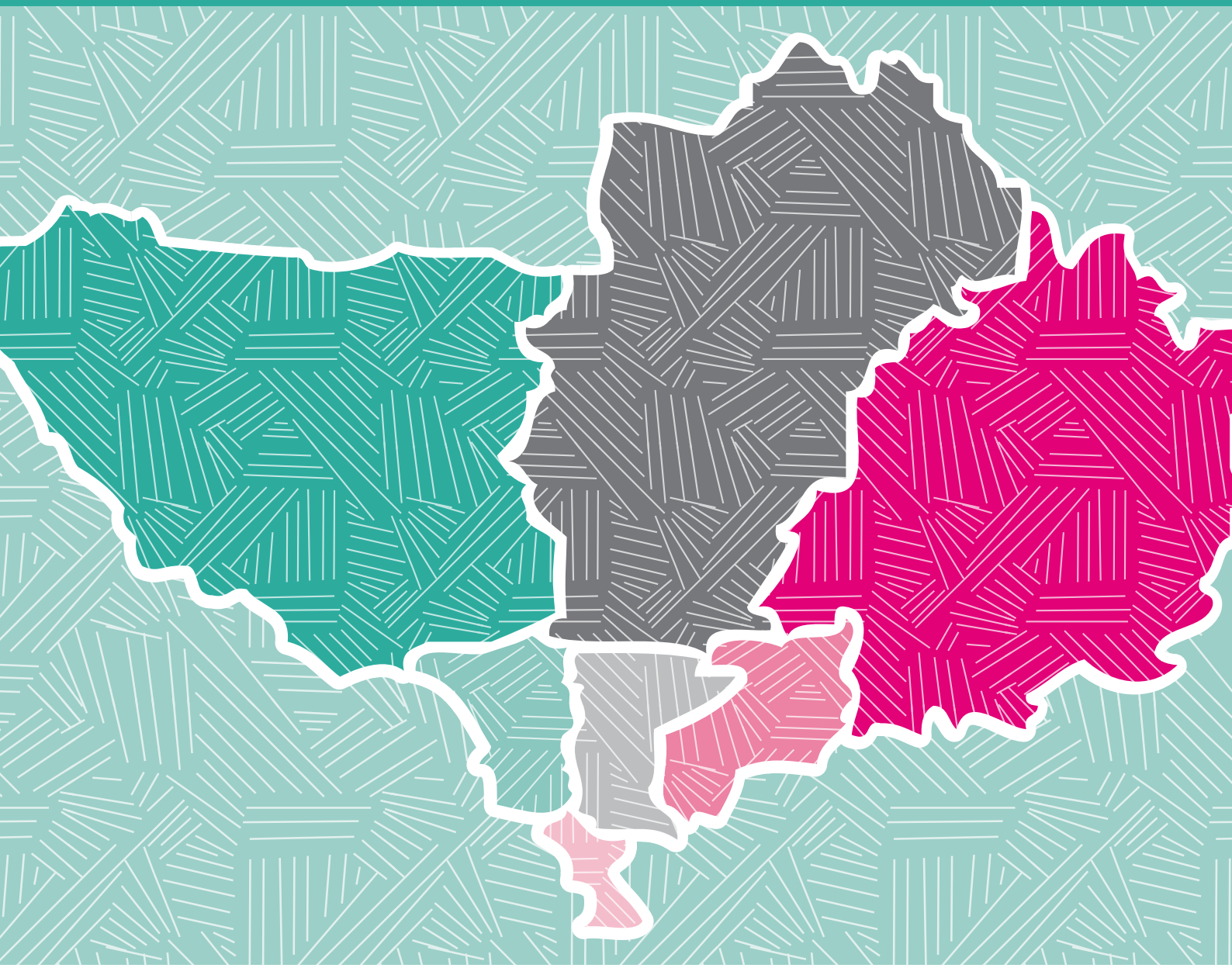
A Strategy For

GOING SOUTH IN THE NORTH

2016 - 2021



WOMEN'S HEALTH IN THE NORTH

voice • choice • power

ACKNOWLEDGEMENTS

Women's Health In the North wishes to thank the members of the Northern Metropolitan Region Sexual and Reproductive Health Network and our other critical friends who have helped to develop an understanding of sexual and reproductive health in the region and inform the development of *A Strategy for Going South in the North*.

A special thank you to our critical friends from:

- Banyule City Council Youth Services
- cohealth
- Department of Education and Training
- Merri Health
- Northern Centre Against Sexual Assault
- PapScreen Victoria
- Plenty Valley Community Health

Suggested citation:

Women's Health In the North, (2016). A Strategy for Going South in the North. Thornbury, Victoria: Women's Health In the North.

Data notes:

Not all data included in the document is sex disaggregated or gendered due to limitations of available data sets. WHIN has worked to ensure that data included in this document is correct at the time of printing. Readers are encouraged to contact WHIN if they have feedback about the accuracy of the data.

For more information:

Women's Health In the North
680 High Street, Thornbury VIC 3071
Telephone: 03 9484 1666
Email: info@whin.org.au
www.whin.org.au

This document has been written and prepared by Hayley Pritchard.

Women's Health In the North acknowledges the support of the Victorian Government.

WHIN acknowledges the traditional owners of the land on which we provide our services. We pay our respects to their Elders past and present, and express our hope for reconciliation, justice and the recognition of the ongoing living culture of all Aboriginal people.

ISBN 978-0-9872194-1-1

CONTENTS

ACRONYMS

CALD	Culturally and Linguistically Diverse
FGC/M	Female Genital Cutting/Mutilation
GLBTQI	Gay, Lesbian, Bisexual, Transgender, Queer and Intersex
HPV	Human Papillomavirus
LARC	Long-acting Reversible Contraception
LGA	Local Government Area
MTOP	Medical Termination of Pregnancy
NMR	Northern Metropolitan Region
PCP	Primary Care Partnership
PHN	Primary Health Network
SES	Socio Economic Status
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
WHIN	Women's Health In the North
WHAV	Women's Health Association of Victoria

> **A desiring and active model of female sexuality, coupled with a focus on social and interpersonal issues around sexual health, is needed** to ensure that all women – and indeed men – can have genuine sexual choices while maintaining safe and positive sexual identities.
>
> (Moran & Lee, 2012)

DEFINITIONS

SEXUAL HEALTH 'A state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled' (World Health Organisation 2006).

REPRODUCTIVE HEALTH 'Addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so'(International Conference on Population and Development 1994).

SEXUALITY 'A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors' (World Health Organisation 2006).

SEXUAL RIGHTS 'The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination' (World Health Organisation 2006).

Sexual rights include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services
- seek, receive and impart information related to sexuality
- sexuality education
- respect for bodily integrity
- choose their partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not, and when, to have children
- pursue a satisfying, safe and pleasurable sexual life (World Health Organisation 2006).

SEX 'Refers to the biological differences between female and males. This includes the reproductive organs and sex-specific hormonal activity. Individuals may identify as being a sex other than the one they were assigned at birth or as being intersex or of indeterminate sex' (Women's Health Association of Victoria 2016).

GENDER 'Refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women, men, boys and girls. Ideas associated with gender play a strong role in determining what society permits, expects and values in women and men and impacts on the economic, social and power relations between the sexes. These opportunities and expectations are not always equal. As gender is culturally determined, societal expectations of gender will change over time' (Women's Health Association of Victoria 2016).

INTRODUCTION: A STRATEGY FOR GOING SOUTH IN THE NORTH

Introduction

A Strategy for Going South in the North ('the Strategy') provides a regional response to improving sexual and reproductive health across the northern metropolitan region (NMR) of Melbourne, Victoria. It has been developed by Women's Health In the North (WHIN), in partnership with the NMR Sexual and Reproductive Health Network and other key regional partners, over three years. It includes a review of the evidence base, a vision and aims, and a range of health promotion interventions that will be implemented over the next five years.

Vision

The northern metropolitan region of Melbourne is a place where:

- women, men and service providers are educated about, and have a developed understanding of, sexual and reproductive health.
- sexual and reproductive health services are appropriate and accessible.
- all women and men are free to express their sexuality without experiencing ill health, discrimination or abuse.

Aims

- To develop environments which are supportive of sexual and reproductive health.
- To empower community involvement in improving NMR sexual and reproductive health outcomes.
- To increase understanding of the sexual and reproductive health status of NMR communities.
- To increase individual and organisational sexual and reproductive health knowledge, attitudes and capacity.
- To improve the prevention, early detection and response to physiological sexual and reproductive health outcomes.

CONTEXT

Women's Health In the North

Women's Health In the North (WHIN) is the regional women's health service for Melbourne's Northern Metropolitan Region. WHIN aims to strengthen women's health, safety and wellbeing, with a strategic focus on:

- Sexual and reproductive health
- Violence against women
- Gender equity and gender analysis
- Economic participation
- Environmental justice

WHIN's mission is to address gender inequities and the determinants of women's health, safety and wellbeing through leadership, advocacy, research, knowledge translation and strategic partnerships. WHIN is committed to carrying out this mission in a way that is feminist, ethical, inclusive and courageous.

WHIN's strategic objectives are to:

- Provide leadership and expertise to improve women's health, safety and wellbeing
- Identify, build and resource strategic partnerships that promote women's health, safety and wellbeing and improve regional service responses
- Undertake and influence research, resource development and knowledge translation to inform innovative approaches to women's health, safety and wellbeing
- Engage with women and communities to facilitate, influence and support positive change to their health, safety and wellbeing
- Build a strong and sustainable future for the organisation.

WHIN has prioritised sexual and reproductive health since its establishment in 1992 and acknowledges that sexual and reproductive health is a broad and holistic area of health that has a defining impact on women's lives, beginning at puberty and continuing past menopause.

The 2014 NMR population is estimated to be **962,935**

WHIN has prioritised **sexual** and **reproductive health** since its establishment in **1992**

Northern Metropolitan Region of Melbourne

The northern metropolitan region (NMR) of Melbourne includes the local government areas of Banyule, Darebin, Hume, Moreland, Nillumbik, Whittlesea and Yarra.

The NMR covers more than 1,600 square kilometres from the inner city area of Richmond to the rural areas of the Kinglake Ranges. In between, the region contains suburbs diverse in ethnicity, socioeconomic status and infrastructure. The NMR contains two growth corridors, Hume and Whittlesea, which are also 'interface councils', along with Nillumbik.

2014 NMR POPULATION ESTIMATES

	GENDER	0-4	5-14	15-24	25-34	35-44	45-54	55-64	64-74	75+	TOTAL
Banyule	F	3,988	6,685	7,883	8,757	9,033	8,540	7,832	5,933	5,645	**114,971**
	M	4,213	7,298	8,200	8,520	8,984	7,873	6,917	5,315	3,887	**61,207**
Darebin	F	4,680	7,058	9,222	15,095	12,129	9,504	6,776	5,397	6,540	**136,902**
	M	4,880	7,318	8,855	14,368	11,794	9,132	6,675	4,595	4,710	**72,327**
Hume	F	7,101	13,384	14,089	14,755	1,321	12,793	9,301	6,059	4,011	**171,355**
	M	7,484	13,801	14,496	14,591	13,088	12,523	9,064	5,879	3,122	**94,048**
Moreland	F	5,208	7,756	10,229	17,235	12,963	9,491	6,910	5,323	7,694	**147,508**
	M	5,313	8,205	10,303	17,945	12,917	9,373	6,695	4,492	5,233	**80,679**
Nillumbik	F	1,645	4,411	4,511	2,794	4,503	5,389	4,589	2,427	1,293	**58,541**
	M	1,737	4,574	4,931	2,957	3,976	5,073	4,468	2,469	1,119	**31,310**
Whittlesea	F	7,200	11,976	12,020	16,446	14,032	11,872	9,424	6,108	4,629	**168,385**
	M	8,060	12,645	12,210	16,326	14,068	11,327	8,794	6,043	3,826	**93,299**
Yarra	F	2,200	2,796	5,386	13,520	6,895	4,687	3,893	2,556	2,286	**81,752**
	M	2,201	2,670	4,658	12,550	7,489	5,032	3,621	2,426	1,640	**42,287**
NMR	F	32,022	54,066	63,340	88,602	72,946	62,276	48,725	33,803	32,098	**487,778**
	M	34,091	53,511	63,653	87,257	72,316	60,339	46,234	31,219	23,537	**475,157**

The 2014 estimated NMR population is 962,935 people. The estimated female resident population is 487,778 (50.6%) and the estimated male resident population is 475,157. There are significant proportions of young people in the NMR, with 30.1% of females (149,428) and 32% of males (154,255) aged less than 25 years (Australian Bureau of Statistics 2015a).

There are 5,156 Aboriginal and Torres Strait Islander people living in the NMR—2,637 female and 2,159 male. This is 13.5% of the total Victorian Indigenous population (Australian Bureau of Statistics 2013b).

In the NMR, 30.1% of residents were born outside of Australia—the top five countries of birth are Italy, the UK, India, Greece and China—and 41.5% of people speak languages other than English at home (Australian Bureau of Statistics Census 2011). In the five years between 2008 and 2013, 5,549 people moved to the NMR on humanitarian visas; the most common countries of origin were Iraq, Iran, Bhutan, Somalia, Afghanistan and Sri Lanka (Department of Immigration and Border Control 2013).

Background

'Improving Sexual and Reproductive Health' is identified as a health and wellbeing priority in the *Victorian Public Health and Wellbeing Plan 2015-2019* with strategic directions to:

- Promote and support positive, respectful, non-coercive and safe sexual relationships and reproductive choice (including planned, safe and healthy pregnancy and childbirth).
- Reduce sexually transmissible infections and blood-borne viruses will focus on prevention, testing, management, care and support, surveillance, research and evaluation, in line with national strategies.
- Work towards eliminating HIV and viral hepatitis transmission and significantly increase treatment rates.

There is no current national or state strategy to holistically address sexual and reproductive health, however, policies have been implemented by the Australian Government for specific sexual and reproductive health areas, including the *Third Sexually Transmissible Infections Strategy*, the *National Hepatitis B Strategy 2014-2017*, the *Sixth National HIV Strategy 2014-2017* and the *Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014-2017*.

Organisations in Victoria and nationally have been advocating for a comprehensive sexual and reproductive health strategy. The Women's Health Association of Victoria (WHAV), of which WHIN is a member, submitted a proposal in 2011 to the Victorian Government strongly advocating for a statewide sexual and reproductive health strategy to:

- strengthen health promotion initiatives that work to redress the social determinants of sexual and reproductive health
- provide an integrated approach to sexual and reproductive health policy, health promotion, service and program delivery
- ensure sexual and reproductive health rights are protected and upheld.

In the absence of a comprehensive, statewide sexual and reproductive health strategy, Victorian women's health services have been developing and implementing regional plans and strategies. In 2013, after scoping partner organisation priorities, WHIN committed to developing a regional strategy to address this gap in the NMR.

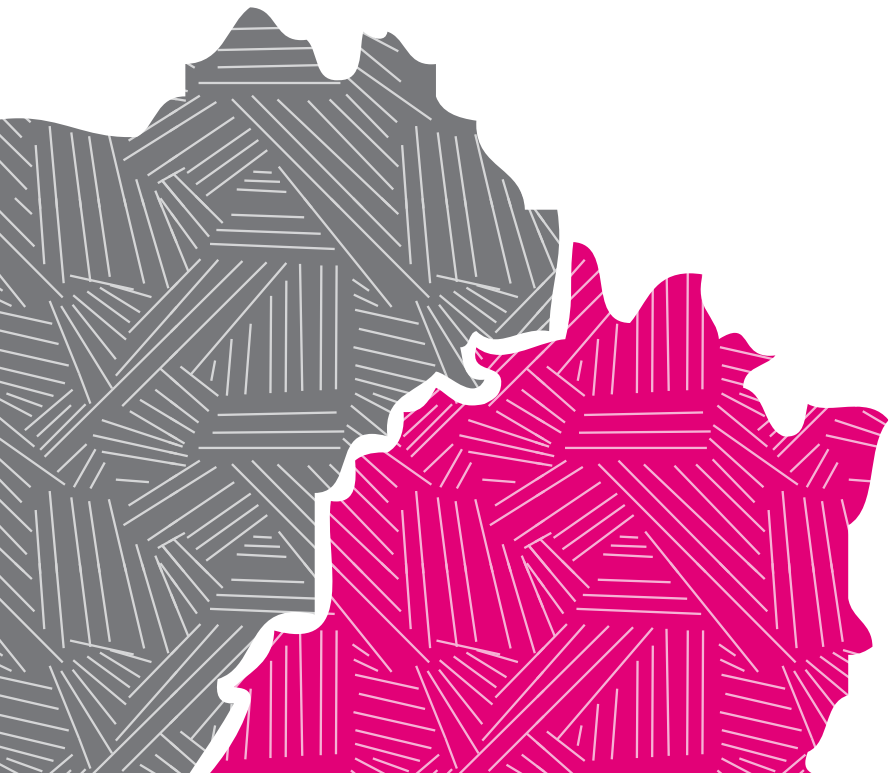
CONTEXT *CONTINUED*

The Need for a Northern Metropolitan Region Strategy

Research undertaken as part of the development of this strategy identified that the NMR of Melbourne is disproportionately affected by poor sexual and reproductive health. In order to successfully improve the sexual and reproductive health of women and men in the NMR, a coordinated and targeted approach must be undertaken.

An individual's sexual and reproductive health is influenced by a wide range of factors, which need to be addressed collaboratively by multiple sectors and disciplines. A regional strategy provides a framework to identify priority areas of need, consolidate and identify partnerships and target collaborative activities in an appropriate and effective manner which uses resources efficiently. As a result, *A Strategy for Going South in the North* was developed.

> "The NMR of Melbourne is **disproportionately** affected by poor sexual and reproductive health."



DEVELOPMENT **OF THE STRATEGY**

Developing the Evidence Base

In late 2013, WHIN began consulting with regional and statewide organisations to:

- map sexual and reproductive health programs and services in the region
- gauge partner interest and investment in sexual and reproductive health
- understand the current burden of sexual and reproductive ill health.

Analysis of available data sets was undertaken and the first NMR Sexual and Reproductive Health factsheets were developed.

Going South in the North

In October 2014, WHIN launched *Going South in the North: A snapshot of the sexual and reproductive health status of women living in Melbourne's northern metropolitan region.* This report documents the current sexual and reproductive health data and statistics for Melbourne's NMR. It also describes the social, cultural and economic context of the NMR and the influence that this has on women's health. Together, this created a picture of the sexual and reproductive health status of women living in the region.

Going South in the North set the scene for WHIN's future work to improve the sexual and reproductive health of women in Melbourne's NMR and informs this strategy. It was also intended for use by WHIN's partner organisations to inform the development of their own responses to women's sexual and reproductive health.

The NMR Sexual and Reproductive Health Network

In June 2015, WHIN established the NMR Sexual and Reproductive Health Network to provide a platform for advocacy work to cement sexual and reproductive health as a health priority in the NMR. The Network functions to develop strong regional partnerships, provide professional education and as an avenue for the collaborative development of *A Strategy for Going South in the North.*

At the time of the development of this strategy, five network meetings have been held with attendance representing 26 organisations.

This strategy has been developed in consultation with members of the NMR Sexual and Reproductive Health Network and other key regional partners.

> "AN INDIVIDUAL'S SEXUAL AND REPRODUCTIVE HEALTH IS INFLUENCED BY A WIDE RANGE OF FACTORS."

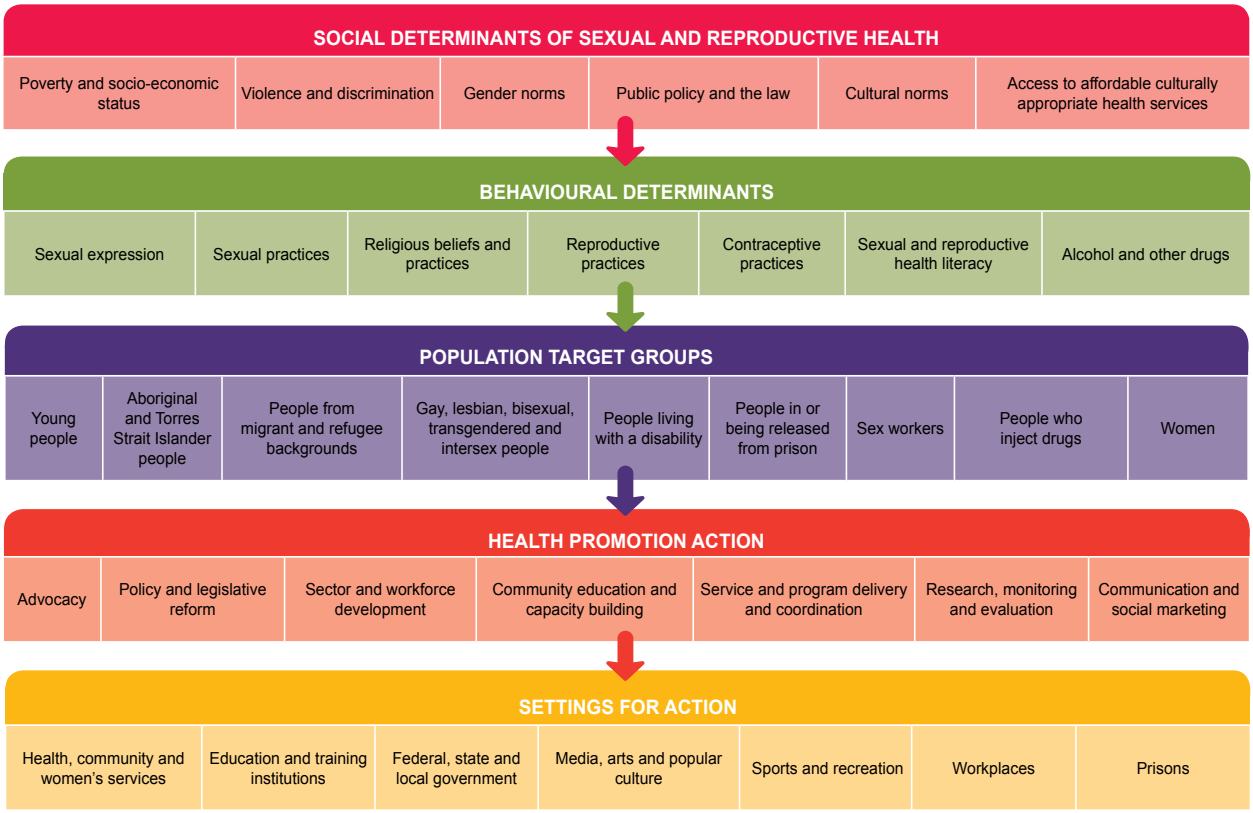
INFLUENCING FRAMEWORKS

Health Promotion Framework

A Strategy for Going South in the North has been developed with a health promotion framework. Health promotion is the process of enabling people to increase control over and to improve their health, and is underpinned by the Ottawa Charter (World Health Organisation 1986). Best practice health promotion should focus on the social determinants of health rather than just individual behaviours. Due to the holistic nature of sexual and reproductive health, clinical and non-clinical interventions are required, alongside environmental and cultural change.

The interventions in *A Strategy for Going South in the North* have been adapted from the Victorian Department of Health and Human Services *Health Promotion Intervention Framework* (2003). This framework provides a continuum of interventions from population-wide approaches to individual approaches. This framework has been used to ensure that strategies were developed to address the spectrum of sexual and reproductive health. This also ensures that all key partners across a range of clinical and non-clinical settings can be engaged in the strategy to improve sexual and reproductive health.

WESTERN REGION SEXUAL AND REPRODUCTIVE HEALTH PROMOTION FRAMEWORK



Source: Women's Health West 2013

Women's Health West's *Western Region Sexual and Reproductive Health Promotion Framework 2011* has been used as a best practice model for sexual and reproductive health promotion. The framework identifies five layers of influence: the social determinants of sexual and reproductive health, behavioural determinants, population target groups, health promotion action and settings for action. The framework recognises that these levels interact and contribute to the sexual and reproductive health of individuals, community and society (Taylor & Vu 2013).

WHIN has used Women's Health West's sexual and reproductive health framework, particularly the social determinants and population target groups, to inform the development of this regional strategy.

> "DUE TO THE HOLISTIC NATURE OF SEXUAL AND REPRODUCTIVE HEALTH, CLINICAL AND NON-CLINICAL INTERVENTIONS ARE REQUIRED, ALONGSIDE ENVIRONMENTAL AND CULTURAL CHANGE."

Social Determinants Framework

Health prevention and response requires a strong understanding of the social determinants of health. The social determinants framework illustrates how environmental and economic factors influence health outcomes. Health promotion uses this model to identify contexts that are not supportive of positive health and implements strategies that are developed and tailored to fit diverse meanings of health and sexual practice.

WHIN has adopted Women's Health West's identified six social determinants of sexual and reproductive health. These are:

- poverty and socio-economic status
- violence and discrimination
- gender norms
- public policy and the law
- cultural norms
- access to affordable culturally health services.

For information about how these social determinants interact and impact the sexual and reproductive health of communities living in the NMR, refer to *Going South in the North: A snapshot of the sexual and reproductive health of women living in Melbourne's northern metropolitan region.*

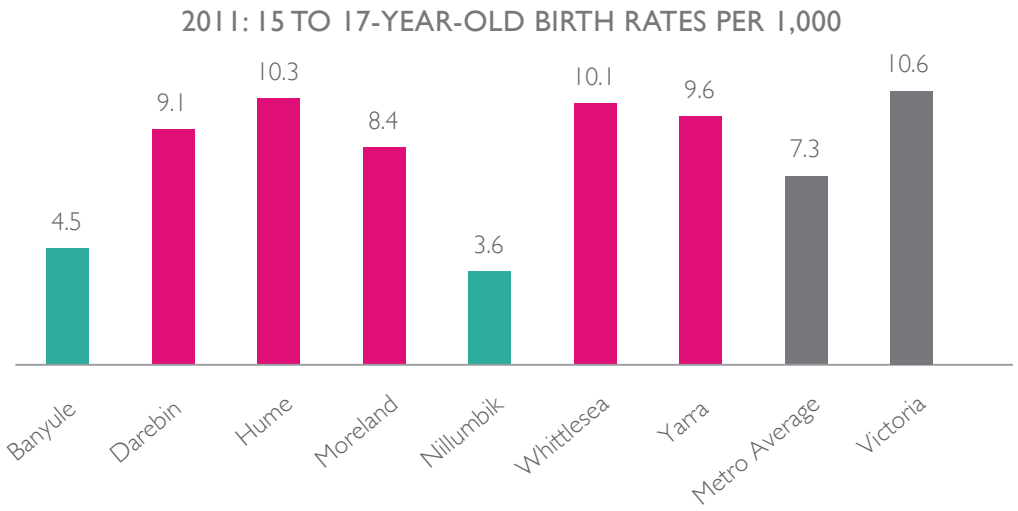
The social determinants framework has been considered throughout the development of this strategy to ensure that activities are holistic and focus on influencing broader environmental change, rather than just individual change.

EVIDENCE BASE

Sexual and Reproductive Health Data

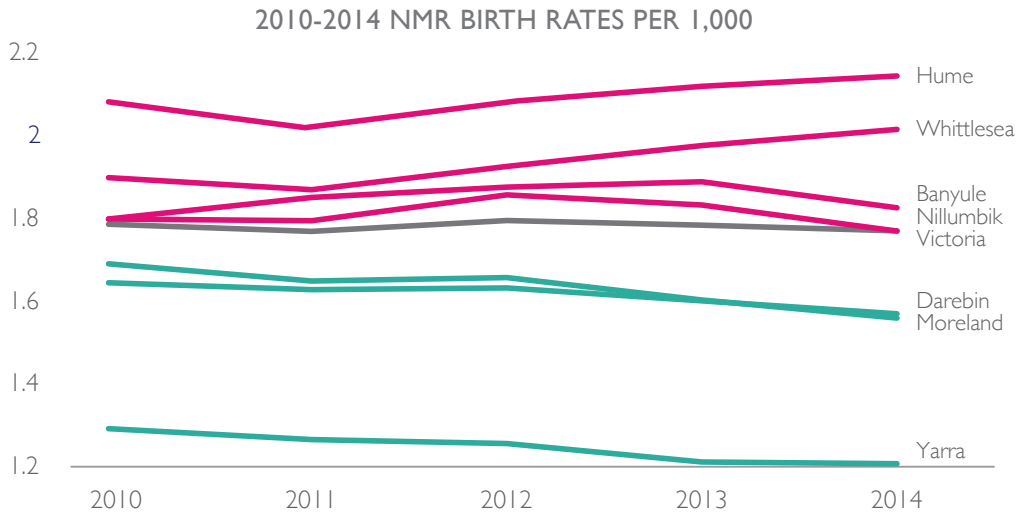
There are multiple sexual and reproductive health indicators that disproportionately affect NMR residents. These include high birth rates (overall and teenage), high prevalence of hepatitis B, low HPV immunisation coverage, low Pap screen participation and under-screening of chlamydia. An overview of these indicators is below and more detailed information can be found in *Going South in the North: A Snapshot of the sexual and reproductive health status of women living in Melbourne's northern metropolitan region.*

In five NMR local government areas (LGAs), the 15 to 19-year-old birth rates were higher than the Melbourne metropolitan average of 7.3 per 1,000 young women in 2011 (Department of Education and Early Childhood Development 2014).

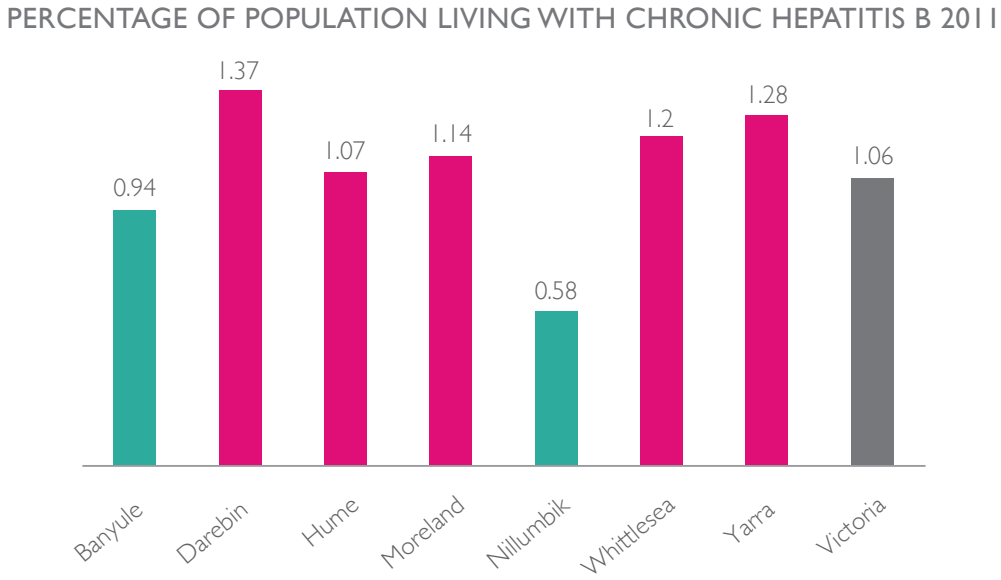


> "IN FIVE NMR LOCAL GOVERNMENT AREAS, THE 15 TO 19-YEAR-OLD BIRTH RATES WERE HIGHER THAN THE MELBOURNE METROPOLITAN AVERAGE OF 7.3 PER 1,000 YOUNG WOMEN IN 2011."

Three NMR LGAs (Hume, Whittlesea and Banyule) had higher birth rates for women than the Victorian average of 1.8 per 1,000 women in 2014 (Australian Bureau of Statistics 2015b).



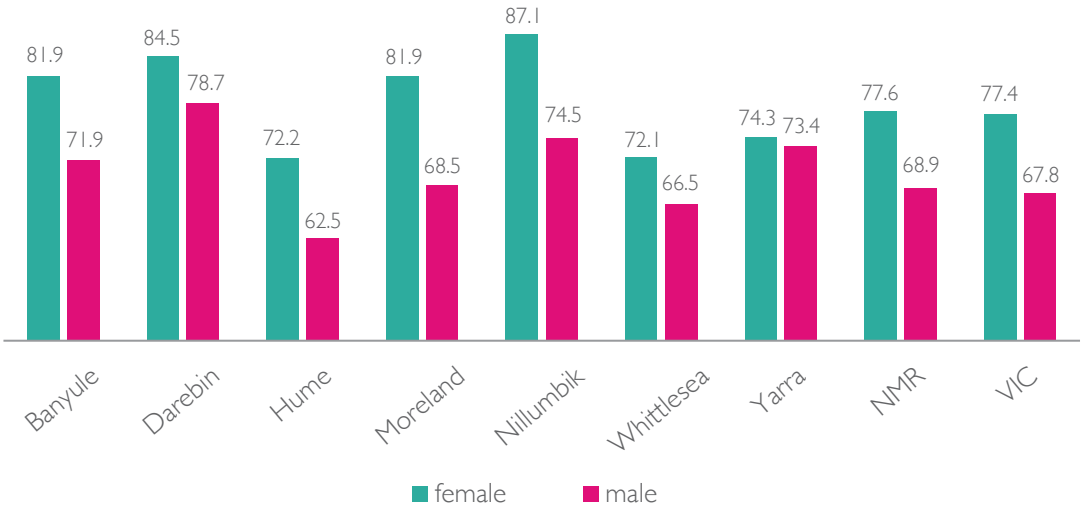
Five NMR LGAs have a prevalence of hepatitis B which is higher than the Victorian prevalence rate of 1.06% (Australasian Society for HIV Medicine and Victorian Infectious Diseases Reference Laboratory 2013).



EVIDENCE BASE *CONTINUED*

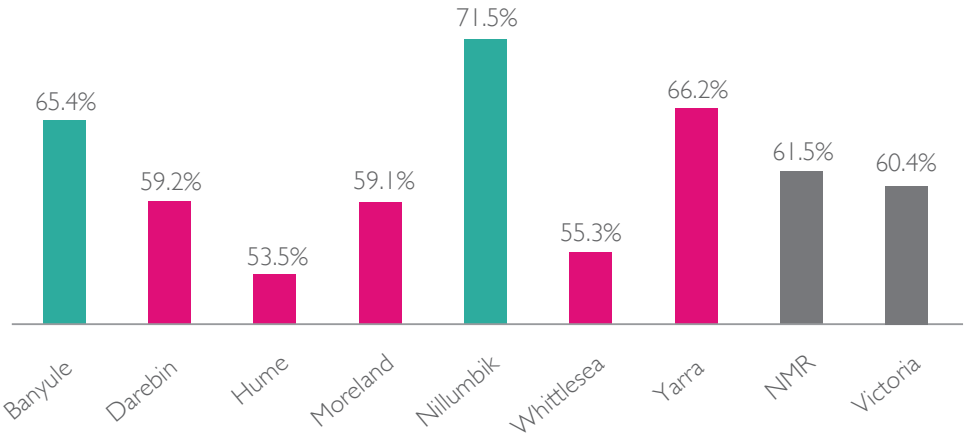
Three LGAs had HPV immunisation coverage rates lower than the Victorian rate of 77.4% for 15-year-old girls in 2014. Two LGAs also had vaccination coverage for 15-year-old boys that was lower than the Victorian average of 67.8% (National HPV Vaccination Program Register 2016).

NMR 15–YEAR-OLD HPV VACCINATION THIRD DOSE COVERAGE 2014



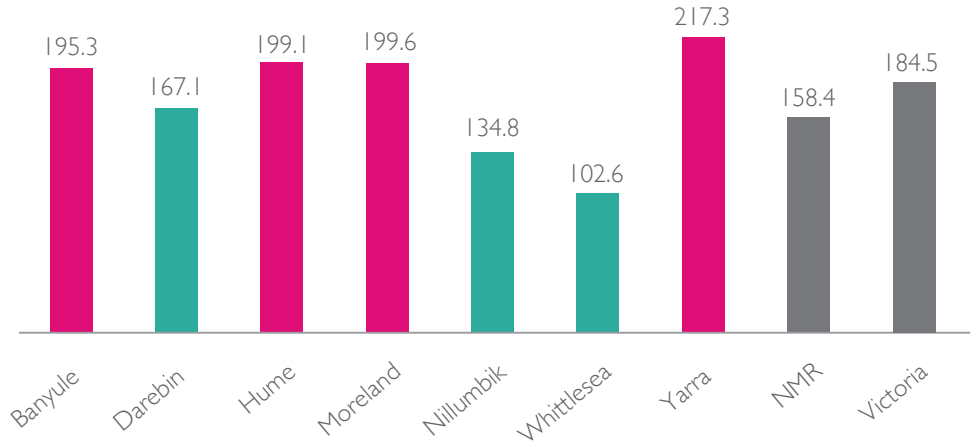
Four LGAs had 2012-2013 Pap screening participation rates that were lower than the Victorian average of 60.4% (Victorian Cervical Cytology Registry 2013).

NMR PAP SCREENING PARTICIPATION 2012-2013



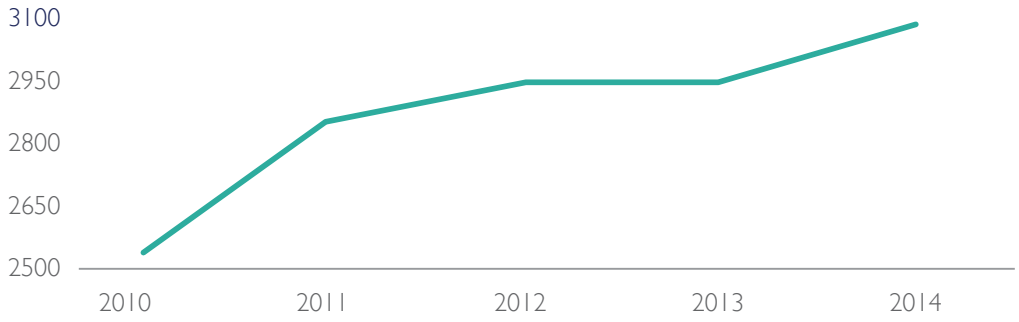
Four LGAs had higher rates of recorded sexual assault (rape) and sexual assault (other) offences per 100,000 than the overall Victorian rate in 2004-2015 (Victoria Police Crime Statistics Agency 2015).

SEXUAL ASSAULT AND SEXUAL ASSAULT 2014-2015 (RECORDED OFFENCES PER 100,000)



Diagnoses of chlamydia have increased 23% across the NMR from 2010 to 2014 (Victorian Department of Health 2014). It is widely acknowledged that chlamydia is underreported due to low testing rates; therefore, the figures reported below would likely represent only the tip of the iceberg.

NMR CHLAMYDIA DIAGNOSES 2010-2014



The NMR is home to a significant population of women who are from communities where female genital cutting or mutilation (FGC/M) is traditionally practiced (Family Planning Victoria 2013). FGC/M is a harmful traditional practice which has no health benefits, but can have significant impacts on a women's sexual and reproductive health, including scarring, menstrual complications, chronic pelvic infection, pain, infertility and issues with physical examinations, including Pap screening.

Women's Experiences

In recognition that sexual and reproductive health is broader than statistics of ill health can portray, consultations with women in the community were undertaken to develop a more comprehensive picture of women's sexual and reproductive health experiences.

WHIN surveyed 163 women about sexual and reproductive health service access through an online survey between June and August 2015 as part of the Northern Health Shared Vision for the North project. Survey responses indicated that women had varied experiences of accessing sexual and reproductive health services and identified barriers to service access.

When asked '*do you think that it's easy for women to access sexual and reproductive health services?*', 31.5% answered yes, 32.2% answered no and 36.3% were unsure. Their responses indicated that ease of access was situational:

'I think for the vast majority of women sexual and reproductive health services are a bit of a mystery - even though they're out there! They may feel they will be stigmatised by asking for info or attending an appt.'

'I do think it is easy for someone like me - English speaking, middle class, educated and financially independent. I fully understand that women from other ethnic groups and socioeconomic groups may have a very different experience.'

'Last time I went to my local GP in one of the large GP bulk billing centres, I had to fight for the doctor to do a pap smear. He didn't want to do it because he had "all these other patients" to see.'

'Not easy for lesbian, bisexual, transgender and queer women to find welcoming, well informed services in my experience….'

'My GP does not [offer Pap tests], so I need to get a referral and then make an appointment elsewhere, which I almost always forget to do. I work full time and am a single mother. I only take time off and go to the doctors if it is really necessary.'

The survey indicated that the majority of respondents are currently accessing their GP as an initial contact for sexual and reproductive health concerns. Of these, 47% also complement GP visits with other professional services:

'I firstly undertake some research/reading and then I approach my GP/health professional if I require further services.'

'Depends on what it is. I initially might go to a chemist and then make a decision as to where to go after that, depending on the advice of the pharmacist.'

When asked which sexual and reproductive health services they will require in the next 12 months, Pap tests were the main response. Other responses indicated that respondents were often hoping to not need to access sexual and reproductive health services.

'Hope not! Only if I get cancer....'

'Hopefully not. My partner and I use condoms. If I were to have an unplanned pregnancy I would probably contact Marie Stopes international.'

Considering that most women who responded to the survey were within reproductive years, a lack of responses regarding emergency contraception, sexually transmitted infection testing and available contraceptive options could be indicative of a poor understanding of sexual and reproductive health options and services.

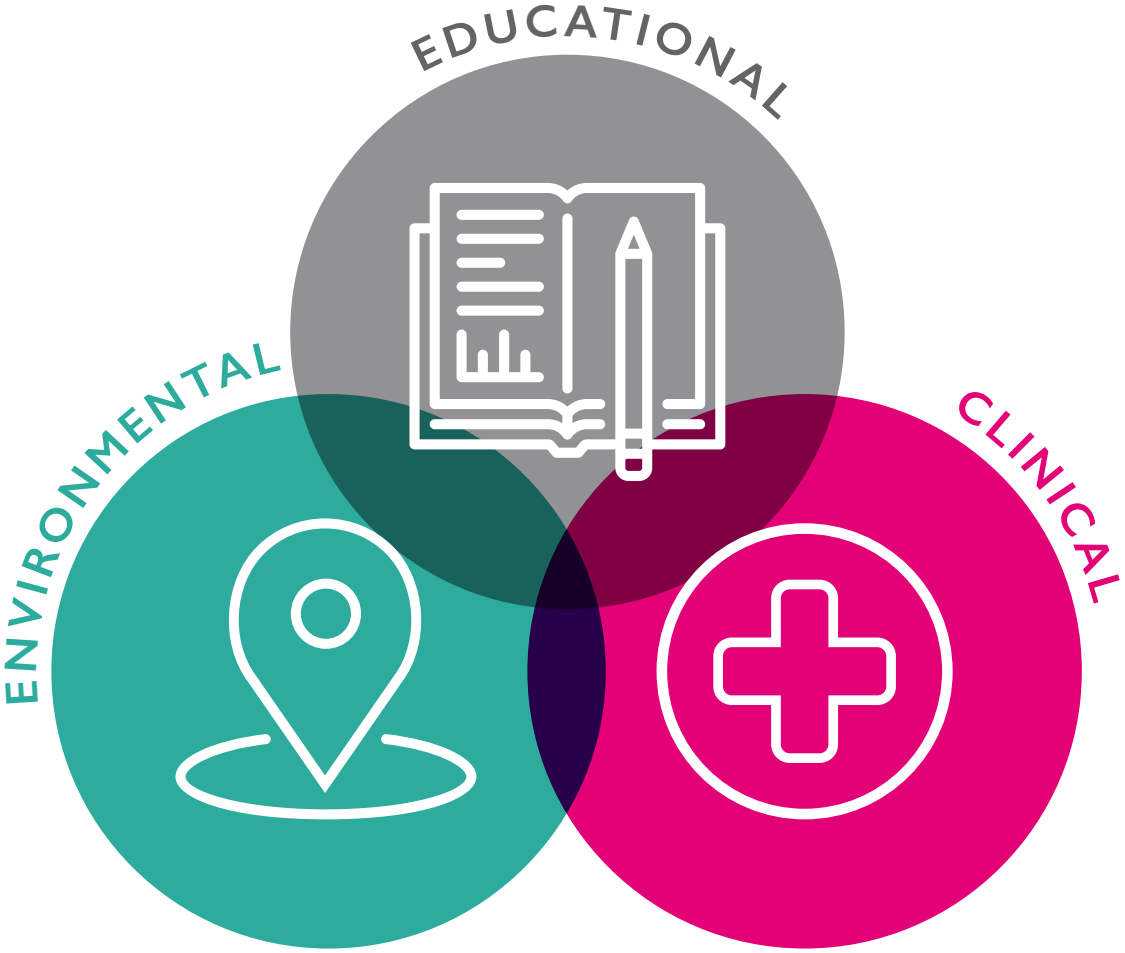
“I think for the vast majority of women sexual and reproductive health services are a bit of a mystery - even though they’re out there! They may feel they will be stigmatised by asking for info or attending an appointment.”

(Survey participant, 2015)

Critical Considerations as Identified by Professionals

Consultations with professionals in the region resulted in the development of a list of sexual and reproductive health issues for consideration. These were grouped into three categories—clinical, educational and environmental.

It is acknowledged that the three categories are all interconnected and in order to improve sexual and reproductive health outcomes, issues in each category need to be addressed simultaneously. The following pages provide an overview of the consultation responses.



CLINICAL CONSIDERATIONS

High rates of **rape** and **sexual assault**

High rates of chronic **hepatitis B**

Fragmented **service system**

High **teenage** birth rates

Lack of **connection** between agencies

LARC and MTOP **prescribers** are unknown

Low **STI** testing

Unknown where women are accessing SRH services

No **specialist** SRH services located in NMR

Low rates of **Pap Smear** screening

Referral **pathways** are unclear

High **fertility** rates

Low HPV **vaccination** coverage

ENVIRONMENTAL CONSIDERATIONS

NMR is diverse: Indigenous, CALD and GLBTQI communities

2 growth corridors and **3** 'interface' councils

SRH is considered as something only for **'experts'** to address

No statewide or **national** SRH strategy

Large **FGC/M** affected communities

High proportion of **12-14 year-olds** sexually active

Many low **SES** areas

SRH is still often considered **taboo**

No **specialist** SRH services located in NMR

Health services are **continually** changing

SRH is rarely prioritised in **health plans** or as a priority health issue in the region

EDUCATIONAL CONSIDERATIONS

Sexuality education is not **specific** to high need groups

Sexuality education lacks **focus** on practical skills

Delivery of **SRH programs** is seen as a niche

School **nurses** are delivering education when available

Many sexuality **education resources** - which to use?

Unknown levels of adult SRH **literacy**

Need **engagement** from principals

Unknown if any **whole-school** approaches exist in NMR

Limited **teacher training** and support

Few specialist **educators** in NMR

Need for **partnerships** with community agencies

Inconsistent **quality** of sexuality education

Need for **parent involvement** and community collaboration

“**A regional response provides collective impact through a shared vision** and commitment for change and the strength of mutually reinforcing activities.”

IMPLEMENTATION

A Regional Response

A commitment is sought from partners to collaboratively implement *A Strategy for Going South in the North* as a regional response. This commitment involves:

- advocating for sexual and reproductive health as a shared priority in the NMR
- supporting the vision and aims of the Strategy
- undertaking ongoing collaborative action which contributes to the Strategy's objectives
- contributing to best practice models for the NMR by sharing learnings with partners.

A regional response provides collective impact through a shared vision and commitment for change and the strength of mutually reinforcing activities. Critical to the success of *A Strategy for Going South in the North* will be its alignment with the organisational structures and plans of key regional partners.

This strategy has been designed to complement existing sub-regional work. Resulting activity should consider program and service gaps in planning and implementation to avoid duplication.

Roles and Responsibilities

A Strategy for Going South in the North has been developed so that it can be implemented by a variety of organisations in a wide range of settings across the NMR.

WOMEN'S HEALTH IN THE NORTH is the regional women's health service for the NMR. WHIN is committed to reducing gender inequities in health that arise from the social, economic and environmental determinants of health. WHIN's role includes:

- leading the development and implementation of the Strategy
- seeking engagement of organisations, policy makers, health planners and local communities in the region to support the implementation of the Strategy
- resourcing and convening the NMR Sexual and Reproductive Health Network
- the development of annual data snapshots to monitor sexual and reproductive health in the region and to inform policy and project development
- the inclusion of sexual and reproductive health as a priority in WHIN's Integrated Health Promotion Plan.

LOCAL GOVERNMENT has obligations to protect and enhance the health and wellbeing of the community under the *Local Government Act 1989*. Sexual and reproductive health work can fit into the scope of many local government activities including:

- the inclusion of sexual and reproductive health as a priority health issue in Municipal Public Health and Wellbeing Plans
- the inclusion of sexual and reproductive health as a priority health issue in Youth Services plans and programs
- the provision of condoms and contraception information through Maternal and Child Health programs and youth services
- targeted efforts to increase HPV vaccination coverage through immunisation programs
- the promotion of respectful and equal relationships in community safety or social development programs
- the promotion of positive sexual and reproductive health and respectful relationships through existing partnerships with community services, resident networks and at council venues.

IMPLEMENTATION *CONTINUED*

COMMUNITY HEALTH services deliver a range of primary care services and community-based programs. The services provided by community health vary dependant on the organisation and, therefore, their potential role in sexual and reproductive health work may also vary, but can include:

- delivery of comprehensive sexual and reproductive health clinical services including long acting reversible contraception and medical termination
- the prioritisation of sexual and reproductive health in Integrated Health Promotion Plans and provision of sexual and reproductive health promotion programs
- the distribution of free condoms at community health service centres
- the promotion of positive sexual and reproductive health and relationships through existing partnerships with community services and local communities.

SCHOOLS AND EDUCATIONAL INSTITUTIONS are a traditional setting for the delivery of sexual and reproductive health messaging. The role of educational institutions can include:

- the delivery of high quality sexuality education curriculum and respectful relationships education, preferably within a whole-school or organisational approach
- the provision of sexual and reproductive health promotion programs
- development of referral pathways for students to access sexual and reproductive health services
- challenging taboos and negative social norms in educational settings
- the distribution of free condoms.

PRIMARY HEALTH NETWORKS (PHNS) have the key objective of increasing the efficiency and effectiveness of medical services and improving coordination of care. Therefore, their role in sexual and reproductive health would centre on primary care services and could include:

- engaging general practitioners to provide best practice, comprehensive sexual and reproductive health clinical services
- providing training to address service gaps, for example, medical termination or implanon insertion
- the development of referral pathways for sexual and reproductive health services.

PRIMARY CARE PARTNERSHIPS (PCPS) focus on better coordination among services, management of chronic disease management, integrated prevention and health promotion and strong partnerships. Their role could include:

- engaging health organisations to provide best practice, comprehensive sexual and reproductive health clinical and educational services
- encouraging partner organisations to address sexual and reproductive health issues and to create relevant and accessible services.

HOSPITALS main role in sexual and reproductive health lies in secondary and tertiary services rather than as a primary point of care. Their role can include:

- providing best practice tertiary sexual and reproductive health services, including termination services
- contraception provision post-birth in maternity services
- supporting primary care to develop comprehensive primary care services.

Other health and community services have an important role in the improvement of sexual and reproductive health outcomes, as well. *A Strategy for Going South in the North* includes a wide range of strategies that can be adapted for implementation in many settings.

Implementation Timeframe

A Strategy for Going South in the North has been developed as a five year strategy. A supporting Action Plan will be developed to guide the activities that are developed as a result of this strategy.

In the first year of implementation from 2016-2017, WHIN will undertake the following tasks in partnership with regional partners, including the NMR Sexual and Reproductive Health Network.

1. Actively engage and seek commitment from partner organisations. This will involve meeting with organisations and planning how the objectives and strategies can be applied in daily practice. WHIN will create a picture of current sexual and reproductive health work in the region to form a baseline picture of the current work.
2. Advocate for the inclusion of sexual and reproductive health as a priority issue in 2017-2021 organisational plans and strategies (including Municipal Public Health and Wellbeing Plans and Integrated Health Promotion Plans) and the use of the Strategy to guide service development and project delivery.
3. Develop a collaborative action plan. Strategies will be collectively prioritised by the NMR Sexual and Reproductive Health Network or other groups of critical friends.
4. Develop an Evaluation Framework for the Strategy.

Population Target Groups

WHIN has adopted the nine population target groups for sexual and reproductive health work which were identified in the *Western Region Sexual and Reproductive Health Promotion Framework* (see page 13). These are:

- Young people
- Aboriginal and Torres Strait Islander people
- People from migrant and refugee backgrounds
- Gay, lesbian, bisexual, transgendered and intersex people
- People living with a disability
- People in or being released from prison
- Sex workers
- People who inject drugs
- Women.

It is recommended that projects and actions resulting from the implementation of *A Strategy for Going South in the North* are targeted to these population groups using appropriate and informed methods in order to have the greatest effect and reduce inequity.

When looking at developing programs to meet the target population groups' needs, it is also important to apply an intersectional lens. Intersectionality is an approach that considers intersecting and overlapping aspects of a person's identity. It recognises the intersection between multiple forms of discrimination or oppression, such as sexism, racism, class oppression, homophobia and ableism (Multicultural Centre for Women's Health 2015).

A person may fit into several of the identified target population groups above and it is important to understand how these overlapping aspects of identity can affect a person's lived experience and may compound the discrimination or disadvantages they experience in relation to sexual and reproductive health. In the context of program or policy development, an intersectional approach means recognising that women and men have complex identities and may face multiple types of discrimination. An intersectional lens is required at all stages of program planning, data collection and policy development.

Gendered Response

It is recognised that in order to improve the sexual and reproductive health of communities in the NMR, the health of both women and men needs to be addressed. However, it is important to acknowledge that women are disproportionately affected by sexual and reproductive health and reflect this in service development and implementation.

Some examples of the gendered differences in sexual and reproductive health are discussed below.

- Women bear disproportionate reproductive responsibility, including control of fertility, reproductive choice and the effects of a continued pregnancy (Australian Women's Health Network 2016).
- NMR women are more commonly the victims of family violence and sexual assault and men are more likely to be the perpetrators (Women's Health In the North 2016). Experience of family violence has a direct impact on sexual and reproductive health outcomes including a women's inability to safely negotiate condom or contraception use, which can result in higher rates of unplanned pregnancy and termination (World Health Organisation 2013).
- Traditional gendered double standards still exist in Australian culture, where differing importance is placed on male and female sexualities. This can result in shame and stigma for women and can restrict sexual expression (Hendry et al. 2013).
- Mainstream culture has normalised the sexualisation of women and porn has directly influenced modern expectations of women in sexual relationships, where sexual acts that were once considered extreme have been mainstreamed (Crabbe & Corlett 2010).
- Women are more likely to test for chlamydia (El-Hayek and Nguyen 2012) which results in increased notification rates and the responsibility of partner notification and treatment.

Gender is regarded as one of the social determinants of health and is a key factor that influences quality of life. Acknowledging the complex ways in which gender can influence a person and a population is crucial to comprehensively addressing the health of the whole community (Women's Health Association of Victoria 2016).

Evaluation

It is expected that organisations implementing projects as part of the *A Strategy for Going South in the North* will be responsible for evaluating their own projects using methods which are most suitable to measure specific outcomes and impacts.

WHIN will develop an evaluation framework for *A Strategy for Going South in the North* to capture the collective reach and scope of the associated actions and the efficacy of the partnership and WHIN's leadership role.

> "IN ORDER TO IMPROVE THE SRH OF COMMUNITIES IN THE NMR, THE HEALTH OF BOTH WOMEN AND MEN NEEDS TO BE ADDRESSED."

A STRATEGY FOR **GOING SOUTH IN THE NORTH**

VISION

A northern metropolitan region of Melbourne where:

- women, men and service providers are educated about and have a developed understanding of sexual and reproductive health
- sexual and reproductive health services are appropriate and accessible
- all women and men are free to express their sexuality without experiencing ill health, discrimination or abuse.

AIMS

- To develop environments which are supportive of sexual and reproductive health.
- To increase community response to the social determinants of sexual and reproductive health.
- To increase the understanding of the sexual and reproductive health status of the NMR.
- To increase individual and organisational sexual and reproductive health knowledge, attitudes and capacity.
- To improve the prevention, early detection and response to physiological sexual and reproductive health outcomes.

GUIDING PRINCIPLES

Best practice, evidence-based sexual and reproductive health programs and services are:

- accessible and affordable
- appropriate for population groups experiencing inequities
- health literate and communicate health information clearly
- inclusive of diversity
- gender transformative and promote equal and diverse gender roles and norms
- sex positive and accept that sex is a natural and healthy part of life.

FRAMEWORK: A STRATEGY FOR GOING SOUTH IN THE NORTH

Health Promotion Interventions

Settings and Supportive Environments	Community Engagement	Social Marketing and Health Information	Health Education and Skill Development	Screening, Immunisation and Clinical Response

Aims

To develop environments which are supportive of optimal sexual health and reproductive health.	To empower community involvement in improving NMR sexual and reproductive health outcomes.	To increase understanding of the sexual and reproductive health status of NMR communities.	To increase individual and organisational sexual and reproductive health knowledge, attitudes and capacity.	To improve the prevention, early detection and response to physiological sexual and reproductive health outcomes.

Objectives

1. Advocate for sexual and reproductive health as a health priority in the NMR. 2. Create positive sexual and reproductive health social and cultural norms in the NMR.	3. Develop the capacity of communities to contribute to improved sexual and reproductive health programs and services.	4. Build and maintain a shared regional understanding of the sexual and reproductive health status of women and men living in the NMR. 5. Educate health professionals and communities about women's and men's sexual and reproductive health needs and response.	6. Increase and improve the sexual and reproductive health literacy and capacity of services and organisations in the NMR. 7. Facilitate, influence and support individual behaviour change.	8. Develop an understanding of the sexual and reproductive health services available in the NMR. 9. Increase access to sexual and reproductive health services in the NMR.

Population ◄·····► **Individual**

SETTINGS AND **SUPPORTIVE ENVIRONMENTS**

AIM: To develop environments which are supportive of optimal sexual and reproductive health.

OBJECTIVES	STRATEGIES
1. Advocate for sexual and reproductive health as a health priority in the NMR.	**1.1** Support, attend and actively engage in the NMR Sexual and Reproductive Health Network.
	1.2 Actively influence sexual and reproductive health policy, planning and program development.
	1.3 Support organisations to implement programs and services supportive of optimal sexual and reproductive health.
	1.4 Identify opportunities to secure increased funding to support sexual and reproductive health work in the NMR.
2. Create positive sexual and reproductive health social and cultural norms in the NMR.	**2.1** Support the development of positive sexual and reproductive norms and the reduction of taboos and the sexualisation of women.
	2.2 Advocate for the elimination of violence against women and the promotion of respectful relationships through the implementation of *Building Respectful Communities – Preventing Violence against women - A strategy for the Northern Metropolitan Region of Melbourne.*

COMMUNITY ENGAGEMENT

AIM: To empower community involvement in improving NMR sexual and reproductive health outcomes.

OBJECTIVES	STRATEGIES
3. Develop the capacity of communities to contribute to improved sexual and reproductive health programs and services.	**3.1** Consult with community members to capture personal experiences of sexual and reproductive health and service access.
	3.2 Facilitate community involvement in all aspects of sexual and reproductive health program planning and delivery.
	3.3 Facilitate community advocacy for sexual and reproductive health including the elimination of FGC/M.

SOCIAL MARKETING AND **HEALTH INFORMATION**

AIM: To increase understanding of the sexual and reproductive health status of NMR communities.

OBJECTIVES	STRATEGIES
4. Build and maintain a shared regional understanding of the sexual and reproductive health status of women and men living in the NMR.	**4.1** Collect, maintain and analyse data to create an ongoing monitored picture of sexual and reproductive health in the NMR.
	4.2 Distribute updated data annually to inform partner organisations and the wider community of trends and priority areas for focus.
5. Educate health professionals and communities about women's and men's sexual and reproductive health needs and response.	**5.1** Develop and disseminate resources for professionals to support sexual and reproductive health knowledge translation.
	5.2 Develop and implement social marketing campaigns to improve sexual and reproductive health literacy in NMR communities.

HEALTH EDUCATION AND **SKILL DEVELOPMENT**

AIM: To increase individual and organisational sexual and reproductive health knowledge, attitudes and capacity.

OBJECTIVES	STRATEGIES
6. Increase and improve the sexual and reproductive health literacy and capacity of services and organisations in the NMR.	**6.1** Engage, consult and educate key stakeholders about sexual and reproductive health.
	6.2 Facilitate professional development for health professionals regarding priority areas of sexual and reproductive health and best practice.
7. Facilitate, influence and support individual behaviour change.	**7.1** Deliver education programs to community groups which provide both knowledge and practical skills to negotiate healthy relationships and optimal sexual and reproductive health.
	7.2 Support the implementation of diversity-inclusive sexuality and respectful relationships education.

SCREENING, IMMUNISATION **AND CLINICAL RESPONSE**

AIM: To improve the prevention, early detection and response to physiological sexual and reproductive health outcomes.

OBJECTIVES	STRATEGIES
8. Develop an understanding of the sexual and reproductive health services available in the NMR.	**8.1** Identify services available and service gaps in the NMR including access to long acting reversible contraception, termination of pregnancy, emergency contraception and condoms.
	8.2 Create referral lists for organisations providing sexual and reproductive health services, including clinician pathways.
	8.3 Create clear service pathway maps for community members to enable appropriate service access.
9. Increase access to sexual and reproductive health services in the NMR.	**9.1** Increase the number of providers of long acting reversible contraception and termination of pregnancy services.
	9.2 Increase opportunistic STI and BBV testing, particularly chlamydia and hepatitis B.
	9.3 Increase access to cancer prevention services of Pap screening and HPV immunisation.
	9.4 Apply best practice models to increase the accessibility and appropriateness of new and existing services for target population groups.

REFERENCES

Australian Bureau of Statistics Census, (2011). *ABS Table Builder used to compile the seven LGAs of NMR. Database: Cultural and language diversity classification - Indigenous status - Indigenouse status - INGP*. [Online] Available at: http://www.abs.gov.au/websitedbs/censushome.nsf/home/tablebuilder?opendocument&navpos=240 [Accessed February, 2013]

(2013). *Census 2011 Community Profiles: Aboriginal and Torres Strait Island Peoples*. [Online] Available at: http://www.abs.gov.au/websitedbs/censushome.nsf/home/communityprofiles?opendocument&navpos=230 [Accessed November 2013]

(2015a). *Population Estimates by Age and Sex, Local Government Areas (ASGS 2014) 2014*. [Online] Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02014?OpenDocument [Accessed February 2016]

(2015b). *Australian Birth Data 2014*. [Online] Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3301.02014?OpenDocument

Australasian Society for HIV Medicine and Victorian Infectious Diseases Reference Laboratory, (2013). *Hepatitis B Mapping Project – Estimates of chronic hepatitis B prevalence and cultural and linguistic diversity by Medicare Local 2011 – National Report*. Melbourne, Australia.

Australian Women's Health Network, (2016). *The Australian Women's Health Charter*. [Online] Available at: http://awhn.org.au/wp-content/uploads/2016/05/AWHN-Australian-Womens-Health-Charter.pdf [Accessed June 2016]

Crabbe, M., & Corlett, D, (2010). "Eroticising Inequality". *DVRCV Quarterly*. Edition 3, Spring 2010. p1-6.

Department of Education and Early Childhood Development, (2014). *VCAMS Indicator 14.9 Teenage Fertility Rate*. [Online] Available at: http://education.vic.gov.au/about/research/Pages/vcamsindicator.aspx [Accessed August 2014]

Department of Immigration and Border Control, (2013). *Settlement Reporting*. [Online] Available at: https://www.immi.gov.au/settlement/ [Accessed October 2013]

El-Hayek, C., & Nguyen, P. (2012). *Victorian Primary Care Network for Sentinel Surveillance on Blood Borne Viruses and Sexually Transmitted* Infections *2011 Annual Report*. Melbourne: Centre for Population Health, Burnet Institute.

Family Planning Victoria, (2013). F*emale Genital Mutilation LGA Profiles – Banyule, Darebin, Hume, Moreland, Nillumbik, Whittlesea and Yarra Community Profiles 2011*. [Online] Available at: http://www.fpv.org.au/advocacy-projects-research/projects/female-genital-mutilation-cutting-in-victoria/ [Accessed October 2013]

Hendry, N., Brown, G., Johnston, K., & Dowsett, G. (2013). "Beyond high school: What do we know about young adults' social and sexual contexts?" *ARCSHS Monograph Series*. No. 90. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

International Conference on Population and Development, (1994). I*CPD Programme of Action*. Cairo: UNFPA.

Multicultural Centre for Women's Health, (2015). *Intersectionality and primary prevention of violence agaisnt women, workshop for the PVAW Community of Practice, workshop notes*. Melbourne: MCWH.

National HPV Vaccination Program Register, (2016). *Requested Data: Population Based Coverage—Females and Males Aged 15, Dose Number and Specified LGA*. Melbourne, Victoria.

Taylor, E., & Vu, A. (2013). *Action for Equity: A sexual and reproductive health plan for Melbourne's west*. Melbourne: Women's Health West.

Victoria Police, (2013). *Corporate Statistics from Law Enforcement Program*. Melbourne, Australia: Victoria Police.

Victorian Cervical Cytology Registry, (2013). *Statistical Report*. Carlton South, Melbourne: Victorian Cervical Cytology Registry.

Victorian Department of Health Communicable Disease Epidemiology and Surveillance, (2014). *Requested data: the number of chlamydia, gonorrhoea, syphilis, HIV and HBV for Banyule, Darebin, Hume, Moreland, Nillumbik, Whittlesea and Yarra broken down by sex and five- year age group for the period 1.01.2013 – 31/12/2013*. Melbourne, Victoria.

Victorian Department of Human Services, (2003). *Integrated Health Promotion Resource Kit*. Melbourne, Victoria: DHS.

Victoria Police Crime Statistics Agency, (2015). *Purchased data extracted from Crime Statistics Agency LEAP on 21 July 2015*. Melbourne: Victoria Police.

Women's Health Association of Victoria, (2016). *Gender Equity Training Manual: A guide for women's health services*. Melbourne: Women's Health In the North.

Women's Health In the North, (2016). *NMR Violence Against Women: Information and Facts 2014- 2015*. [Online] Available at: http://whin.org.au/images/PDFs/FViolence/FVFactsheets2014to2015/FV%20Factsheet%2015%20-%20NMR.pdf [Accessed June 2016]

Women's Health West, (2011). *Social Determinants of Sexual and Reproductive Health 2011 Report*. Melbourne: Women's Health West.

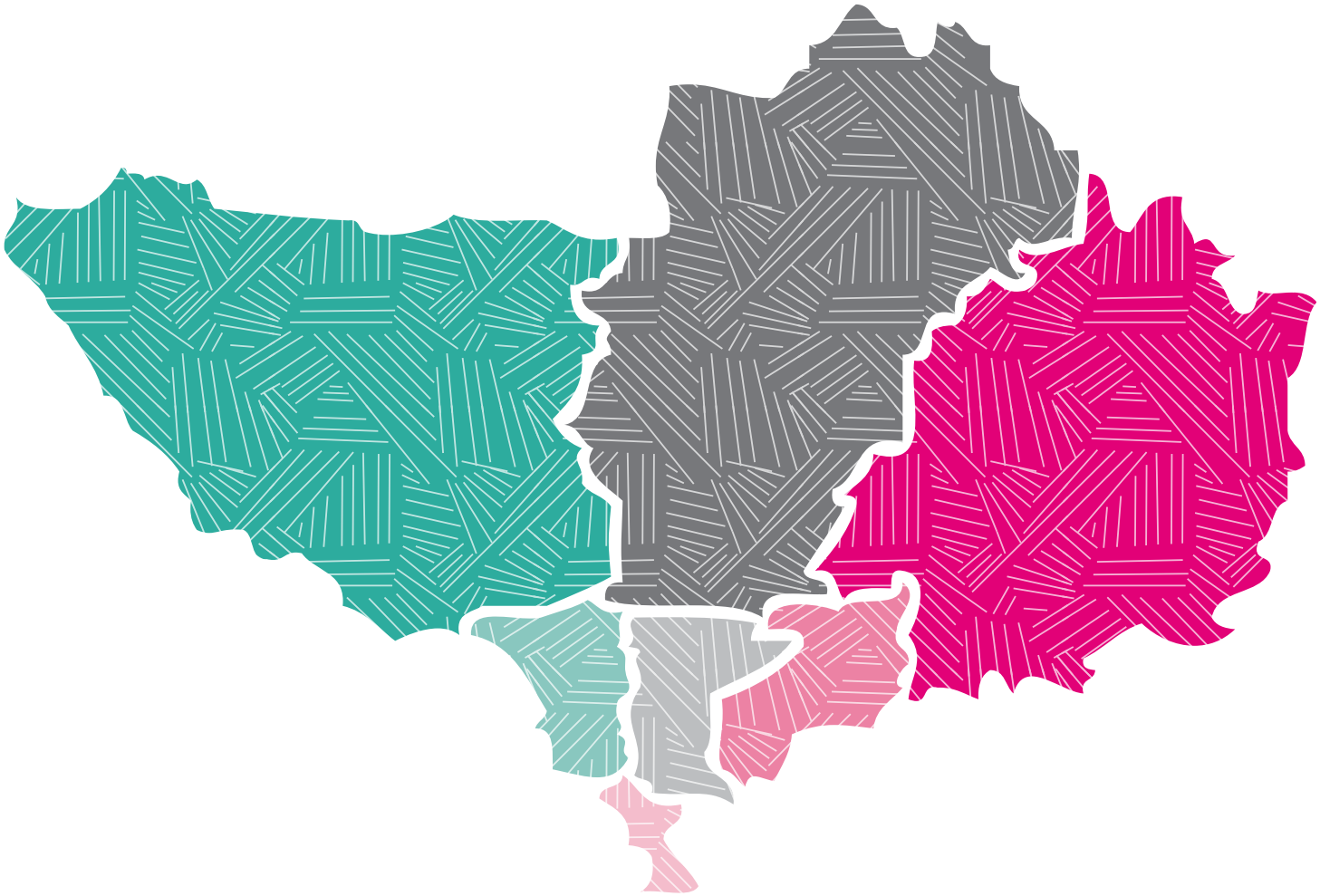
World Health Organisation, (1986). *The Ottawa Charter*. Geneva: WHO.
(2006). Defining Sexual health: Report of Technical Consultation on Sexual Health, 28-31 January 2002. Geneva, Switzerland.

World Health Organisation, (2013) "Intimate partner violence, abortion and unintended pregnancy: Results from the WHO multi-country study on women's health and domestic violence". *International Journal of Gynaecology and Obstetrics*. Vol. 120: pp. 3-9.

Gender is regarded as one of the social determinants of health and is a key factor that influences quality of life. Acknowledging the complex ways in which gender can influence a person and a population is crucial to comprehensively addressing the health of the whole community.

(Women's Health Association of Victoria 2016).

NORTHERN METROPOLITAN REGION



Moreland
Banyule
Nillumbik
Darebin
Whittlesea
Hume
Yarra

WOMEN'S HEALTH
IN THE NORTH

voice • choice • power

www.whin.org.au