

FREEDOM, RESPECT & EQUITY

IN SEXUAL HEALTH

2022-2026



whin.org.au



**WOMEN'S HEALTH
IN THE NORTH**

voice • choice • power

ACKNOWLEDGEMENTS



Women's Health In the North acknowledges Victorian Aboriginal people as the Traditional Owners of the land on which we provide our services – the Wurundjeri Woi Wurrung people of the Kulin nation – and pay our respects to their Elders past and present. We acknowledge the historical trauma and ongoing systemic injustice that continues today, particularly in relation to sexual and reproductive health. As First Peoples, Aboriginal Victorians are best placed to determine a culturally appropriate path to promoting sexual and reproductive health in their communities. WHIN acknowledges that Aboriginal sovereignty was never ceded and expresses hope for justice and reconciliation.

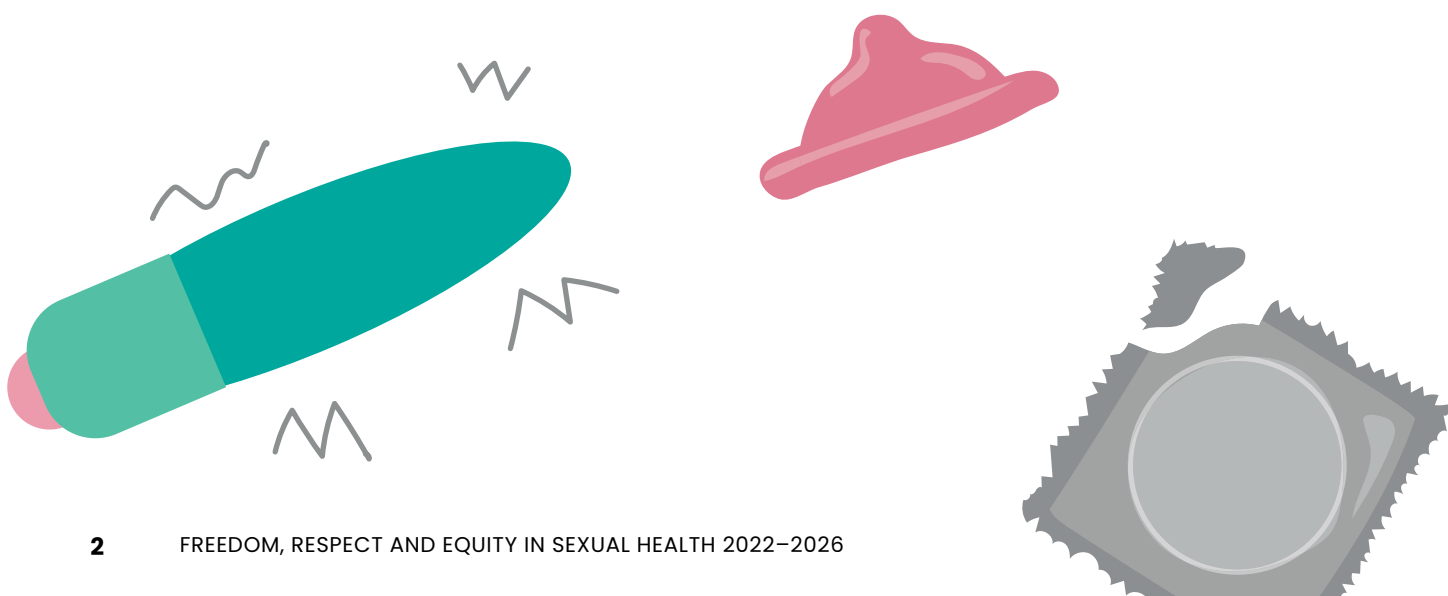
CONTRIBUTORS

Allen + Clarke Consulting was engaged to assist with a background paper to inform the development of *Freedom, Respect and Equity in Sexual Health 2022–2026*. The background paper was based on key inputs from WHIN, as well as a document review and stakeholder engagement.

Thank you to all stakeholders who participated in the consultation process for this Strategy. Input from these engagements have helped to shape an understanding of sexual and reproductive health in the northern metropolitan region and have been integral to the development of this Strategy.



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



CONTENT WARNING

This document makes reference to gender-based violence, sexual assault and reproductive coercion. If this document raises feelings of distress and you need support, you can contact 1800 RESPECT on 1800 737 732.

A NOTE ON LANGUAGE USED IN THIS DOCUMENT

This document refers to 'women and gender diverse people' to include cisgender women, transgender women, and gender diverse people who are pregnancy capable. This phrase includes people who are impacted by the harmful gender norms and stereotypes associated with sexual and reproductive health, and those who may access and use sexual and reproductive health services including, but not limited to, abortion, contraception, assisted reproductive technology, and screening for sexually transmissible infections/ blood-borne viruses (STIs/BBVs).



ACRONYMS

BBV	Blood-borne virus
COVID-19	SARS-CoV-2 virus
FARREP	Family and Reproductive Rights Education Program
FGC	Female genital cutting
HIV	Human immunodeficiency virus
IUD	Intrauterine device
LARC	Long-acting reversible contraception
LGA	Local government area
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and other people of diverse genders and sexualities
NMR	Northern metropolitan region
PCOS	Polycystic ovary syndrome
STI	Sexually transmissible infection
WHIN	Women’s Health In the North

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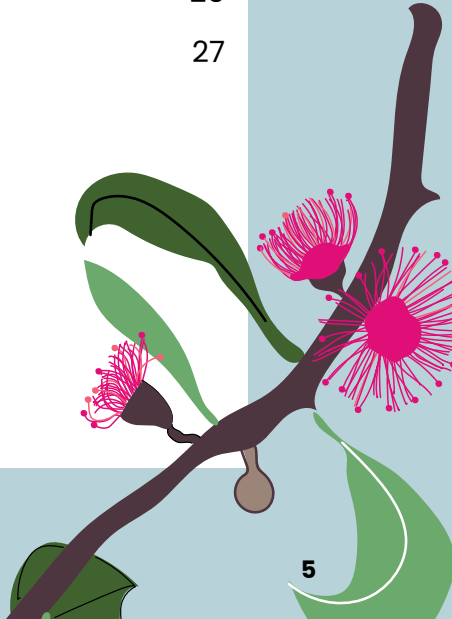
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FOREWORD

Sexual and reproductive health has a defining impact on the lives of women and gender diverse people across the life course. We recognise sexual and reproductive health as a core component in the fight for gender equality, and are committed to challenging the norms, structures and practices that limit women and gender diverse people's access to sexual and reproductive health.

Melbourne's north is disproportionately affected by poor sexual and reproductive health. At present, the northern metropolitan region does not have a publicly-funded sexual and reproductive health service that provides access to the full suite of sexual and reproductive health services. Even if sexual and reproductive health literacy and health seeking is increased among the community, we cannot achieve equitable access to support without a dedicated service in the region.

Freedom, Respect and Equity in Sexual Health 2022–2026 has been designed to guide regional action to improve sexual and reproductive health across the northern metropolitan region of Melbourne. We welcome collaboration and engagement across sectors with this strategy, and are eager to work together towards an NMR where all women and gender diverse people can freely exercise their rights to positive, pleasurable and affirming sexual and reproductive health outcomes. We are particularly eager to work with LGBTQIA+ organisations to challenge and redress the harmful gender norms and stereotypes associated with sexual and reproductive health that

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Melbourne's north is disproportionately affected by poor sexual health and reproductive health.

disproportionately impact women and gender diverse people who are pregnancy capable.

We have many people to thank who have contributed to the development of this strategy: our partners and stakeholders, our consultants at Allen + Clarke, and others whose collective knowledge and lived experience has strengthened our understanding of the sexual and reproductive health needs among women and gender diverse people across the region.

In solidarity,

Helen Riseborough



ABOUT WOMEN'S HEALTH IN THE NORTH

As the regional women's health promotion and advocacy organisation for the northern metropolitan region of Melbourne (NMR), Women's Health In the North (WHIN) seeks to eliminate gender inequalities and improve the health, safety and wellbeing of women and gender diverse people.

WHIN's vision is that women and gender diverse people in the north have voice, choice and power in all aspects of their health, safety and wellbeing.

The principles that form the basis of WHIN's work include: human rights and social justice, feminism, collaborative leadership, intersectionality, inclusivity, and environment and place.

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 and gender diverse people throughout their lives.

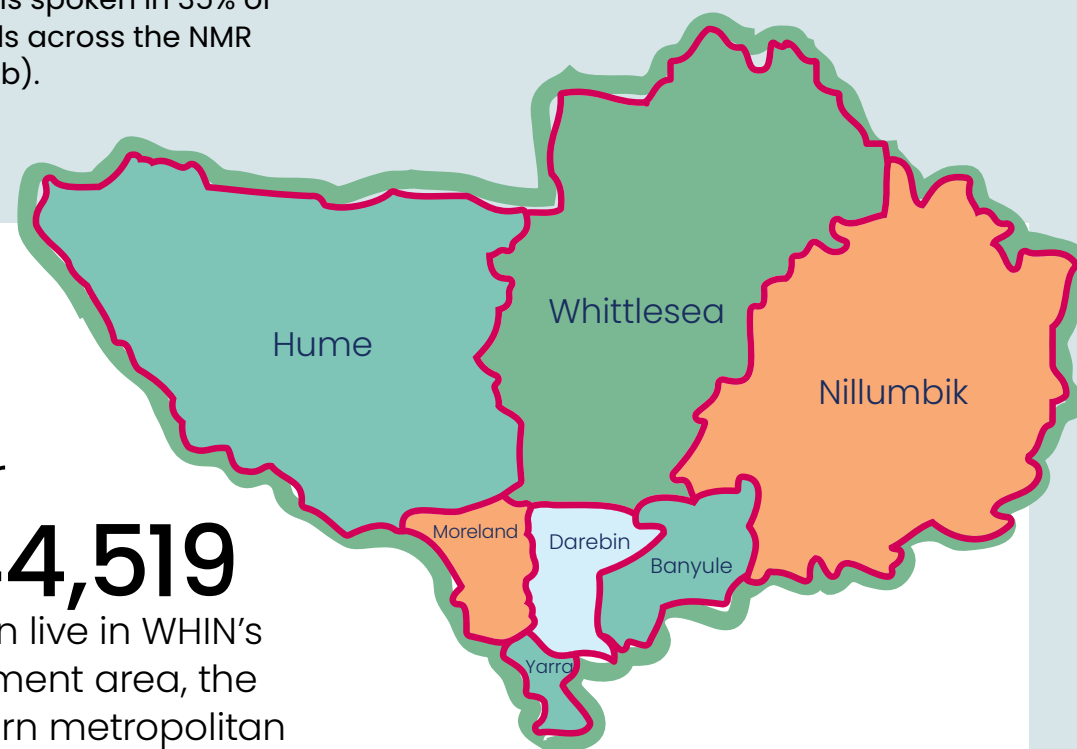
CONTEXT & EVIDENCE BASE

ABOUT THE NMR

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

The latest census estimates that the NMR is home to 1,072,469 people; 544,519 of whom are female (51%). There are 8,426 people who are Aboriginal or Torres Strait Islander (0.8%). 399,308 people were born overseas (37%), and a non-English language is spoken in 35% of households across the NMR (ABS, 2022b).

While there is a lack of population-level data on the number of trans and gender diverse people in the NMR, international studies estimate that approximately 1% of people identify as transgender, though this is higher for young people (Carman et al., 2020). However, existing studies have not captured the breadth of trans and gender diverse identity in their questions, so fail to represent gender non-conforming and non-binary identities.



Over
544,519
women live in WHIN's
catchment area, the
northern metropolitan
region (NMR) of Melbourne

(Australian Bureau of Statistics 2022, Census figures)

THE NEED FOR A REGIONAL STRATEGY: EVIDENCE FOR ACTION

The NMR is disproportionately affected by poor sexual and reproductive health. Key data indicating sexual and reproductive health outcomes for the NMR are outlined below, however more detailed data can be found in the sexual and reproductive health fact sheets on our resources page.

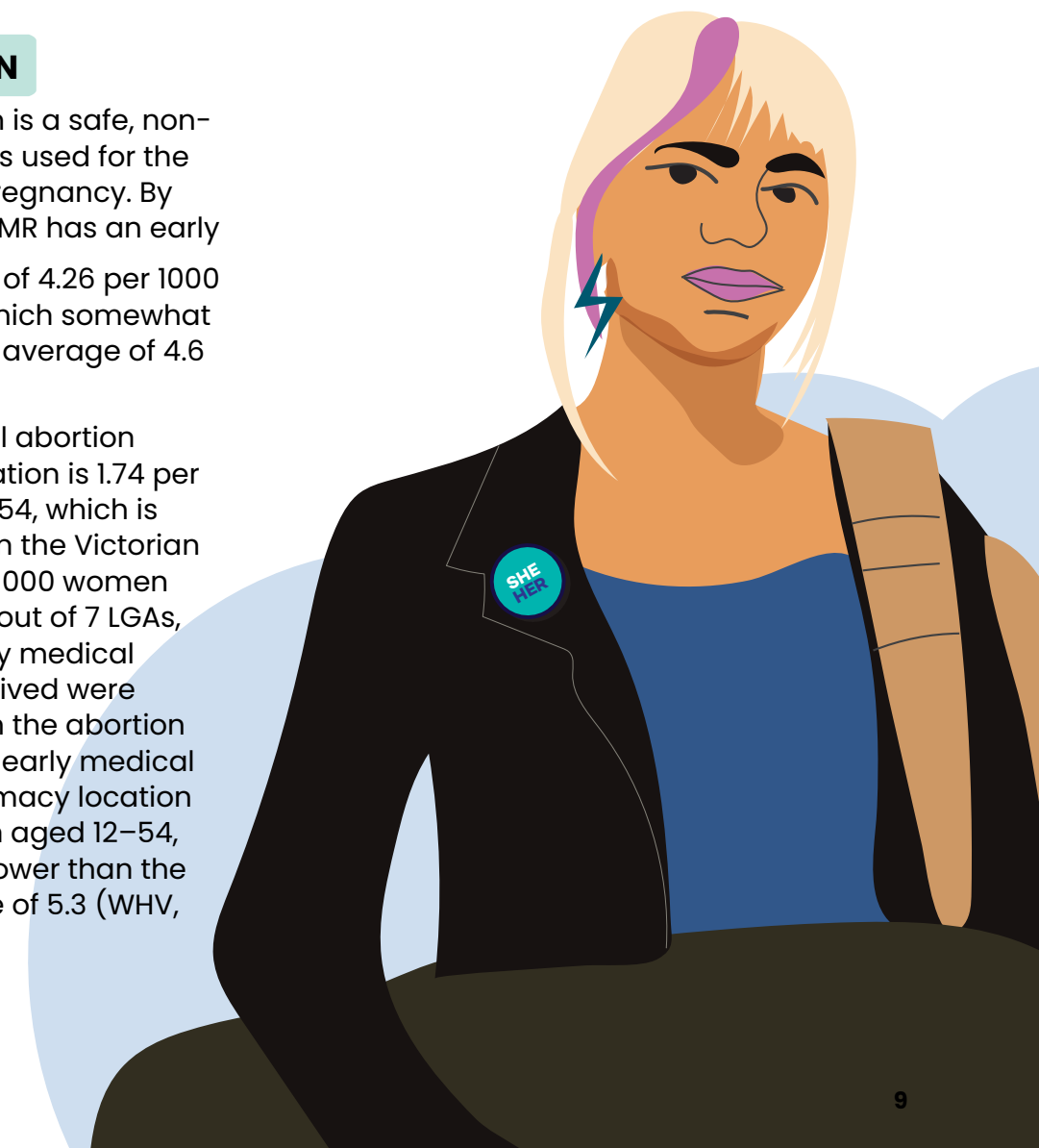
It is acknowledged that many of the publications that are referenced approach sexual and reproductive health in heteronormative and cisnormative ways which is not inclusive of trans and gender diverse people or the broader LGBTQIA+ community, who face significant barriers to sexual and reproductive health support and disparities in sexual and reproductive health outcomes.

These data indicate that there is an inadequate number of early medical abortion prescribers and dispensing pharmacies in the NMR, which results in patients having to travel to other LGAs to receive these services or not receiving these services at all. **For access to early medical abortion to be equitable, the prescriber and pharmacy rates should align to patient rates.**

MEDICAL ABORTION

Early medical abortion is a safe, non-surgical method that is used for the termination of early pregnancy. By patient location, the NMR has an early medical abortion rate of 4.26 per 1000 women aged 12–54 which somewhat aligns to the Victorian average of 4.6 (WHV, 2022).

The NMR early medical abortion rate by prescriber location is 1.74 per 1000 women aged 12–54, which is significantly lower than the Victorian average rate of 4 per 1000 women in this age range. In 5 out of 7 LGAs, fewer than half of early medical abortion services received were prescribed from within the abortion seeker's LGA. The NMR early medical abortion rate by pharmacy location is 2.16 per 1000 women aged 12–54, which is significantly lower than the Victorian average rate of 5.3 (WHV, 2022).





LONG-ACTING REVERSIBLE CONTRACEPTION

66% of heterosexually active women aged 16–49 report contraception use (Richters et al., 2016). While less effective methods of contraception (such as the oral contraceptive pill and condoms) are still favoured, the NMR has seen increased accessibility and uptake of long-acting reversible contraception (LARCs). LARCs are the most effective forms of contraception and people who use them report higher levels of satisfaction (Freilich et al., 2017).

In 2020, the NMR rate of people seeking contraceptive implants was 7.24 per 1000 females, compared to the Victorian average rate of 9. The rates of contraceptive implants being prescribed by provider location was 7.47 per 1000 females compared to the Victorian average rate of 8.1 (WHV, 2022).

In 2020, the NMR rate of people seeking intrauterine devices (IUDs) was 6.43 per 1000 females, compared to the Victorian average rate of 6.7. The rate of IUDs being prescribed by provider location was 6.35 per 1000 females compared to the Victorian average rate of 5.4 (WHV, 2022).

Although the provider rate aligns with the patient rate in both cases, most LGAs in the NMR have lower provider rates compared to patient rates, with the bulk of the burden falling to Yarra to provide LARCs for the region. Yarra also shares borders with the Eastern Metropolitan Region and the Western Metropolitan Region so may be servicing those areas as well.

SEXUALLY TRANSMISSIBLE INFECTIONS (STIS)

For women, chlamydia is the most commonly reported STI in the NMR, accounting for approximately 81% of all notifications. In Yarra, the chlamydia rate per 100,000 women is higher than the Victorian average rate. **While gonorrhoea and syphilis rates are comparatively low in relation to chlamydia, cases are still on the rise throughout the NMR and Victoria** (Department of Health, 2022).

STIs are common and preventable. Some STIs are treatable, all are manageable. STIs should not be stigmatised, and STI care should be timely and non-judgemental.

FEMALE GENITAL CUTTING

Female genital cutting (FGC) is the removal of some or all of the external female genitalia. There are different types of FGC and it is of no health benefit; rather it can be harmful to health. **A significant population of women and gender diverse people in the NMR are from communities where FGC is practised.**

Feedback indicates that people with a lived experience of FGC do not see themselves as ‘mutilated’. Rather, they see themselves as empowered and beautiful, and prefer terminology that reflects this.

We work towards the abandonment of the practice of FGC, and recognise it as a violation of human rights, specifically the sexual and reproductive rights of women, girls, and gender diverse people. We believe that in order to eradicate FGC, responses must be holistic, community-based and led, culturally sensitive and delivered in a sexual and reproductive health context. For more information on FGC, see our [resources page](#).

CERVICAL SCREENING

Since the implementation of human papillomavirus (HPV) vaccination, prevalence of HPV types that are targeted by the vaccine has declined by 92% among women aged 18–35 (Hall et al., 2019).

47.9% of women in the NMR participated in cervical screening in 2018–2019. This is a drop of 12.4% since 2014–2015. It is anticipated that these figures will drop further due to the impact of COVID-19 (AIHW, 2021b). Changes to the cervical cancer screening program now recommend that all people with a cervix aged 25–74 should have a cervical screening test every 5 years, even if they have received their HPV vaccination.

ENDOMETRIOSIS

Endometriosis is an under-recognised chronic disease where cells similar to those that line a person’s uterus grow in other parts of the body, usually around the pelvis. **It is estimated that 11% of Australians (who have a uterus and are in the reproductive age bracket) have endometriosis.** The average time between the onset of symptoms and diagnosis of endometriosis is between 7 to 12 years, leaving many people without support (AIHW, 2019).

POLYCYSTIC OVARIAN SYNDROME

Polycystic ovarian syndrome (PCOS) is a common, complex endocrine condition affecting approximately 13% of women. PCOS is a significant health issue with reproductive, metabolic and psychological features which vary significantly between individuals (Teede et al., 2018).

SEXUAL VIOLENCE

Sexual assault is any sexual behaviour that makes a person feel uncomfortable, frightened, or threatened. It is sexual activity to which a person does not consent. This includes using emotional or physical violence to force another person to engage in sexual activity. In 2020, 1080 sexual offenses were reported by women in the NMR. **In two LGAs, Yarra and Hume, the rates of victim reports per 10,000 women were higher than the Victorian average rate** (WHV, 2022). In 2021, the number of police recorded victims of sexual assault increased by 13% from 2020 (ABS, 2022a).

PRIORITY GROUPS

There is little research that goes beyond explanations that use single categories to describe issues, and we hope that an intersectional approach will be applied to future studies in the sexual and reproductive health space to strengthen the evidence base. In the absence of such data, we have highlighted a selection of key statistics outlining examples of inequitable access to sexual and reproductive health for some groups. In doing so, we acknowledge that some people may be represented within multiple areas and that no group is homogenous.

FIRST NATIONS PEOPLES

First Nations peoples continue to experience a disproportionate burden of disease in relation to sexual health. Underlying factors influencing this disparity are complex and inherently linked to the ongoing impact of colonisation. They include, but are not limited to, greater financial barriers, racism and discrimination, Western models of health, fear of forced child removal, and a lack of culturally responsive health services and information (AHRC, 2020).

- In 2017, notification rates of chlamydia, gonorrhoea and syphilis were 3, 7 and 7 times greater than the non-First Nations population, respectively (Kirby Institute, 2018).
- Between 2012 and 2019, First Nations women were three times more likely to die in childbirth than other Australian women (AIHW, 2021a).
- PCOS affects up to one in six First Nations women of reproductive age (Boyle et al., 2012).

PEOPLE FROM MIGRANT AND REFUGEE BACKGROUNDS

There is a paucity of data exploring the specific experiences of people from migrant and refugee backgrounds in relation to their sexual and reproductive health. The available evidence shows that compared to Australian-born, non-First Nations women, migrant and refugee women are:

- at greater risk of suffering poorer maternal and child health outcomes
- at greater risk of contracting an STI such as human immunodeficiency virus (HIV) and hepatitis B
- at greater risk of experiencing family violence and are more likely to face barriers to obtaining support
- less likely to have access to evidence-based, in-language and culturally appropriate information which will enable them to manage their own fertility, contraceptive choices, and menstrual health
- more likely to experience barriers to sexual and reproductive health care, including abortion care and support services (MCWH, 2021).

LGBTQIA+ PEOPLE

The 2018 Trans and Gender Diverse Sexual Health Survey highlighted the need for specific attention to the sexual health and wellbeing of trans and gender diverse populations. Study participants reported experiencing very high rates of marginalisation in sexual health care because of their gender, with less than half of participants saying they had experienced inclusive sexual health care. This was associated with lower STI testing rates among sexually active participants (Callander et al., 2019).

There continues to be misinformation about the risks of STI transmission between women who have sex with women. STI rates among cisgender women who have sex with women are estimated to be the same as heterosexual women, but research indicates that 37% of women in the LGBTQIA+ community have never had an STI test despite being sexually active (ASRHA, 2021).

PEOPLE LIVING WITH DISABILITY

Almost 1 in 5 women and girls in Victoria are living with a disability (WDV, 2012). In 2016 in the NMR, the percentage of women who needed assistance with core activities was 5.6% compared to the Victorian average of 5.8% (WHV, 2022). However, this indicator only measures severe disability, rather than the broad spectrum of disability.

Women and girls living with disabilities are twice as likely as women living without disabilities to experience violence throughout their lives but are less likely to receive adequate service response. 90% of women with an intellectual disability have been subject to sexual abuse, with more than two thirds having been sexually abused before they turn 18 (ALRC, 2010).

In all social and economic measures, women living with disabilities are disadvantaged compared to men living with disabilities, as well as people living without disabilities. Women living with disabilities often have minimal or no access to sexual and reproductive health services or information often due to not being viewed by the community or health systems as sexual beings (WDV, 2012).

YOUNG PEOPLE

Findings from the 6th National Survey of Australian Secondary Students and Sexual Health indicated that among Victorian participants aged 14–18:

- most of the young people surveyed engaged in some form of sexual activity
- 27% of young people had experienced unwanted sex, mostly reported by trans and gender diverse young people, and young women
- 87% of young people believed that they were at low or no risk of getting an STI
- 80% of young people had used the internet to find sexual health information
- only 32% of young people had spoken to a general practitioner about sexual health (Kauer & Fisher, 2022).

OLDER PEOPLE

Between 2000 and 2018, diagnosis rates of chlamydia, gonorrhoea and syphilis all increased among Australian women aged 55 – 74, and did so at faster rates than among younger women (Bourchier et al., 2020). There is an absence of sexual health policy that is inclusive of older Australians, as well as lower STI testing rates and a lack of sexual history-taking by general practitioners. As such, many sexual and reproductive health interventions are aimed at younger cohorts, often leaving behind the older population. This is arguably tied to ageist notions that older people are not sexual beings, however research shows that older adults continue to have sex and consider sexual intimacy as an important part of their lives (Freak-Poli et al., 2017).

There are many other factors that influence women and gender diverse people's access to sexual and reproductive health information, support and services including, but not limited to:

- geography and the ability to travel
- employment and access to financial resources
- childcare responsibilities
- health literacy
- working in the sex industry
- substance use
- STI/BBV status
- interaction with the justice system
- experiences of gender-based violence, including reproductive coercion.

SEXUAL AND REPRODUCTIVE HEALTH AND GENDER EQUALITY

Sexual and reproductive health is often understood as a purely clinical issue, however it is a key piece in the fight for gender equality. Poor sexual and reproductive health outcomes are both determinants and products of gender inequality.

In sexual and reproductive health promotion, we must consider the drivers of inequality and the underlying social conditions that produce poor sexual and reproductive health outcomes and experiences. We must make explicit the connections between gender inequality, other forms of discrimination and disadvantage, and sexual and reproductive health. This includes the inextricable link between sexual and reproductive health and gender based violence, made clear in experiences of sexual assault and reproductive coercion. Action to promote sexual and reproductive health needs to be implemented at every level of society and tailored to different contexts and the needs of different groups.

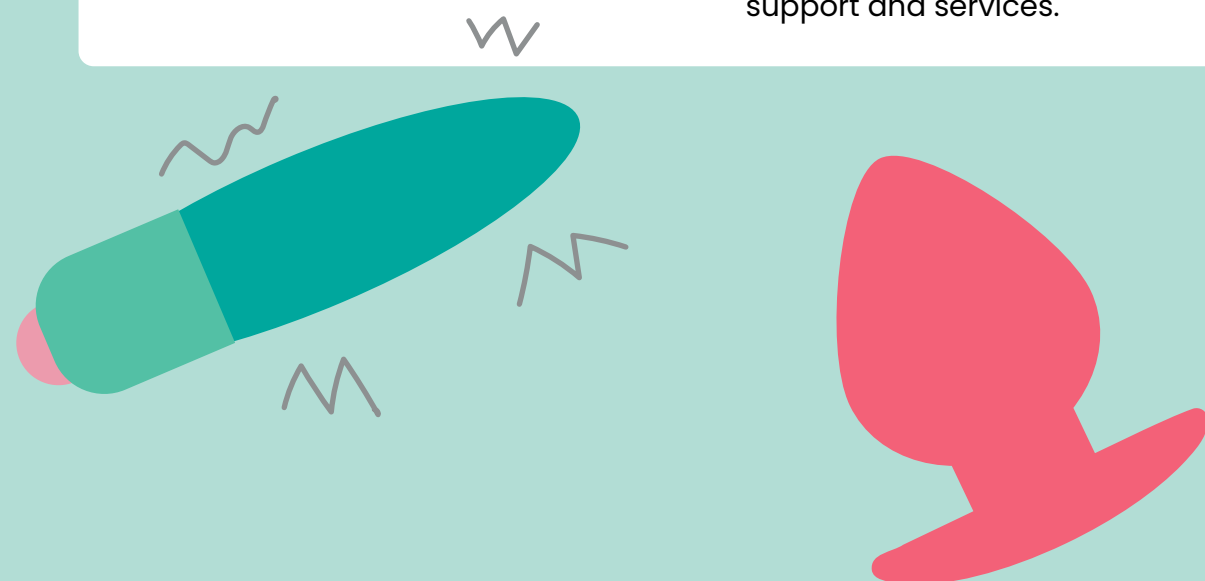
In an ideal world, all women and gender diverse people would be able to freely exercise their rights to positive, pleasurable and affirming sexual and reproductive health outcomes. If this were the case in reality, among women and gender diverse people we would anticipate to see better mental health outcomes, the ability to participate fully and equitably in society, increased representation in the workforce and positions of leadership, and the freedom to express and explore sexuality without shame or stigma.

For more information about WHIN's work in gender equity and the prevention of gender based violence, see the [Building a Respectful Community Strategy 2022–2026](#).

STAKEHOLDER CONSULTATION

Stakeholder contributions were integral in informing the key priorities of *Freedom, Respect and Equity in Sexual Health 2022–2026*. We engaged representatives from local government, community health services, other women’s health organisations and sexual and reproductive health experts in the consultation process. High-level feedback centred around consistent themes:

- taking a life course approach to sexual and reproductive health that recognises and addresses the challenges and opportunities at different life stages
- advocating for a consistent approach to sexuality education that is holistic and evidence-based, and incorporates meaningful conversations about pleasure, affirmative consent, gender, sexuality, communication and informed decision-making
- promoting accessibility and affordability of sexual and reproductive health services through strategic advocacy for improved service models that can adapt to an agile environment
- engaging directly with community to promote sexual and reproductive health literacy and address shame, stigma and taboos that persist around sexual and reproductive health
- building workforce capacity to support the sexual and reproductive health needs of women and gender diverse people, including advocating for a dedicated sexual and reproductive health service in the NMR
- providing practical support and training to health professionals across the NMR to improve understanding of sexual and reproductive health and build a regional network of advocates
- integrating sexual and reproductive health with other health priorities, including mental health, social inclusion, economic equality and prevention of gender-based violence
- tailoring sexual and reproductive health interventions to the specific needs of different communities to address systemic barriers and promote equitable access to sexual and reproductive health information, support and services.



INFLUENCING DOCUMENTS AND FRAMEWORKS

In recent years, advances have been made in sexual and reproductive health policy and planning at both a state and federal level as part of a greater focus on gender equity. *Freedom, Respect and Equity in Sexual Health 2022–2026* has been informed by the Victorian and national sexual and reproductive health policy context including, but not limited to:

- National Women’s Health Strategy 2020–2030
- Delivering optimal sexual health outcomes for Victorian women: Priorities for the next women’s sexual and reproductive health plan 2021–2025
- A Theory of Change in Sexual and Reproductive Health for Victorian Women
- The Victorian Public Health and Wellbeing Plan 2019–2023
- Women’s Sexual and Reproductive Health: Key Priorities 2017–2020
- Victorian Sexual, Reproductive Health and Viral Hepatitis Strategy 2022–2030 (soon to be released).



INFLUENCING APPROACHES IN SEXUAL AND REPRODUCTIVE HEALTH PROMOTION

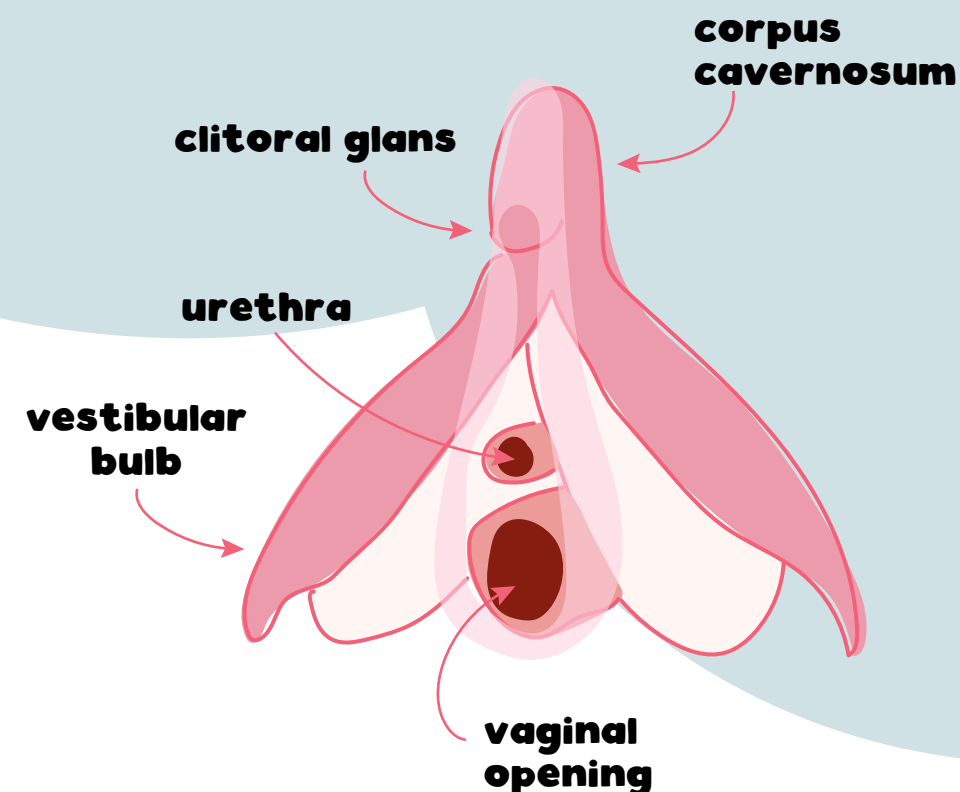
Freedom, Respect and Equity in Sexual Health 2022–2026 considers the broader underlying structures that create or reinforce barriers and supports to sexual and reproductive health. It incorporates primary prevention initiatives that address the social, cultural and economic drivers of sexual and reproductive health inequities through four core concepts: the social determinants of health, a gender transformative approach, intersectionality and the socio-ecological model.

SOCIAL DETERMINANTS OF HEALTH

Taking a social determinants approach to sexual and reproductive health, we consider the underlying conditions in which people are born, grow, live, work and age (WHO, 2022). Sexual and reproductive health is influenced by a myriad of factors including gender, sexuality, economic security, access to quality health services and education, health literacy, public policy, and violence and discrimination. Disparities in sexual and reproductive health outcomes between individuals and groups follow a social gradient, and require us to develop targeted interventions which redress the social, economic and cultural conditions that create health inequities.

GENDER TRANSFORMATIVE APPROACH

A gender transformative approach to sexual and reproductive health requires interrogation of the harmful gender norms and power imbalances that contribute to inequitable sexual and reproductive health outcomes. Through this approach, we challenge the causes of gender inequality, and break down rigid gender stereotypes, norms and practices that limit people of all genders (Varley & Rich, 2019). We understand gender transformation as a process that identifies, questions and ultimately changes gendered power imbalances that contribute to poor sexual and reproductive health outcomes among women and gender diverse people.



INTERSECTIONAL FEMINISM

Access to sexual and reproductive health is inequitable, and this requires us to consider the broader underlying social and economic structures that create disparities in sexual and reproductive health outcomes. Taking an intersectional approach to sexual and reproductive health helps us to understand how power intersects and conspires within systems and structures creating overlapping forms of discrimination or disadvantage for either an individual or group based on social characteristics. This means that we balance population level strategies with tailored approaches; challenging systems of discrimination that create barriers for women and gender diverse people to freely exercise their rights to positive, pleasurable and affirming sexual and reproductive health outcomes.

SOCIO-ECOLOGICAL MODEL

A socio-ecological model allows us to consider and address the complex interplay in the relationships between individuals and their environments. By identifying factors at the individual, interpersonal, organisational, community and societal levels, we get a holistic picture of the structures, norms and practices that enable or constrain a person's access to good sexual and reproductive health. To create lasting, meaningful change, we must work simultaneously across all levels of the socio-ecological model to promote freedom, respect and equity in sexual and reproductive health outcomes.

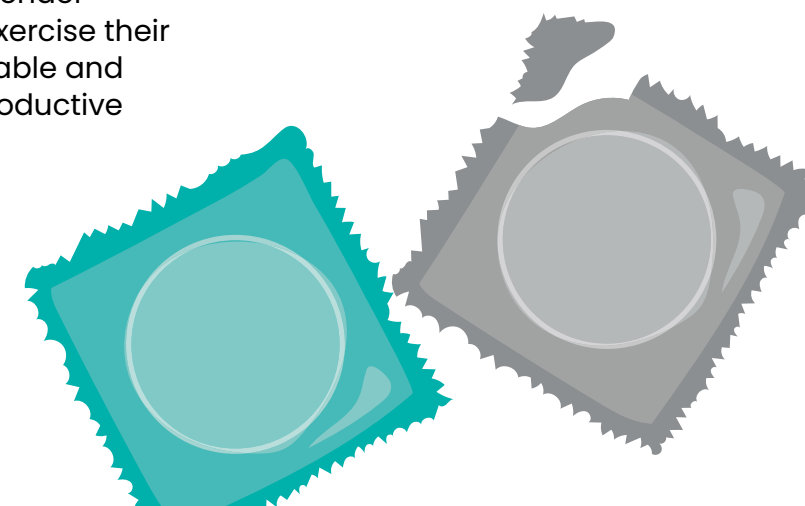
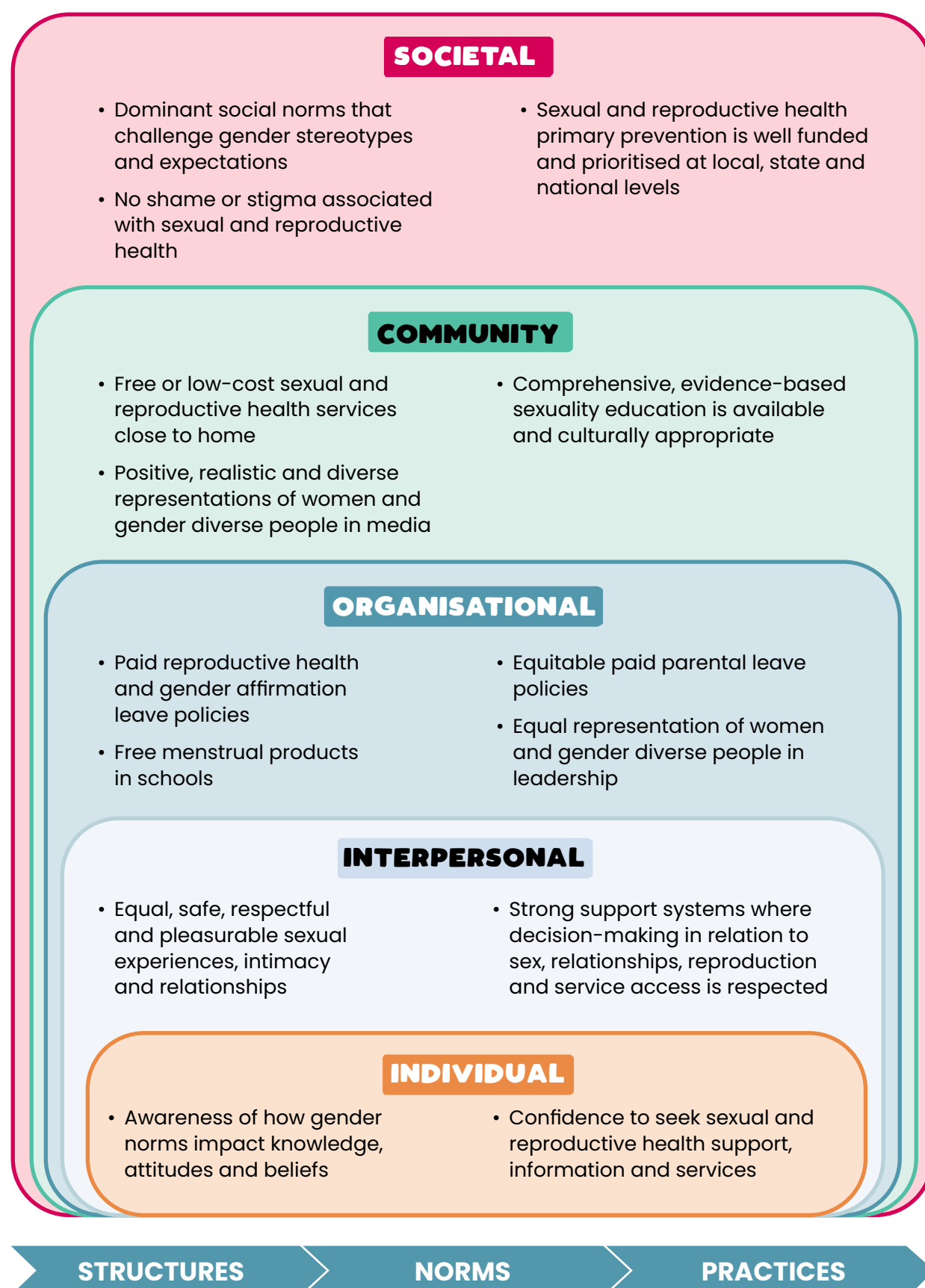


Figure 1. Examples of structures, norms and practices that could support sexual and reproductive health outcomes at different levels of the social ecology.



FREEDOM, RESPECT AND EQUITY IN SEXUAL HEALTH

Sexual and reproductive health is not a luxury; it is a right. We were purposeful in naming our *Strategy Freedom, Respect and Equity in Sexual Health 2022–2026*, to highlight three necessary elements in realising our vision that “all women and gender diverse people in the NMR can freely exercise their rights to positive, pleasurable and affirming sexual and reproductive health outcomes”.

FREEDOM TO:

- choose if, when, how and how often to have children
- express and explore sexuality without shame or stigma
- live without coercion, discrimination or violence.

RESPECT FOR:

- genders, sexualities and bodies beyond cis-heteronormative binaries
- decision-making in relation to sex, relationships, reproduction and service access.

EQUITY IN:

- access to appropriate, affordable sexual and reproductive health services and support when and where they are needed
- access to evidence-based, positive sexual and reproductive health information and resources that promote health-seeking behaviours
- access to equal, safe, respectful and pleasurable sexual experiences, intimacy and relationships.

Incorporating sexual pleasure within sexual and reproductive health and rights interventions can improve sexual health outcomes. Placing pleasure at the centre of safe-sex messaging builds people’s sexual agency and confidence to talk openly about sex (Zaneva et al., 2022). In *Freedom, Respect and Equity in Sexual Health 2022–2026*, we spotlight pleasure as a key component of sexual and reproductive health to combat gendered narratives that delegitimise feminine sexuality, and to break down the persistent shame and stigma that surrounds sexual and reproductive health.



OUR FRAMEWORK

To support the implementation of *Freedom, Respect and Equity in Sexual Health 2022–2026*, a Framework (Figure 2) has been developed to facilitate rights-based, collaborative action promoting sexual and reproductive health for women and gender diverse people in the NMR. The Framework is underpinned by the Ottawa Charter for Health Promotion, which focuses on five key health promotion priority action areas:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services (WHO, 1986).

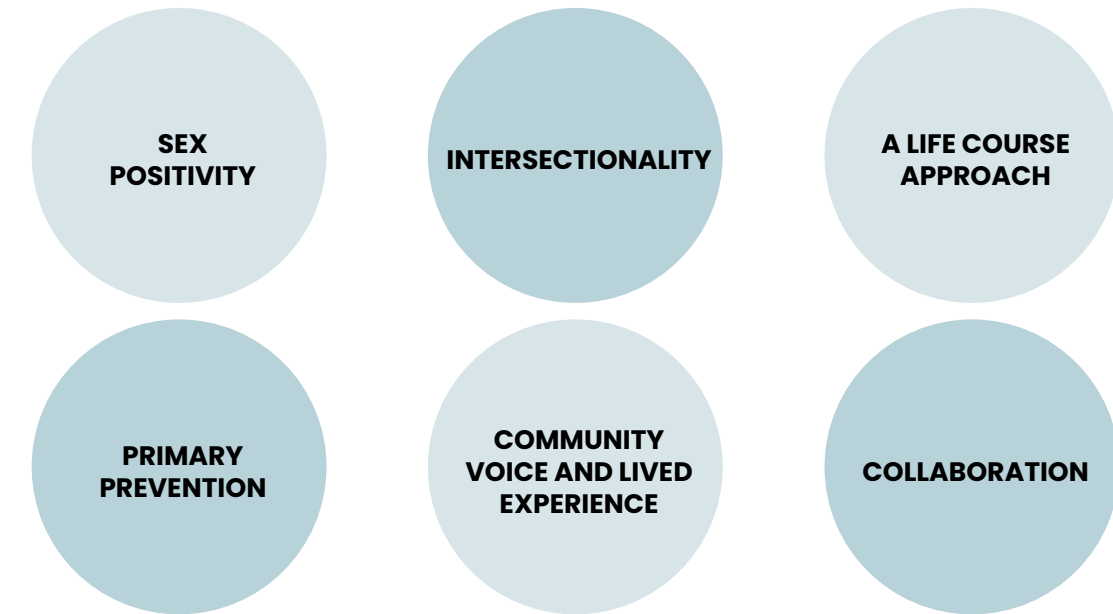
It is acknowledged that the strategic priorities and implementation strategies are all interconnected and in order to improve sexual and reproductive health outcomes in the NMR, elements from each category need to be addressed simultaneously. Due to the holistic nature of sexual and reproductive health, clinical and non-clinical interventions and actions are required, alongside environmental and cultural change.

THE FREEDOM, RESPECT AND EQUITY IN SEXUAL HEALTH FRAMEWORK

VISION

All women and gender diverse people in the northern metropolitan region (NMR) can freely exercise their rights to positive, pleasurable and affirming sexual and reproductive health outcomes.

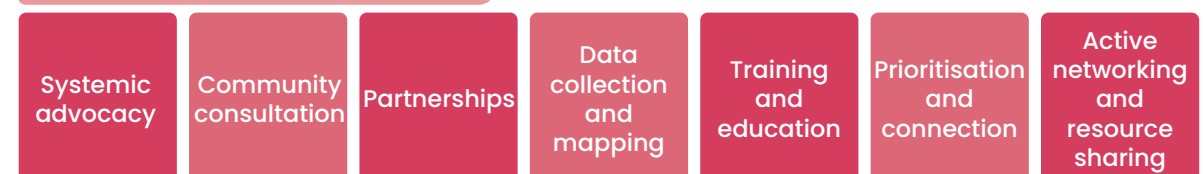
GUIDING PRINCIPLES



STRATEGIC PRIORITIES

Laws, policies and structures	Environments	Community	Capacity building	Integration
Addressing the laws, policies and structures that currently limit women and gender diverse people's access to sexual and reproductive health	Fostering inclusive environments, supportive of sexual and reproductive health in health services, workplaces, education and community settings	Facilitating community engagement and centre lived experience in sexual and reproductive health promotion activities and advocacy	Building capacity of health professionals, organisations and communities to support the sexual and reproductive health of women and gender diverse people	Supporting and facilitating an integrated approach to sexual and reproductive health through collaborative, multi-setting partnerships

IMPLEMENTATION STRATEGIES



INFLUENCING APPROACHES



Figure 2. The Freedom, Respect and Equity in Sexual Health Framework.

GUIDING PRINCIPLES

Freedom, Respect and Equity in Sexual Health 2022–2026 is underpinned by six guiding principles:

SEX POSITIVITY

Sex positivity is about having a healthy attitude towards sex, whether or not you're having it. Through a sex positive lens, we fight the social norms of what society says sexuality can be and embrace all forms of consensual sexual expression – including the choice not to have sex. This approach rejects shame and stigma, instead opening avenues for honest conversations and celebration of sexuality.

INTERSECTIONALITY

An intersectional lens strengthens our feminist practice by incorporating affirmative action to address systems and structures that perpetuate discrimination and oppression, including colonisation, racism, ableism, classism, heteronormativity, and cissexism. We proactively work to disrupt these colonial and patriarchal systems and build alternative systems that benefit women and gender diverse people.

A LIFE COURSE APPROACH

Sexuality and sexual experiences are not restricted to a specific period of life. Taking a life course approach, we acknowledge that there are different challenges and opportunities at different life stages, we reject ageist stigma that surrounds sexuality, and we strive to deliver age-appropriate, tailored health promotion to support women and gender diverse people, whatever their age.

PRIMARY PREVENTION

In taking action to promote health, it is necessary to address the social determinants which structurally impact the health, safety and wellbeing of women and gender diverse people. Through primary prevention, we work to address the underlying social conditions which create inequitable sexual and reproductive health outcomes.

COMMUNITY VOICE AND LIVED EXPERIENCE

Women and gender diverse people are experts on their own experiences. By centring community voice across sexual and reproductive health promotion, we will strengthen our understanding of the lived experiences of women and gender diverse people in the northern metropolitan region and be adaptable in our approaches according to community needs.

COLLABORATION

Addressing the social determinants of health to generate long-term positive changes in health outcomes requires collective effort across many sectors. Actions arising from this strategy will be informed by partner organisations and other initiatives within the NMR, and we will work towards building and sustaining intersectoral partnerships and collaborative effort.



STRATEGIC PRIORITIES

LAWS, POLICIES AND STRUCTURES

Addressing the laws, policies and structures that currently limit women and gender diverse people's access to sexual and reproductive health

We recognise that many of the barriers to sexual and reproductive health lie within legislation and policy. Through strategic advocacy and targeted interventions, we seek to challenge and redress the laws, policies and structures that currently limit women and gender diverse people's access to sexual and reproductive health, including Medicare ineligibility, conscientious objection, and the lack of reproductive health leave policies.

WHAT MIGHT THIS LOOK LIKE?

- advocating for, and providing guidance to organisations for implementing policies to support paid reproductive health leave and gender affirmation leave
- combined systemic advocacy to remove barriers to accessing sexual and reproductive health services.

ENVIRONMENTS

Fostering inclusive environments, supportive of sexual and reproductive health in health services, workplaces, education and community settings

Relationships between people and their environments form the basis of the socio-ecological model of health. We seek to address the structures, norms and practices that enable or constrain women and gender diverse people's access to good sexual and reproductive health across multiple settings, and support stakeholders to acknowledge and prioritise sexual and reproductive health as a fundamental component of overall health and wellbeing.

WHAT MIGHT THIS LOOK LIKE?

- advocating for a dedicated sexual and reproductive health hub in the NMR
- identifying gaps in local service provision and improving regional mapping for clinicians and consumers
- multi-sector collaboration to challenge normative concepts of masculinity and femininity that limit people of all genders.



COMMUNITY

Facilitating community engagement and centring lived experience in sexual and reproductive health promotion activities and advocacy

Involving community in health promotion initiatives fosters self-determination and strengthens collective impact. We seek to centre the voices of women and gender diverse people in sexual and reproductive health promotion activities and advocacy to actively inform our understanding of regional needs, and to drive regional priorities in sexual and reproductive health.

WHAT MIGHT THIS LOOK LIKE?

- consulting with community to identify barriers to accessing sexual and reproductive health information, support and services, including availability, geographic access, physical access, cultural safety, affordability and community awareness
- co-designing sexual and reproductive health promotion projects and programs with community to determine appropriate activities.

CAPACITY BUILDING

Building capacity of health professionals, organisations and communities in the NMR to support the sexual and reproductive health of women and gender diverse people

Sexual and reproductive health promotion requires collective effort across many sectors, in clinical and non-clinical settings. We seek to build sector and workforce capacity and confidence to deliver sexual and reproductive health prevention practice that is culturally safe, equitable, supportive and free from shame or stigma.

WHAT MIGHT THIS LOOK LIKE?

- increasing coordination across the Family and Reproductive Rights Education Program (FARREP) to work with communities to prevent FGC, and build workforce capacity to provide culturally appropriate services
- strengthening partnerships with local health services and practitioners
- developing, disseminating and providing guidance on creating tailored sexual and reproductive health resources across different settings.

INTEGRATION

Supporting and facilitating an integrated approach to sexual and reproductive health through collaborative, multi-setting partnerships

We seek to integrate sexual and reproductive health promotion within other health and wellbeing priorities including mental health, social inclusion, economic equality and prevention of gender-based violence. We recognise that sexual and reproductive health is interlinked with many other aspects of health, and seek to identify opportunities to support regional partners to embed sexual and reproductive health promotion in existing projects and planning processes.

WHAT MIGHT THIS LOOK LIKE?

- supporting health professionals, service providers and community leaders to acknowledge and address the link between sexual and reproductive health and gender based violence
- facilitating regular networking opportunities for communities, local councils and the sector.

IMPLEMENTATION STRATEGIES

SYSTEMIC ADVOCACY

Collective voice is powerful in advocating for positive change. Through this implementation strategy we seek to:

- advocate to local, state and federal government for increased funding for primary prevention in Melbourne's north and a dedicated sexual and reproductive health hub
- support and facilitate access to universal free and/or low-cost access to basic sexual and reproductive health care across all priority groups in the NMR
- transform dialogue around sexual and reproductive health in the NMR, with a focus on messaging that is evidence-based, sex positive, inclusive and free from shame or stigma.

COMMUNITY CONSULTATION

A rights-based approach to health recognises women and gender diverse people as the experts in their own lives. Through this implementation strategy we seek to:

- reflect diverse voices in sexual and reproductive health policy, legislation, planning and program development across the NMR
- promote health literacy and address shame, stigma and taboos that persist in relation to sexual and reproductive health
- involve women and gender diverse people in the design and implementation of health promotion activities that are responsive to their sexual and reproductive health needs.

PARTNERSHIPS

Partnership approaches strengthen collective impact and a shared commitment to positive change. Through this implementation strategy we seek to:

- assist organisations and workplaces to develop and foster positive and supportive cultures for sexual and reproductive health
- identify opportunities for shared projects and programs that support sexual and reproductive health.

DATA COLLECTION AND MAPPING

Service mapping and research builds our understanding of where the needs of women and gender diverse people are met or not met. Through this implementation strategy we seek to:

- clarify and promote clear service pathways that enable appropriate and timely access to local sexual and reproductive health services
- advocate for more accurate data collection that captures the diverse genders, sexualities, cultures, values and experiences among the NMR community.

TRAINING AND EDUCATION

Facilitating training opportunities can enhance sector and community knowledge and confidence in sexual and reproductive health, and build support networks among health professionals and the community service workforce. Through this implementation strategy we seek to:

- educate and resource professionals and communities to support good sexual and reproductive health across the life course for women and gender diverse people

- support the delivery of comprehensive sexuality education in schools, tertiary institutions and community settings, including education about sexual consent and respectful relationships.

PRIORITISATION AND CONNECTION

Sexual and reproductive health is interlinked with many other aspects of health and wellbeing. Through this implementation strategy we seek to:

- make clear the connections between sexual and reproductive health and other NMR priorities including, improving mental health and reducing social isolation, improving economic equality and preventing gender based violence, including reproductive coercion
- support organisations and community to embed sexual and reproductive health messaging across existing programs and planning processes, tailored and relevant to their contexts.

ACTIVE NETWORKING AND RESOURCE SHARING

Resource sharing and collaboration is integral to building regional capacity to support women and gender diverse people's sexual and reproductive health. Through this implementation strategy we seek to:

- establish a sustainable mechanism that facilitates knowledge and resource sharing, networking and collaboration
- strengthen relationships within and across sectors to build a regional network of sexual and reproductive health champions.

SUPPORTING NETWORKS

Freedom, Respect and Equity in Sexual Health 2022–2026 has been developed to provide a framework which facilitates rights-based, collaborative action promoting sexual and reproductive health for women and gender diverse people in the NMR. We intend to engage with organisations across the NMR and to work together towards achieving our objectives.

WHIN will lead the implementation and evaluation of *Freedom, Respect and Equity in Sexual Health 2022–2026*. Our responsibilities include:

- planning and coordinating regional action to improve women and gender diverse people's sexual and reproductive health
- facilitating resource sharing and networking opportunities across the NMR and beyond
- leading advocacy for the inclusion of sexual and reproductive health as a priority in health planning and policy development at local, state and federal levels
- supporting workforces to increase their knowledge and confidence in promoting the sexual and reproductive health of women and gender diverse people
- developing data snapshots to monitor sexual and reproductive health in the NMR and inform regional priorities

- engaging with women and gender diverse people across the region to integrate community voice into action planning processes and evaluation.

Organisations that are encouraged to engage with *Freedom, Respect and Equity in Sexual Health 2022–2026* and commit to positive change in sexual and reproductive health include:

- local government
- community health services
- regional Public Health Units
- regional Primary Health Networks
- schools and educational institutions
- clinical services
- state-wide sexual and reproductive health organisations
- women's health services and gender equity organisations.

CHALLENGING STRUCTURES

Gender norms, stereotypes and expectations shape our understandings of sex, sexuality and relationships. They also impact how we communicate about our pleasure, pain, boundaries and values. Taking a gender transformative approach, we seek to challenge and address rigid gender norms and structures that perpetuate gender inequality. Dismantling binaries and the patriarchal systems that reinforce them is a joint cause; we cannot create change alone. Gender is where feminism and LGBTQIA+ advocacy meet. We seek to initiate collaborative action with community-led LGBTQIA+ organisations to develop initiatives that improve the sexual and reproductive health and agency of women and gender diverse people across the NMR.





TAKING ACTION

ENGAGING PARTNERS

In the first year of implementation, WHIN will focus on actively engaging and seeking commitment from partner organisations, including local government, community health services and state-wide organisations. We acknowledge that sexual and reproductive health is a complex, multi-faceted area that requires clinical and non-clinical interventions – which can seem daunting. A regional approach that facilitates knowledge sharing, networking and collaboration will strengthen collective impact through a shared vision and commitment towards positive change.

ANNUAL ACTION PLANS

Annual action plans will be created to support the implementation of the Strategy, identifying which actions WHIN will focus on for that period. The action plans will also outline opportunities for partnerships and collaboration with regional stakeholders. At the end of each year, WHIN will prepare an achievements report with input from participating partners. This process will include reflection on the actions, and refinement for the following year, if needed.

EVALUATION FRAMEWORK

An evaluation framework for the Strategy and action plans will be developed with input from regional stakeholders. The evaluation will aim to build the evidence base for sexual and reproductive health promotion at a regional level.

GLOSSARY

The following is an explanation of key terms used in this strategy.

Cisgender – Refers to people whose gender identity and gender expression corresponds with the dominant social expectations of the sex assigned to them at birth (APA, 2015; Rainbow Health, 2022).

Cisnormativity – Refers to a general perspective that sees cisgender experiences as the only, or central, view of the world. This includes the assumption that all people are one of two distinct and complementary genders (man and woman), and that this corresponds to their sex assigned at birth. This assumption is often called the 'gender binary'.

Gender – The socially learnt roles, behaviours, activities and attributes that any given society considers appropriate for men and women; gender defines masculinity and femininity (Australian Women's Health Network, 2014). Gender expectations vary between cultures and can change over time (World Health Organization, 2015).

Heteronormativity – Refers to a general perspective that sees heterosexual experiences as the only, or central, view of the world, and assumes a linear relationship between sex, gender and sexuality (for example, that all men are heterosexual and cisgendered). This includes the unquestioned assumption that all people fall into one of two distinct and complementary genders (man and woman), which corresponds to their sex assigned at birth. It also assumes that heterosexual is the only 'normal' sexual orientation, and that sexual and marital relations are only appropriate between a man and a woman.

Intersectionality – An approach that considers intersecting aspects of a person's social, biological or cultural identity, and how they are affected by systems of oppression and access to power and resources. Aspects of identity can include gender, ability, class, ethnicity, age and sexuality, among others. An intersectional approach is particularly concerned with how different forms of discrimination can overlap and intersect (Murdolo and Quiazon, 2015).

Reproductive coercion – Refers to behaviour that interferes with the autonomy of a person to make decisions about their reproductive health. Reproductive coercion includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making and can take a variety of forms including sabotage of another person's contraception, pressuring another person into pregnancy, controlling the outcome of another person's pregnancy, or forcing or coercing a person into sterilisation (Marie Stopes, 2020).

Reproductive health – A state of complete physical, mental and social wellbeing and not merely the absence of disease, in all matters relating to the reproductive system. Reproductive health implies that people are able to have satisfying and safe sex and that they have the capability to reproduce and the freedom to decide if, when, how and how often to do so (UNFPA, 2022)



Reproductive rights – The right of all people to decide freely if they have children, and the number, spacing and timing of children. This includes having access to the information and means to do so, as well as the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion or violence (Centre of Reproductive Rights, 2013).

Sex – A person's physical characteristics relating to genitalia, chromosomes or hormones, and secondary sex characteristics that emerge at puberty (Rainbow Health, 2022).

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 (WHO, 2006).

Sexual health – A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease or dysfunction. 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 (WHO, 2006).

Sexual rights – All people have the right to control and decide freely on matters related to their sexuality; to be free from violence, coercion, or intimidation in their sexual lives; to have access to sexual and reproductive health care information, education, and services; and to be protected from discrimination based on the exercise of their sexuality (SRI, 2022).

Trans and gender diverse – Refers to people whose gender does not align with the gender that was presumed and recorded for them at birth. In the same way that sexual orientation and gender expression are not binaries, gender identity is not a binary. It is important to challenge our thinking beyond the binary constructs of female and male. Within this grouping, people use a range of different terms such as trans woman, trans man, non-binary, genderqueer, agender, bi- gender Brotherboys, Sistergirls and third-gendered. Language in this space is dynamic and people may have self- defined terms for their gender identities (Fairchild et al., 2021; Visin, 2021).

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