to ensure they have the knowledge and commitment to drive their school's program and ensure sexuality education is embedded, consistent and ongoing
- professional development for teachers to develop the knowledge base, skills and confidence needed to teach an effective program
- input from local parents, teachers and students to ensure the program reflects and meets local learning needs
- a clearly articulated sample Year 5-10 program that is consistent with VELS and can be adapted to address local learning needs
- support resources, including activities and assessment tools to enhance consistency in the quality of programs offered across the region
- a mentoring network to provide teachers with a mechanism for addressing their own professional development needs to encourage sustainability and growth
- a train-the-trainer component so staff who receive professional development are equipped to train colleagues.

Diagram 1 illustrates how these strategies work together to comprise the FPV Sexual Health Literacy Capacity Building model.

Diagram 1 FPV key strategies

Expert provider	Strategy	Best practice goal
Expert provider The Centre for Excellence in Rural Sexual Health (CERSH)	Strategy 1 Evaluate CERCH designs evaluation strategy and collects baseline data.	Best practice goal The program is rigorously evaluated, so data and findings can be used to develop policies and programs.
Expert provider FPV WHGNE DEECD SPOs	Strategy 2 Build sustainable school and community partnerships The School and Community Liaison Officer identifies key community links and school-based champions and works with them to build support within schools and create strong links between schools and local health services.	Best practice goal Schools and local health agencies work together, sharing expertise and resources and encouraging students to use health services.
Expert provider FPV WHGNE DEECD SPOs	Strategy 3 Collect local data The School and Community Liaison Officer collects parent/teacher views. This information is used to design the local program and professional development.	Best practice goal Local views and needs are used as the starting point in program development.
Expert provider FPV	Strategy 4 Develop local program FPV develops a 12- week program based on best practice sexual health literacy guidelines and local needs.	Best practice goal The school program is relevant to local needs and meets best practice guidelines.
Expert provider FPV	Strategy 5 Develop support resources FPV develops resources to support this program. These resources are distributed to teachers at the PD.	Best practice goal Teachers and schools have all the resources they need to implement the program.
Expert provider FPV	Strategy 6 Deliver professional development FPV provide PD for two teachers and one school leader from each school to prepare them to deliver the program in their own schools.	Best practice goal Teachers and school leaders develop the knowledge, skills and confidence to implement an effective program.
Expert provider FPV	Strategy 7 Provide peer mentoring network. FPV provides an online mentoring network providing professional support.	Best practice goal Teachers have access to ongoing, self-directed support from colleagues.
Expert provider FPV	Strategy 8 Deliver program in schools Teachers deliver the program in their schools.	Best practice goal Teachers have the opportunity to practise teaching the program before learning to teach others.
Expert provider FPV	Strategy 9 Train-the-trainer professional development FPV provides train-the-trainer professional development.	Best practice goal Teachers refine their skills by teaching others. Schools increase their capacity to provide ongoing, comprehensive programs.
Expert provider The Centre for Excellence in Rural Sexual Health (CERSH))	Strategy 10 Evaluate CERSH conducts impact / outcome evaluation.	Best practice goal The program is rigorously evaluated and data can be used to develop policies and programs.

Key outcomes

The project aims to deliver the following outcomes:

- strong links and partnerships between schools and community agencies in Hume to support the delivery of sexuality education
- a growing database detailing baseline and project data to enable impacts and outcomes to be measured to inform future projects and policy
- a workforce of teachers skilled and equipped to teach effective sexuality education
- a workforce of school leaders skilled to support whole-school learning of sexuality education
- a workforce of teachers skilled and equipped to train other teachers in the delivery of effective sexual literacy programs
- an online community of sexuality educators to support emerging educators and aid workforce development
- a package of ready to use practical classroom resources available for teachers
- a critical mass of schools with effective sexuality education and a growing workforce of teachers who are skilled to effectively advocate for, and deliver, sexuality education
- a growing number of students who will receive consistent and high-quality sexuality education as they move through years 5-10. Assessment tools will enable teachers to measure the impact this has on students' sexual health literacy.
- an adaptable model ready and suitable for application in both primary and secondary schools in other regions across Victoria, with the capacity to deliver the above outcomes and build sexual literacy in students across the state as the model is replicated.

Budget

We estimate this model could be rolled out across all DH regions in Victoria for approximately $5000 per school. This sum includes backfill for teachers which is imperative to ensure all schools participate in the professional development component. Currently this model of capacity building is not funded.

1500 schools x $5000 = $7,500,000	Approx $937, 500 per region

Effective Sexual Health Literacy Checklist for Principals[79]

Build capacity for effective sexual health literacy instruction

- Build capacity through sharing and engagement with other schools and professional bodies.
- Create professional learning clusters and teams.
- Analyse and interpret school data as a part of normal school practice.
- Access targeted sexual health literacy professional learning focusing on DEECD resources and guidelines.
- Use coaching as a powerful process for building capacity.

Develop a school sexual health literacy plan

- Develop a Whole School Sexual Health Literacy Plan and assessment schedule.
- Enact in all classrooms, and discuss across year levels, allowing transitions in teaching and learning for students from year to year.
- Consider the elements of the effective models as per *Catching On*.
- Set sexual health literacy targets in AIP and Performance Plans.
- Appoint a trained sexual health literacy co-ordinator.
- Use sexual health literacy audit and/ or review tools.

Create sexual health literacy school environments and communities

- Develop your sexual health literacy plan in consultation with members of the community.
- Inform parents and caregivers about the instructional practices so they can assist in the development of their child's sexual health literacy skills.

Respond to diverse student needs

- Identify potential difficulties as early as possible and include ongoing assessment and monitoring of progress.
- Implement programs and interventions to support the individual learning needs of students.
- Develop and monitor individual Learning Plans for students with special needs.
- Use evidence-based interventions.
- Ensure the learner is at the centre of planning for sexual health literacy learning.

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