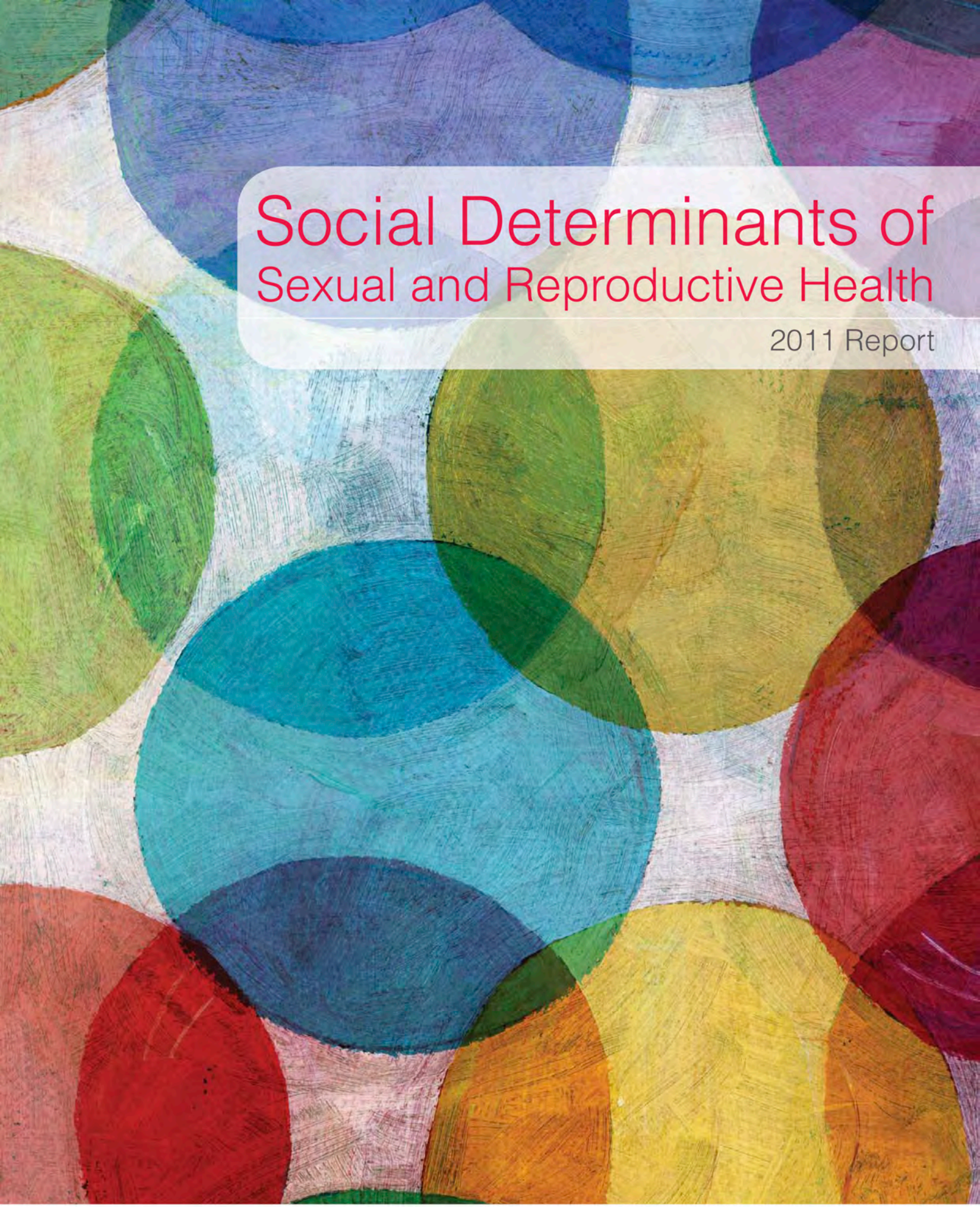

Social Determinants of Sexual and Reproductive Health

2011 Report

Developed by Women's Health West
for the Western Region Sexual and Reproductive Health Working Group

women's health west

HealthWest Partnership

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Contents

Introduction

Sexual and reproductive health, as with other areas of health, is influenced by a complex interplay of biological, psychological and social determinants (O'Rourke, 2008). Sexual and reproductive ill health accounts for almost twenty per cent of the global burden of disease for women and fourteen per cent for men[1] (Hunt and Bueno de Mesquita, 2010). In Australia there is limited evidence about the full extent of the burden of disease associated with sexual and reproductive ill health and the social and economic impact it has on the community (O'Rourke, 2008). Research has shown that violence and coercion,[2] unwanted pregnancy, homophobia, sexually transmitted infections, infertility, and cancers of the sexual and reproductive organs are major contributors to morbidity rates (Pitts, 2005; Shuttleworth, 2004). While Victoria's population is statistically among the healthiest in the world, the burden of disease associated with sexual and reproductive ill health continues to rise. There have been annual increases in most notifiable sexually transmitted infections in Victoria, with chlamydia notification rates doubling between 1997 and 2001, and more than doubling again between 2001 and 2006 (DoH, 2010a).

There is an emerging body of international and Australian literature that shows that many sexual and reproductive health problems are preventable (Temple-Smith and Gifford, 2005; Pitts, 2005; Shuttleworth, 2004). The World Health Organisation (WHO) insists that sustainable prevention is achievable through strategies and initiatives that work to redress the social determinants of sexual and reproductive health. Such an approach is complex yet pivotal, as sexual and reproductive health interventions that fail to account for the social determinants of health are less likely to see tangible health improvements, particularly among disadvantaged communities. Primary prevention action is urgently needed as it is the most effective method of reducing and, most importantly, preventing sexual and reproductive morbidity (O'Rourke, 2008; Moodie, 2005).

This report examines the social determinants of sexual and reproductive health and the complex way in which they influence and exacerbate health inequities. Consolidating the evidence-base for the social determinants of sexual and reproductive health is a new development in the public health field, therefore making this report timely (WHO, 2010). In addition, the findings have been used to inform the development of a *Western Region Sexual and Reproductive Health Promotion Framework* (WHW, 2011), which is contained in this report.

The *Western Region Sexual and Reproductive Health Promotion Framework* provides an overarching conceptual guide for use in evidence-based sexual and reproductive health promotion action planning. It is modeled on prominent VicHealth health promotion frameworks and comprises five layers. The first layer identifies the social determinants of sexual and

[1] For various reasons, sexual and reproductive ill health is severely underestimated and statistics often fail to capture the full burden of ill health. The data provides an indication of the magnitude of the problem.
[2] Gender-based violence leads to a number of poor sexual and reproductive health outcomes, including maternal death and disability due to problems before, during and after pregnancy and childbirth. Women who experience intimate partner violence have also been found to be at increased risk of sexually transmitted infections, unplanned pregnancy, and termination of pregnancy.

reproductive health, which is the focus of this report. Layer two outlines the behavioral determinants of sexual and reproductive health, and is based on a review of key literature. Layer three outlines the population target groups identified in the *Mapping and Needs Analysis: Sexual and Reproductive Health in the HealthWest Catchment, 2010 Report*. The final layers draw on the work of VicHealth (2005 & 2007) to outline seven evidence-based health promotion actions that are known to be effective in other areas of health promotion (layer four), and identify settings in which effective and sustainable health promotion activity can occur (layer five).

Best-practice sexual and reproductive health promotion works to redress social determinants of health, rather than focusing exclusively on lifestyle and behavioral risk factors (WHO, 2010; Keleher, MacDougall and Murphy, 2008). It uses the best available evidence to identify target populations and the health promotion actions and settings that are most likely to achieve sustainable, equitable health outcomes.

Background

The western metropolitan sub-region comprises the western portion of the north and west metropolitan region of Melbourne as defined by the Victorian Government Department of Human Services (WHW, 2009a). The western region encompasses the seven local government areas of Brimbank, Hobsons Bay, Maribyrnong, Melbourne, Melton, Moonee Valley and Wyndham. There are two Primary Care Partnerships within the region - HealthWest and Inner North West. In its 2009–2012 Integrated Health Promotion Plan, HealthWest identified sexual and reproductive health as a priority area for health promotion action. A working group was established with membership from Women's Health West, HealthWest, ISIS Primary Care, Western Region Health Centre, Djerriwarrh Health Service, Maribyrnong City Council and the Braybrook/Maidstone Youth Partnership. Women's Health West is the lead agency for this work across the region.

Between June 2009 and May 2010 the working group completed the *Mapping and Needs Analysis Report 2010*. The report reviewed 69 sexual and reproductive health programs and services from 23 agencies in the region to map existing health promotion programs and clinical service provision. Information gathered at the *Sexual and Reproductive Health Forum: A Partnership for Improved Sexual and Reproductive Health in the West,* attended by 31 local service providers in March 2010, contributed to the findings. The event provided workers and practitioners with a forum to discuss the sexual and reproductive health concerns they were observing in their professional practice, while also identifying opportunities for regional action.

The *Mapping and Needs Analysis Report 2010* identifies the population groups experiencing the greatest levels of sexual and reproductive ill health and, significantly, the communities that are under-resourced with appropriate primary prevention initiatives. The report recommends a more targeted and coordinated approach to meeting sexual and reproductive health needs in the region. It also recommends that, in order for initiatives to achieve equitable and sustainable health outcomes, programs must respond to the social determinants of sexual and reproductive health that exacerbate health inequities. The working groups' need to better understand the social determinants of sexual and reproductive health formed the rationale for this report.

Definitions

An individual's right to a safe and pleasurable sex life with the partner of their choice, to control their body and make informed decision about their sexual and reproductive health free from violence, discrimination and social prejudice are the cornerstones to optimal sexual and reproductive health. All members of the community, regardless of their age, ethnicity, religion, sexuality, ability or martial status, have the right to the highest standard of sexual and reproductive health. This report is informed by the following definitions:

> ***Reproductive health*** *implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so. (ICPD, 1994)*
>
> ***Reproductive rights*** *is the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health. (ICPD, 1994)*
>
> ***Sexual health*** *is 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, sexual rights of all persons must be respected, protected and fulfilled. (FWCW, 1995)*

Sexual health and reproductive health are often segregated in policy and practice. This report has integrated sexual and reproductive health, based on the rationale that sexual and reproductive health are inherently interconnected, as sexual health is vital for, and therefore part of reproductive health (O'Rourke, 2008).

In recent years there has been an increasing recognition that a rights-based approach is crucial in ensuring communities achieve optimal sexual and reproductive health. Sexual and reproductive health is among the 'most sensitive and controversial issues in international human rights law, but also among the most important' (Hunt and Bueno de Mesquita, 2010). This is because the underlying drivers of poor sexual and reproductive health are multifaceted and often deeply entrenched. For instance, the lower social status of girls and women in many countries, including Australia, is a key contributor to their sexual and reproductive ill health and represents a violation of their right to health and freedom from violence and discrimination (Hunt and Bueno de Mesquita, 2010).

Health promotion is defined in this report as a conceptual framework and approach that is informed by a holistic understanding of health. Health promotion:

> *… not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and*

economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health (WHO, 1986).

The objective of ***sexual health promotion*** is therefore to enable and facilitate individuals, communities and population groups to enhance control over the determinants of health and thus increase people's capacity to achieve optimal sexual and reproductive health over their life course (WHO, 2002).

The importance of focusing on equity to improve sexual and reproductive health

Sexual and reproductive health strategies must aim to achieve health equity. Population health, which focuses on improving health and wellbeing through priority health approaches that tackle the disparities in health status between social groups, is essential in achieving sexual and reproductive health equity. Rather than advocating for individual behaviour change, this approach focuses on a broad range of factors that influence health and wellbeing at a population level – these are known as the social determinants of health.

The social determinants of health are the conditions in which people are born, grow, live, work and play that impact on their health, safety and wellbeing. The social determinants of health are for the most part responsible for health inequities - the unfair and avoidable differences in health status seen within and between population groups.

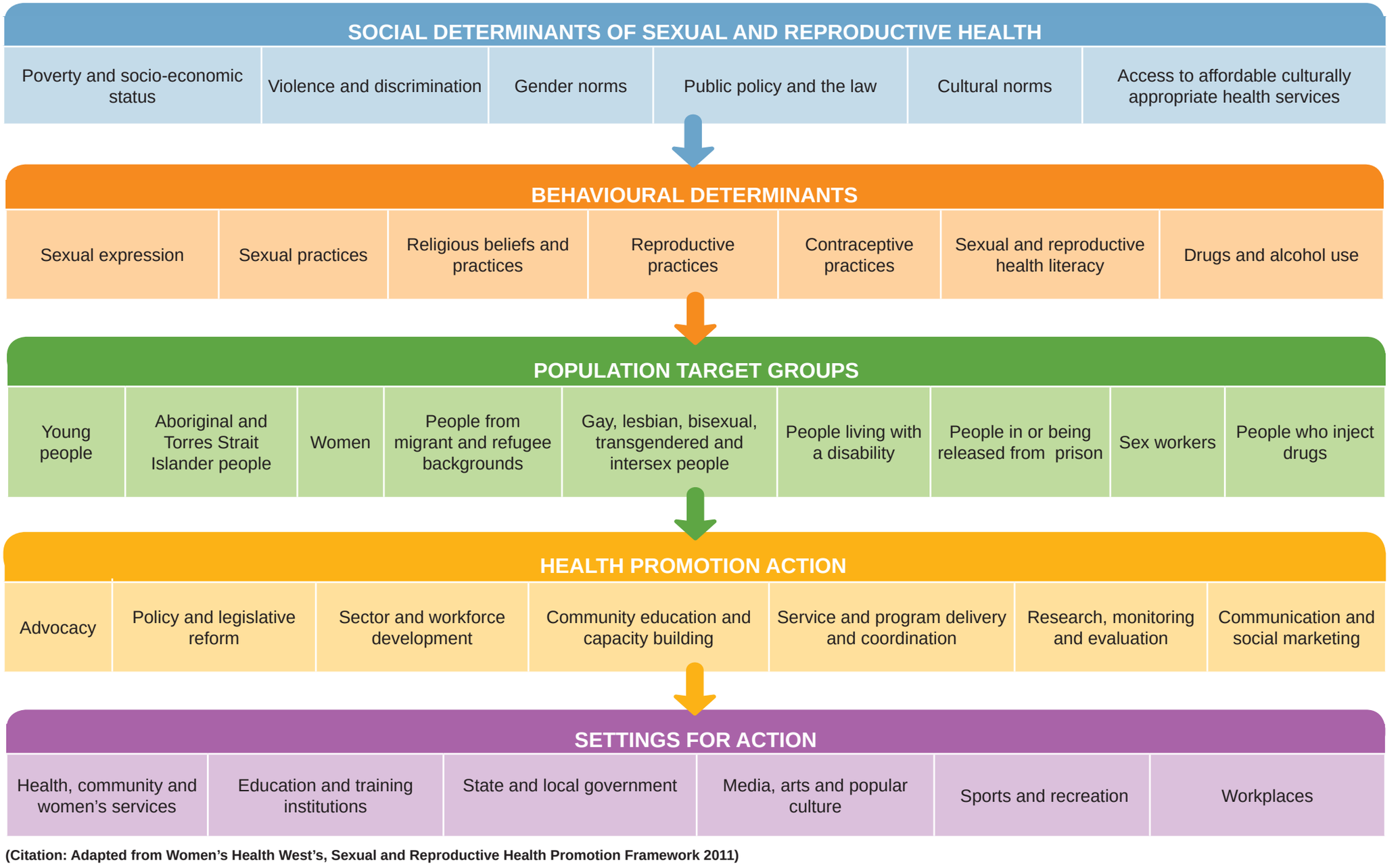
In 2010, WHO released the *Social determinants of sexual and reproductive health: Informing future research and programme implementation* report, which examined the complex way in which the social determinants of sexual and reproductive health exacerbate global health inequities (WHO, 2010). WHO maintains that the social determinants of sexual and reproductive health work 'at different levels to influence exposure to the risks of unintended pregnancy or sexually transmitted infection, care-seeking behaviours, and access to and use of preventative services, care and treatment' (WHO, 2010: 10).

WHO (2010) insists that a focus on people's lifestyle and behaviour is inadequate in alleviating long term sexual and reproductive health inequities if such interventions fail to also work towards redressing the social conditions that drive poor health outcomes. Lifestyle and behaviour change interventions are also unlikely to see tangible health improvements, particularly among disadvantaged communities.

Population health interventions are essential in the sexual and reproductive health field, as appropriate and accessible primary prevention initiatives that work to redress the social determinants of health will prevent ill health and disease in a way that is both sustainable and cost-effective (WHO, 2010; Keleher, MacDougall and Murphy, 2008).

This report builds the evidence-base for the social determinants of sexual and reproductive health, to inform primary prevention action in Melbourne's western region. While the purpose of the report is to enable health promotion action planning across the target populations outlined in the *Western Region Sexual and Reproductive Health Promotion Framewo*rk, many of the examples provided in this analysis are women-specific. This is because numerous social determinants, such as violence and discrimination or public policy and the law, disproportionately affect women and girls' sexual and reproductive health (O'Rourke, 2008; DoH, 2010a; DoH, 2010b).

Western Region Sexual and Reproductive Health Promotion Framework



(Citation: Adapted from Women's Health West's, Sexual and Reproductive Health Promotion Framework 2011)

A guide to understanding the framework

The framework for action featured below comprises five layers and recognises that factors influencing sexual and reproductive health lie at multiple and interacting levels of influence – individual, community and societal. This overarching conceptual framework builds the evidence and knowledge base for health promotion and primary prevention action across a range of settings. Opportunities to prevent many sexual and reproductive health problems and disorders before they occur are most effective when a range of coordinated and mutually reinforcing strategies are targeted across these levels of influence (VicHealth, 2007).

SOCIAL DETERMINANTS OF SEXUAL AND REPRODUCTIVE HEALTH

The framework begins with the social determinants of sexual and reproductive health. These are the social conditions that impact on health and wellbeing. To be effective, sustainable and equitable interventions must redress the social determinants of sexual and reproductive health.

BEHAVIOURAL DETERMINANTS OF SEXUAL AND REPRODUCTIVE HEALTH

The second layer of the framework outlines key behavioural determinants that impact upon individuals' sexual and reproductive health outcomes. As previously noted, sexual and reproductive health promotion strategies often concentrate on behavioural determinants through health education and behaviour change programs (Keleher, MacDougall and Murphy, 2008). While such strategies are important, focussing solely on lifestyle and behaviour change will not alleviate deeply entrenched health inequities or prevent sexual and reproductive health morbidity. Ideally service and program provision that aims to challenge behavioural determinants does so in combination with integrated strategies that focus on the social determinants that drive sexual and reproductive ill health (Keleher, MacDougall and Murphy, 2008).

POPULATION TARGET GROUPS

The population target groups identified in the third layer of the framework are those experiencing the most significant sexual and reproductive health inequity in Melbourne's western region, as informed by the Mapping and Needs Analysis Report 2010. Sexual and reproductive ill health disproportionately affects population target groups already experiencing inequities related to gender, cultural background, sexual orientation, ability and other factors (O'Rourke, 2008). Many people are members of more than one target population, which can increase their vulnerability to sexual and reproductive health morbidity. People can also transition in and out of target populations over their life course or as their life circumstances change.

HEALTH PROMOTION ACTION

The fourth layer of the framework engages well-established health promotion actions to promote and optimise sexual and reproductive health. These are:

- Conduct **advocacy** activity at community, organisational and broader societal levels with a view to foster attitudes, practices, policies and legislation conducive to optimal sexual and reproductive health
- Achieving **policy and legislative advocacy and reform** to further the sexual and reproductive health rights and responsibilities of the community
- **Research, monitoring and evaluation** to advance the evidence-base for what is deemed best practice in sexual and reproductive health promotion, and ensure that work is targeted and responsive to populations that are disproportionately affected by sexual and reproductive ill health
- Achieving **service and program delivery and coordination** to ensure quality, comprehensive and integrated service provision
- Support **community development and education** activities that redress the social and behavioural determinants of sexual and reproductive health
- Increase organisational capacity through **sector and workforce development** to strengthen understanding of health promotion theory and practice to build a trained and skilled sexual and reproductive health promotion workforce (adapted from VicHealth, 2005).
- Conduct **communication and social marketing** about sexual and reproductive health promotion priorities through local, regional and national media and other avenues such as social media.

SETTINGS FOR ACTION

The six settings for action are in keeping with those identified by VicHealth (2005) as effective areas for primary prevention work to occur. The action settings are also informed by the increasing recognition that the social determinants that drive sexual and reproductive health sit outside the health sector and as such approaches must be coordinated across various sectors to achieve sustainable change (WHO, 2010).

The social determinants of sexual and reproductive health

1. Poverty and socio-economic status

The relationship between socio-economic status and sexual and reproductive health is well established in the public health field. Socio-economic disadvantage is both a cause and an outcome of poor sexual and reproductive health (WHO, 2010). Socio-economic disadvantage can be indicated by low income, poor levels of educational attainment, employment in relatively unskilled occupations, and high unemployment. The western metropolitan sub-region is home to some of Melbourne's most disadvantaged communities - with four of its seven local government areas ranking in the top ten most disadvantaged in metropolitan Melbourne[3] (WHW, 2009a).

There are two levels at which socio-economic disadvantage operates as a determinant of sexual and reproductive health. One is the macro level, which identifies the economic systems and structures that impact on the sexual and reproductive health of population groups. At a macro level the amount of government funding allocated to health, education, housing, transport, childcare and income support impacts upon the level of socio-economic disadvantage in the community, and exacerbates the underlying drivers that compromise sexual and reproductive health (WHO, 2010). For example, governments' replacing state-funded services with user-pays services has had a significant impact on people's access to, and choices about, sexual and reproductive healthcare (Gregory and Wheeler, 2005).

Disadvantage also operates at a micro level, which identifies the association between an individual's socio-economic status and their sexual and reproductive health (Phillips, 2003). A micro level analysis explores how low socio-economic status '…limits access to material and psychosocial resources and affects individuals' ability to exercise autonomy and decision-making', both of which are essential for optimal sexual and reproductive health (VicHealth, 2005). Socio-economic disadvantage can affect men and women's ability to access health services, contraception, abortion and timely screening and treatment for sexually transmitted infections (WHO, 2010). People experiencing socio-economic disadvantage are less able to exercise reproductive choice because of reduced access to resources and services such as high quality medical care (WHW, 2009b).

A micro level analysis also reveals that women from socio-economic disadvantaged households are less likely to use preventive and curative sexual and reproductive health services than women from wealthier households, including antenatal care and preventive screening (WHO, 2010). In addition, research has found that poverty influences women and their partners' choices and decisions about childbearing. For example, access to abortion services can be costly in Victoria, where few public services are available. However, research into Victorian women's experiences of unplanned pregnancy and abortion found

[3] Disadvantaged Local Government Areas in Melbourne's west include Brimbank (ranked 2nd), Maribyrnong (ranked 3rd), Hobsons Bay (ranked 9th) and Melton (ranked 10th).

that financial concerns was one of the leading contributors in decisions to terminate a pregnancy (Rosenthal et al, 2009).

2. Violence and discrimination

A considerable body of research shows that violence and discrimination has significant and often long-lasting physical and psychological health consequences, particularly for sexual and reproductive health (WHO, 2010). The prevalence of sexual violence in Australia is profound. An estimated one in five women will experience sexual assault during their lifetime, while one in ten women will be raped by their partner (NCRV, 2009). Sexual violence and coercion takes many forms, including sexual assault, intimate partner rape, gang rape, female genital mutilation, human trafficking for sexual exploitation, forced prostitution, and sexual harassment and intimidation in the workplace and other social settings.

There is a large body of evidence that suggests sexual assault during childhood and early adolescence is associated with poor sexual and reproductive health outcomes. In Australia the prevalence of child sexual assault is estimated at 5.1 per cent for men and a significantly higher 27.5 per cent for women (O'Rourke, 2008). Young homeless people are particularly vulnerable to sexual violence, with one Australian study reporting that 45 per cent of young homeless men and 59 per cent of young homeless women had at some time experienced unwanted sex (Temple-Smith and Gifford, 2005). Sexual abuse in childhood is linked to earlier consensual sexual debut, sex with multiple partners, unprotected sex, and the incidence of sexually transmitted infections and early pregnancy (Heise et al, 2005).

Women and girls bear the overwhelming burden of ill-health, injury and disease caused by violence, which for the most part is perpetrated by men they know (VicHealth, 2007). According to Victoria Police crime data, women living in Melbourne's west experience higher rates of intimate partner violence when compared to the state average (WHW, 2010). Sexual violence and discrimination is associated with a range of sexual and reproductive health problems with immediate and long-term consequences. A large body of research has found that victim/survivors of rape are at increased risk of contracting sexually transmitted infections including HIV, and a range of gynaecological problems including vaginal bleeding and infection, fibroids, chronic pelvic pain and urinary tract infections (Eby, 1995). Sexual assault has also been linked to subsequent high risk behaviours, including unsafe sexual practices, excessive alcohol consumption and illicit drug use (de Visser et al, 2007).

Australian and international research has consistently shown that women subjected to violence by their partner are more likely to experience an unplanned pregnancy and seek an abortion (WHO, 2010; Taft & Watson 2006). An Australian longitudinal study found that partner violence was a strong predictor of abortion, as young women experiencing partner violence were more than twice as likely to terminate a pregnancy as those not subjected to violence (Taft & Watson 2006). In addition, women experiencing intimate partner violence are more likely to experience adverse pregnancy outcomes, including miscarriage, low birth

weight, preterm births or foetal death than women who live free from violence (Taft and Watson, 2007; WHO, 2010). Research has also found that some male perpetrators of intimate partner violence use reproductive coercion to maintain control over their female partner by pressuring them to become pregnant through threats, physical violence or birth control sabotage. For women experiencing reproductive coercion the risk of unintended pregnancy doubles (Miller et al, 2010). Victim/survivors of sexual violence are also less likely to present for cervical screening within the recommended timeframe, with sexual assault affecting women's regular participation in and attitudes toward pap testing (Koss, 1991; Springs & Friedrich, 1992; Farley et al, 2002; Carlson, 2002).

In recent years there has been increasing recognition of the extent of sexual violence during and after situations of armed conflict and its impact on sexual and reproductive health morbidity among refugee communities (WHO, 2010). Melbourne's west is home to many people who have escaped persecution and human rights violations (WHWb, 2009). Rape and other forms of sexual torture are commonly perpetrated by persecutory regimes against women, children and men (DHS, 2008). The prevalence of men perpetrating acts of sexual violence against women and girls in post-conflict settings remains high, as does the rate of women who are forced to engage in sex as a result of economic deprivation and forced displacement (WHO, 2010).

People living with a disability, and particularly women with a disability, are subject to multiple forms of violence and discrimination. Women with a disability have their rights to sexual and reproductive freedom denied in a myriad of ways. This includes the ongoing practice of 'non-therapeutic'[4] or 'forced' sterilisation,[5] systematic denial of appropriate reproductive healthcare and sexual health screening, denial of access to assisted reproductive technologies and poorly managed pregnancy, birth and postnatal care (Frohmader, 2010: 18). Women living with a disability are also twice as likely to experience violence and are less likely to receive an adequate service response (NCRV, 2009).

Research has consistently found that racism affects men and women's sense of safety, identity, self-confidence, and their experiences of healthcare and treatment (WHW, 2009b; Mansouri et al, 2009). Racism has been identified as the root cause of the extreme health disadvantage experienced by Indigenous Australians (Larson et al, 2007). Racism experienced by migrant and refugee communities further contributes to health inequalities and impacts on sexual and reproductive health outcomes (Fenton, 2001; Francis & Cornfoot, 2007). For instance, research undertaken to investigate how young people from refugee backgrounds access, interpret and utilise sexual health information found that experiences of racism and discrimination act as barriers to young people accessing sexual and reproductive health information and healthcare services (McMichael, 2008).

[4] 'Non-therapeutic sterilisation' is sterilisation for a purpose other than to 'treat some malfunction or disease' (Frohmader, 2010)
[5] 'Forced sterilisation' refers to the performance of a procedure which results in sterilisation in the absence of the consent of the individual who undergoes the procedure. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to health or life (Frohmader, 2010)

Violence and discrimination associated with homophobia and transphobia has significant sexual and reproductive health consequences for people identifying as gay, lesbian, bisexual, transgender and intersex (GLBTI). One of the largest Australian surveys conducted with GLBTI people, found that a significant number of participants (14 per cent), particularly gay men (10 per cent), always avoided disclosing their sexual identity for fear of discrimination and violence (Hillier et al, 2005). A striking finding of the *Writing Themselves in Again: 6 Years On* report was that same sex attracted young people who had experienced homophobic abuse fared worse on almost every indicator of health and wellbeing, including sexual and reproductive health, when compared with those who had not experienced such violence (Hillier et al, 2005).

Indeed, there is a strong body of evidence that suggests that primary prevention initiatives that work to ensure freedom from violence are crucial in optimising sexual and reproductive health. Similarly, initiatives must work to eliminate discrimination associated with sexuality, gender identity, ethnicity and ability, if there is to be an impact on the high levels of sexual and reproductive health morbidity in Melbourne's west.

3. Gender norms

Gender norms are a significant determinant of sexual and reproductive health (WHO, 2010). Gender refers to the socially constructed roles, obligations, behaviours and attributes assigned to men and women as a result of their sex; while gender norms refer to the social and cultural meanings associated with masculinity and femininity.

Gender norms have a powerful influence on people's sexual identity, practices and behaviour, and the way in which they enact their sexuality. For example, the cultural ideology of masculinity and what it means to be a 'man' sees young men encouraged to actively engage in sexual activity to prove their virility (Wellings et al, 2006), while for girls it is considered appropriate for sex to take place within the confines of a monogamous, committed relationship (Carmody, 2009; Warr et al, 1997; Mitchell, 2005). Despite the increasing normalisation of pre-marital sex among Anglo-Australian youth, this gendered double standard persists (Bearinger et al, 2007). For example, research on the sexual health of Australian secondary school students found that young men in year 12 were more than twice as likely as their female counterparts (51.1 percent and 18.2 percent, respectively) to have had three sexual partners or more (Smith et al, 2009). The double standard of sexual restraint for girls and excess for boys, compounds sexual and reproductive ill health for both sexes (Bearinger et al, 2007).

One outcome of this double standard is that young women with 'regular' or 'steady' partners are less likely to use condoms, as their use is associated with 'casual' relationships (Smith et al, 2009). As a result, the oral contraceptive pill frequently becomes the sole method of contraception, as for many young women going on the pill symbolises the transition from a casual to a committed relationship (Moore and Rosenthal, 2006).

Gender-based power inequities lead to social pressures and constraints through which women, particularly young women, negotiate sexual encounters, which impact directly on their ability to negotiate and make decisions about safe sexual practices (Holland et al, 1990; Rosenthal & Browning 2005; Langford 1996). Sex occurs in a social context characterised by gendered power relations and this has considerable implications for safer sex practices. For example, Australian research found that many young men admit to emotional blackmail in order to persuade their girlfriends to have sex without a condom (Moore and Rosenthal, 2006).

Masculine gender stereotypes are detrimental to the sexual and reproductive health of both sexes. For instance, a study of adolescent males' heterosexual relationships found that young men who held traditional attitudes toward masculinity reported having more sexual partners and were more likely to believe that relationships between women and men are adversarial (Pleck et al, 1993). The study also found that young men who have traditional attitudes about gender roles report negative attitudes about condoms that translated into low condom use (Pleck et al, 1993).

Pervasive masculine stereotypes define men's sexuality as biologically driven and unstoppable, despite evidence that discredits this view (Lees, 1997). Dominant forms of masculinity encourage men and boys to assume the qualities of 'control, a sense of entitlement to power … as well as a series of myths that justify men's violence and power' (Flood 2009: 3). While most men conduct themselves in respectful and non-violent ways, it is usually men who commit acts of aggression and sexual violence against women, children and other men. The social construction of masculinity and traditional gender norms play a major role in influencing the behaviour of men who perpetrate violence (VicHealth, 2007). Evidence shows that the risk of violence against women increases in communities that perpetuate gender stereotypes and that support attitudes and behaviours associated with male dominance and superiority (VicHealth, 2007; NCRV, 2009).

The way that men perform masculinity often remains invisible in sexual and reproductive health discourse. For example, criminological, sociological and public health approaches to the sex industry focus primarily on women's involvement in sex work and their sexual health, while little attention has been paid to men who buy sexual services (Smith et al, 2003). This remains the case even though the sex industry is driven by men's demand for the provision of sexual services, evident by the fact that one in six Australian men (or 15.6 percent) have paid for sex, compared with only 0.1 percent of women who have purchased sexual services (Smith et al, 2003).

In the same way that masculinity often remains invisible when considering sexual and reproductive health, there continues to be limited public health discourse around the importance of men and boys' sexual and reproductive health. Despite an official recognition at the International Conference on Population and Development (1994) that men and boys play a 'crucial' role in sexual and reproductive health promotion, there are still limited interventions designed to transform the behaviours of men and boys and redress the

negative social norms associated with masculinity (Sternberg and Hubley, 2004). Undoubtedly, more targeted primary prevention and health promotion interventions for men and boys are needed, so that they can become partners in the prevention of sexually transmitted infections, unwanted pregnancy and infertility, responsible parenthood, in violence prevention and in optimising their own and their partners' sexual and reproductive health (Sternberg and Hubley, 2004; DoHb, 2010).

To improve the sexual and reproductive health and wellbeing of communities living in Melbourne's west strategies must promote respectful, equitable and non-violent relationships, where the responsibility for safe sexual practices, fertility and parenthood - among other facets of sexual and reproductive health - is shared.

4. Public policy and the law

Public policy and the law play a central yet often controversial role in sexual and reproductive health. Governments frame sexual and reproductive health policy and legislation within the 'prevailing political, social, medical and philosophical attitudes' (Tibbits 2005: 262). Sexual and reproductive health policy and legislation, or the absence of such, is therefore rarely without value or judgment. The law and public policy shape, and in many instances determine, individuals' sexual and reproductive rights and options.

Current policy context

The Australian Federal Government shares responsibility for health policy and funding with state and territory governments (Tibbits, 2005). Subsequently, there is a plethora of national and state strategies that address particular aspects of sexual and reproductive health, including sexually transmitted infections, blood born viruses and Indigenous sexual health. However, Australia remains without a national sexual and reproductive health strategy that provides a comprehensive overarching evidence-based framework for research, policy and program development, implementation and evaluation (O'Rourke, 2008).

The background paper *Time for a National Sexual and Reproductive Health Strategy for Australia* (2008) strongly advocates for a comprehensive national strategy, as current sexual and reproductive health policies are inconsistent with best practice and tend to:

- Focus on single issues, usually sexually transmitted infections, often at the expense of primary prevention and health promotion initiatives
- Aim to alter health outcomes in isolation from the broader social and cultural context that these issues sit within
- Not focus on or link with strategies that redress the social determinants of sexual and reproductive health (O'Rourke, 2008).

A national strategy, Kerryn O'Rourke (2008) insists, would provide leadership for a cohesive and consistent approach between government and non government agencies, research

organisations, service providers, private practitioners, and the community, for the improvement of sexual and reproductive health and wellbeing for all Australians.

In keeping with the National context, Victoria is without a comprehensive statewide strategy, and therefore responses to sexual and reproductive health are compartmentalised and primarily focussed on treatment of disease and ill health as well as individual behaviour change. Statewide sexual health strategies tend to focus narrowly on sexually transmitted infections and blood born viruses[6], and in many instances are outdated.

In an effort to improve the communities' overall health, the Victorian Government selected seven health promotion priorities from 2007 until 2012, one of which is sexual and reproductive health. Despite its inclusion as a health promotion priority, sexual and reproductive health makes up only two percent of the total priorities chosen by Victorian Primary Care Partnerships (DoH, 2011).

A comprehensive, uniform national and state data collection system for sexual and reproductive health is necessary to enable appropriate monitoring and evaluation of the sexual health status of priority populations. Currently there is an absence of accurate information regarding rates of unwanted pregnancies and abortions, use of contraception including emergency contraception, rates of sexually transmitted infections and the population groups that are primarily affected (O'Rourke, 2008). For example, while abortion will be part of the reproductive health experience of approximately one third of all Australian women, there is no national method of data collection[7] (Pratt, 2005). In the absence of accurate sexual and reproductive health statistics, determining the priorities for resource allocation for both primary prevention and intervention strategies is problematic at best (WHW, 2009b).

[6] For example, see Victorian Sexually Transmissible Infections Strategy 2006-2009, Victorian HIV/AIDS Strategy 2002-2004 and Addendum 2005-2009, and Victorian Hepatitis C Strategy 2002-2004 and Addendum 2005-2009.

[7] South Australia is the only jurisdiction that collects and routinely publishes comprehensive data on termination of pregnancies performed in the state. This includes demographic information, statistics on the gestational age at which the pregnancy was terminated, the grounds for abortions taking place and information relating to the type of medical practitioner who performed the procedure (Pratt, 2005).

The influence of the law

The law plays a central but inevitably controversial role in determining population groups' sexual and reproductive health status (Magnusson, 2005). When assessing the impact on sexual and reproductive health, it is necessary to examine the laws' effectiveness, its underlying values, and identify the population groups that are affected. The following examples outline the practical and ethical complexity of the law's influence on sexual and reproductive health.

The legal status of female genital mutilation (known as FGM) is an example of how the law relating to sexual and reproductive health carries inherent bias. FGM is a practice that includes 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons' (WHO, 2008: 4). FGM is becoming increasing relevant in Melbourne's western region as a consequence of a growth in immigration and settlement of FGM affected communities.[8] In Victoria, FGM is illegal under the *Crimes (Female Genital Mutilation) Act 1996*. However, surgical procedures such as labiaplasty involving the excision of the labia for cosmetic reasons are legal and is becoming an increasingly normalised cosmetic procedure among Anglo-Australian women.

The law still overtly discriminates against certain groups within the community. The Federal Government in 2004 amended the *Marriage Act 1961* to explicitly state that marriage means the union of a man and a woman to the exclusion of all others. The Victorian Gay and Lesbian Rights Lobby argue that such legislation must be changed as the right to marry the partner of one's choice is a 'key marker of adulthood and citizenship, social participation and belonging to family and community. The denial of the right to marry stigmatises same-sex attracted couples and their families as second-rate and dysfunctional' (VGLRL, 2010).

The law also plays an important role in upholding sexual and reproductive rights. In 2008 the Victorian Parliament passed the *Abortion Law Reform Act,* which removed abortion from the *Crimes Act* making termination of pregnancy legal in Victoria. Under the changes, women can independently access abortion in Victoria up to 24 weeks gestation. Similarly, the introduction of the *Assisted Reproductive Treatment Act 2008* saw Victorian single and lesbian women secure the right to access in-vitro fertilisation irrespective of whether or not they were medically infertile. Indeed, both Acts are pivotal in supporting women's ability to control their fertility and enact their reproductive rights.

[8] FGM is practiced by Muslims and Christians in north, east and western Africa, parts of Asia and the Middle East and immigrant communities in North America and Europe (WHO, 2008).

5. Cultural norms

Cultural norms are a key determinant of sexual and reproductive health. Cultural norms include beliefs, behaviours, customs, traditions, rituals, dress, and language of a society or group of people (WNWE, 1992). In keeping with other social determinants of health, cultural norms can promote or undermine sexual and reproductive health.

Heterosexism is one such example. Heterosexism is a term used to explain a cultural and institutional bias that assumes that everyone is heterosexual (Peterson, 1996). Due to heterosexism and the socially constructed notion that it is the 'normal' and 'natural' sexual orientation, people whose sexual identity sits outside this are seen as 'abnormal' or 'inferior' (Rubin, 1984; Peterson, 1996; Hillier et al, 2005). Heterosexism serves to silence and make invisible the lives of GLBTI people in education, healthcare, workplaces, the legal system, in family life and the media. Cultural norms that support and embrace freedom and equity of sexual expression are essential to optimising sexual and reproductive health.

Cultural norms about sexuality, parenthood and ability have similarly negative implications for people living with a disability. There are still widespread misconceptions and stereotypes about people with a disability, which leads to high unmet need for health promotion initiatives, services and support that enable them to enact their sexuality and reproductive health rights (Frohmader, 2010). This is in part attributed to the misconception that people with a disability, particularly people living with an intellectual disability, are asexual or that their sexual expression is somehow inappropriate (Rosengarten, 2005).

In recent years, the impact of pornography on cultural norms and in particular young people's sexuality, attitudes and behaviours, has gained increasing attention. The proliferation of mainstream pornography and the ease by which it can be obtained has created unprecedented access to free and unlimited sexuality explicit material. Concerns exist that much of the sexually explicit material available online 'presents a narrow and distorted view of sex, shows women in sexist and stereotyped ways, and some material depicts and eroticises violence.' (Flood, 2009: 2). As such, research has found that pornography can teach young people sexist and unhealthy notions of sex and relationships and that regular consumption of pornography, and particularly violent pornography, is a risk factor for boys' and young men's perpetration of sexual assault (Flood and Hamilton, 2003).

In recent decades cultural norms surrounding reproduction and motherhood for Anglo-Australian women have shifted. There has been a decrease in fertility rates as well as a tendency to postpone having children (Maher and Saugeres, 2007; DoH, 2010a). Cultural norms surrounding attitudes to pregnancy and parenthood are not homogonous. Indigenous women, for instance, have a higher fertility rate when compared to non-Indigenous Australians, while teenage births are four times more common among Indigenous women (ABS, 2010). Research suggests that cultural norms such as motherhood being a respected life-course for young women, plays a part in these trends (Larkins et al, 2010).

6. Access to affordable culturally appropriate health services

People's ability to access affordable, culturally appropriate healthcare is a key determinant of sexual and reproductive health. Equitable access to health care, community involvement, participation and integration of services are increasingly being recognised as key principles of effective sexual and reproductive health care.[9]

Sexual and reproductive health services can be inaccessible due to cost, location, lack of awareness of available healthcare or because services are perceived to be culturally inappropriate. People of non-English speaking backgrounds experience a range of barriers to accessing sexual and reproductive health services (Rawson & Liamputtong, 2009). Numerous researchers emphasise the importance of interpreters as well as bilingual and culturally competent healthcare professionals (Dolman et al., 1996; Rawson & Liamputtong, 2009). Similarly, for people living with a disability physical access to health services including ramps, disability toilets and examination tables are an essential aspect of accessible service provision. Additional time and resources, including flexible, longer and multiple appointments, are also often needed (Horsley and Kavanagh, 2011). Another aspect of ensuring appropriate and accessible health care for people with a disability is having informed and competent staff who acknowledge the role of carers and family without diminishing the decision-making power of the client (Horsley and Kavanagh, 2011).

Health providers'[10] attitudes and practices impact on sexual and reproductive health outcomes, as practitioners play a central role in the quality of, and people's access to sexual and reproductive health services (WHO, 2010). More often than not service providers determine who is permitted to obtain health care and under what circumstances, thus placing them in a position to either enhance or subvert a person's right to health (WHO, 2010). One reason as to why service providers exercise such power is because of the sensitive and often taboo nature of sexual and reproductive health, which means that people accessing these services are often embarrassed, anxious and socially vulnerable (WHO, 2010). Another reason that service providers are so influential is because they are frequently deemed the most accurate source of sexual and reproductive health information. For people with low literacy or limited access to resources, service providers may be their only source of sexual and reproductive health information (WHO, 2010).

Practitioners can operate as service delivery 'gatekeepers', in part due to the discretionary power they have to determine how policies and guidelines are implemented (WHO, 2010). For example, in Victoria general practitioners (GP) who have a conscientious objection to

[9] Comprehensive Primary Health Care is an emerging model that holds considerable promise in improving the sexual and reproductive health of local communities (SACHRU, 2009).

[10] The term health provider refers to general practitioners, nurses, midwives, community-based distributors, pharmacists.

abortion must inform their client of this and refer her to another health practitioner. However, there is no penalty for GP's non-compliance.[11]

In recent years, service provision has moved towards redressing health inequities through more targeted activities with population groups that are most at risk of sexual and reproductive morbidity. For instance, young people experience an array of barriers to accessing sexual health services. Research has highlighted the need for healthcare professionals to be trained in adolescent health and in effective communication strategies to engage with young people.

[11] Although there is no penalty for non-compliance with the requirement to inform and refer women to another practitioner under Section 8 of the Abortion Law Reform Act 2008, health practitioners who fail to follow these guidelines may be liable for charges of professional misconduct by their registering authority.

Conclusion

This report provides an analysis of the social determinants of sexual and reproductive health and describes the complex way in which they influence and exacerbate health inequities. Clinical services that offer screening, testing and treatment are integral to decreasing rates of sexual and reproductive health morbidity. However, a focus on social determinants is necessary to tackle persistent and widening sexual and reproductive health inequities, and most importantly, to prevent sexual and reproductive ill health before it occurs. Indeed, the Commission on Social Determinants of Health maintains 'tackling the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life in which people are born, grow, live, work and age' (WHO, 2008) is the essential principle for action.

The *Western Region Sexual and Reproductive Health Promotion Framework* provides an overarching conceptual guide for use in health promotion planning. Together with the analysis provided in this report and the findings from a 2010 regional mapping and needs analysis, the framework will guide the development of a regional primary prevention action plan. The regional action plan will be strategic, rather than aiming to operationalise the entire framework. The plan will be evidence-based and select a series of entry points such as sector and workforce development, policy advocacy, research, monitoring and evaluation and community engagement.

The forthcoming action plan will be designed to redress sexual and reproductive health inequities in Melbourne's western region using an integrated and coordinated approach. The need for a regional approach to sexual and reproductive health is informed by the recognition that an integrated approach to health promotion practice is essential to optimise the health and wellbeing of disadvantaged communities living in Melbourne's west.

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