The health inequities of sexual and reproductive health: A review of the literature
A review for the Action for Equity partnership 2016
Women’s Health West acknowledge the traditional custodians of the land on which we work, the people of the Kulin Nation, and we pay our respects to Elders and community members past and present. We express solidarity with the ongoing struggle for land rights, self-determination, sovereignty and the recognition of past injustices. We express our hope for reconciliation and justice.

Published by: Women’s Health West

Authors: Dr Melissa Graham, Dr Hayley McKenzie and Ms Greer Lamaro Haintz from the Centre for Health through Action on Social Exclusion (CHASE) School of Health and Social Development, Deakin University.

We would also like to thank Megan Bugden for her valuable contribution. Megan conducted the extensive search strategy, screening of documents for inclusion and setting up the Endnote database to manage all of the documents included in this literature review.

Author of the report’s background: Elly Taylor

Editors: Elly Taylor and Karin Holzknecht

Women’s Health West would like to acknowledge the Helen Macpherson Smith Trust who commissioned this report on behalf of the Action for Equity Partnership.

© Women’s Health West 2016


www.whwest.org.au

Women’s Health West acknowledge the support of the state government.
# Contents

- Background ........................................................................................................................................... 2
- Executive summary .............................................................................................................................. 3
- Introduction ........................................................................................................................................... 4
  - Defining health inequity ................................................................................................................... 4
  - Defining sexual and reproductive health ...................................................................................... 5
- Methods ................................................................................................................................................ 7
  - Socioeconomic, political and cultural context ....................................................................................... 9
    - Gender norms .................................................................................................................................. 9
    - Cultural and societal norms and values ....................................................................................... 10
    - Violence, discrimination and stigma ........................................................................................... 11
    - Public policy and law reform ...................................................................................................... 14
    - Socio-economic status ............................................................................................................... 17
      - Access to culturally appropriate, accessible healthcare and services ........................................ 18
  - Daily living conditions ......................................................................................................................... 20
    - Work and employment .................................................................................................................. 20
    - Education .................................................................................................................................... 20
    - Healthcare service provision and delivery .................................................................................. 21
    - Experiences of parenting ............................................................................................................ 26
  - Individual health-related factors .......................................................................................................... 27
    - Knowledge .................................................................................................................................. 27
    - Attitudes ..................................................................................................................................... 29
    - Behaviours ................................................................................................................................... 31
  - Differences in health and wellbeing outcomes .................................................................................... 35
    - General health and wellbeing status ............................................................................................ 35
    - Intimate partner violence, coercion and discrimination .................................................................. 38
- Conclusion and recommendations ........................................................................................................... 40
- References .............................................................................................................................................. 45
Background

Sexual and reproductive health, like other areas of health, is influenced by a complex interplay of biological, physical and social determinants. In Victoria, the burden of disease associated with sexual and reproductive health continues to rise (Department of Health, 2015). The burden of disease is not equally distributed among Victorians. Rather, different population groups are disproportionately impacted by health inequities, which are associated with differences in education, income, employment status, and other socio-economic, political and cultural factors (VicHealth, 2014). Health inequities are observed among different population groups in rates of death and disease, health behaviours, health risk factors and health service access and utilisation (VicHealth, 2014).

It is now widely recognised that health inequities are largely determined by factors outside of the health system and are driven by people’s access to social, economic and cultural resources and opportunities (Public Health Association, 2001). These factors intersect across macro political and economic structures and policies, living and working conditions, at a community level and via individual lifestyle factors (VicHealth, 2014; Public Health Association, 2001). Action on health inequities is essential as such differences are unjust and remain beyond the control of the individual. Indeed, poor health associated with social inequity is avoidable and amendable. If action is taken to redress health inequities, there will be a notable reduction in the burden of morbidity and mortality, which will have a significant impact on decreasing the health and social costs associated with poor sexual and reproductive health.

In recent years, work has begun to better understand the key influences of health inequities. The World Health Organization (WHO), VicHealth and other health institutions have investigated the burden of disease associated with health inequities; the cost of health inequities on society, families and individuals; and the effect of health inequities on specific population groups. Work is also being done to better understand the key influences of health inequities on specific health topics, such as tobacco and physical activity. However, for many health topics, such as sexual and reproductive health, this evidence base is yet to be rigorously investigated.

Since 2009, Women’s Health West, the regional women’s health service for Melbourne’s west, has led a regional sexual and reproductive health promotion action plan and partnership known as Action for Equity. In 2009, the Action for Equity partnership undertook a service mapping and needs assessment to determine the sexual and reproductive health needs of communities in Melbourne’s west. During this phase, 23 agencies contributed to an exercise to map health promotion programs and clinical services provision across the region. The partnership subsequently held a regional forum and produced the Mapping and needs analysis: Sexual and reproductive health in the HealthWest catchment, 2010 report.

In 2010, Women’s Health West conducted a literature review and analysis on the social conditions that drive sexual and reproductive health and wellbeing, with the aim to inform regional practice. The Social determinants of sexual and reproductive health, 2011 report builds on the work of the WHO and makes a case for six social determinants of sexual and reproductive health that Victorian organisations and practitioners must redress and integrate into their practice to achieve sustainable and equitable health outcomes. This report informed the development of the sexual and reproductive health promotion framework, which comprises five layers of influence and recognises that factors that contribute to sexual and reproductive health lie at multiple and interacting levels (see page 46).

This framework is the overarching conceptual guide for health promotion action outlined in Action for Equity: A sexual and reproductive health plan for Melbourne’s west 2013-2017. This health promotion plan incorporates primary prevention initiatives that work to redress the social determinants of sexual and reproductive health in order to achieve health equity. The plan has seventeen formal partners who work toward objectives and strategies across a range of settings and sectors to generate and maintain the social and cultural change needed to achieve optimal sexual and reproductive health in Melbourne’s western region.

On behalf of the Action for Equity partnership, Women’s Health West successfully gained a social impact grant from the Helen Macpherson Smith Trust in 2014. The three-year grant, which will support Action for Equity work, includes a project dedicated to undertaking a literature review of the social determinants of sexual and reproductive health inequities. This research, undertaken by Deakin University, is an international first and will support evidence-based practice in Melbourne’s western region and throughout Victoria and Australia.
Executive summary

Sexual and reproductive health are conceptually interlinked and enabled, affected and influenced by a multiplicity of circumstances, from the micro through to macro level environment. This literature review examined the effect of sexual and reproductive health inequities, focusing on population groups who are disproportionately impacted by poor health outcomes.

The review is divided into four sections and is structured to reflect ‘Fair Foundations: The VicHealth framework for health equity’ (VicHealth, 2015). Three layers of influence are examined (socio-economic, political and cultural context; daily living conditions; and individual health-related factors), culminating in differences in health and wellbeing (VicHealth, 2015).

Examination of the research literature at the macro layer identified key socio-economic, political and cultural contexts that influence sexual and reproductive health inequities: gender norms; cultural and societal norms and values; violence, discrimination and stigma; public policy and law; socio-economic status; and access to culturally appropriate, accessible healthcare and services.

The mid-stream level of influence considers one’s daily living conditions and experiences. The literature identified healthcare services, work and employment, education, and the experiences of parenting as daily conditions and experiences that create sexual and reproductive health inequities with negative consequences for health and wellbeing.

At the micro level, sexual and reproductive health inequities were identified in relation to knowledge, attitudes and behaviours. In particular, the research highlighted how individual health-related factors, knowledge, attitudes and behaviours are influenced by social and cultural beliefs, as well as by gender norms and gender power imbalance.

The sexual and reproductive health inequities identified across and within the three layers of influence culminated in differences in health and wellbeing outcomes. Notably, the review of the literature highlighted the multiple intersectionalities experienced by some population groups, creating additional layers of influence and implications for sexual and reproductive health equity and differences in health and wellbeing outcomes. Furthermore, the role of socio-cultural beliefs and norms, and in particular ascribed gender roles, contributed to sexual and reproductive health inequities and could be seen across and within the layers of influence.

However, for some population groups, including people who use and misuse drugs and alcohol, sex workers, people with a disability, prison populations, mid-life and older adults, and those who identify as exclusively heterosexual, there is little or no research available in relation to sexual and reproductive health inequities. Additionally, much of the available evidence focused on the disease and functional aspects of sexual and reproductive health, thus failing to account for the scope of sexual and reproductive health as defined by the WHO.

Recommendations for further research are provided to redress the current gaps identified in the evidence base. Importantly, it is recommended that future research is cognisant of socio-economic, social, cultural, political and geographical differences between and within population groups across the breadth of sexual and reproductive health and the life course.

Women’s Health West’s ‘Sexual and reproductive health promotion framework’ (Taylor, 2011; Taylor & Vu, 2013) is congruent with ‘Fair Foundations: The VicHealth framework for health equity’ (VicHealth, 2015). At the conclusion of this report, recommendations for action are presented according to the layers of the sexual and reproductive health promotion framework: social and behavioural determinants of health; population target groups; health promotion action; and settings for action.
Introduction

The purpose of this literature review is to examine the effect of sexual and reproductive health inequities on specific population groups who are disproportionately impacted by poor health outcomes, in order to provide recommendations to redress poor sexual and reproductive health.

Defining health inequity

Health inequalities are consistently defined as observable or measurable differences in health status between and among individuals, subgroups of a population, and groups occupying unequal positions in society (CSDH, 2008; WHO, 2015b). Sub-groups in a population can be defined by demographic, geographical or socio-economic factors such as age, economic status, education, sex and place of residence (WHO, 2015b).

Health inequity is the term used to define health inequalities that are socially produced, avoidable, unfair and systematic in their unequal distribution across the population (VicHealth, 2015; WHO, 2015b). These inequities have significant social and economic costs for both individuals and societies (WHO, 2011). The social determinants of health are known as the conditions in which people are born, grow, live, work and play that influence health (CSDH, 2008; WHO, 2012). When social conditions, and the structural processes that distribute these conditions, are unequal within a society, health inequities arise (CSDH, 2008; Newman et al., 2015; WHO, 2012).

VicHealth has developed a conceptual and planning tool to guide action on the social determinants of health inequities in order to promote fairness and opportunities for better health (VicHealth, 2015). Based on the conceptual framework developed by the WHO Commission on the Social Determinants of Health (Solar & Irwin, 2010), ‘Fair Foundations: The VicHealth framework for health equity’ depicts the social determinants of health inequities as layers of influence and entry points for action that aim to assist with health promotion planning (VicHealth, 2015). These range from macro (upstream, social, cultural, political and environmental influences on health) to micro (downstream, individual level influences). The social determinants of health inequities are depicted as three layers that result in differences in health and wellbeing outcomes:

1. Socioeconomic, political and cultural context
2. Daily living conditions
3. Individual health-related factors

Within these layers, the process of social stratification — that is, when individuals are assigned different positions within a social hierarchy — occurs (VicHealth, 2015). Social stratification results in unequal distributions of power, money, resources and, as such, differential exposures and vulnerability to health-damaging conditions (Solar & Irwin, 2010). At each layer, social stratification interacts with each concept to create health inequities (Newman et al., 2015; Solar & Irwin, 2010; VicHealth, 2015).

To adequately review research and evidence-based health promotion practices in relation to the social determinants of sexual and reproductive health inequities in Australia, this framework has been adopted to guide this literature review.
Defining sexual and reproductive health

Sexual health is increasingly recognised as an essential component of an individual or family's physical and emotional health and wellbeing (WHO, 2010a). Definitions of sexual health vary from basic general health-related definitions to broad human-rights-based definitions. However, it is commonly understood that sexual health relates to the rights of all people (from all sexual orientations and backgrounds) to have the knowledge and opportunity to pursue safe, pleasurable sexual lives, free of violence and coercion (WHO, 2010a). Sexual health is a broad concept encompassing various components, including:

- Sexual and gender identity
- Relationships
- Sexual expression
- The right to pleasurable and safe sex experiences, free from coercion, violence and discrimination (WHO, 2010a; WHO, 2015a)
- Negative consequences and conditions (WHO, 2010a) such as:
  - Sexually transmitted infections (STIs) and blood-borne viral infections (BBVIs), including human immunodeficiency virus (HIV)
  - Reproductive tract infections and outcomes associated with these health issues
  - Unintended and unwanted pregnancy and termination
  - Sexual dysfunction
  - Sexual violence, including violence related to a person's sexuality
  - Harmful practices such as female genital mutilation or cutting, as it is otherwise known (FGM/C) (WHO, 2010a).

The most current working definition of 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, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2006 updated 2010, p. 5).

Sexuality is a key component that underlies and influences behaviours and outcomes that impact sexual health. The WHO suggests sexual health cannot be defined, understood or made operational without considering sexuality (WHO, 2015a), which is defined as:

...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 updated 2010, p. 5).

Similar to definitions of sexual health, reproductive health has long been defined by the WHO as:

...a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO, 2006 updated 2010, p. 4).

Inherent in this definition is the right for women and men to be informed of, and able to access, safe, effective, affordable and acceptable methods of fertility regulation of their choosing and the right to access appropriate healthcare services to enable women to safely progress through pregnancy and childbirth in order to have healthy children (WHO, 2006 updated 2010).
Although sexual health is closely related to reproductive health, it has recently been argued that sexual health encompasses more than reproductive health alone, and underpins it as necessary for the achievement of reproductive health (WHO, 2015a). Components of reproductive health include:

- Reproductive processes, functions and system at all stages of life
- The capability to reproduce, which includes the freedom to decide if, when and how often to reproduce
- The right to be informed of, and able to access, safe methods of fertility regulation and appropriate healthcare services to enable women to safely progress through pregnancy and childbirth

Human rights are integral components for both sexual and reproductive health. In particular, the WHO emphasises the importance of respect for human rights in order to achieve and maintain sexual and reproductive health (WHO, 2015a). Sexual rights aim to protect an individual’s right to fulfil and express their sexuality and enjoy sexual health (WHO, 2006 updated 2010). A working definition of sexual rights is provided below. This definition is not an official WHO definition. However, the key human rights outlined below offer a strong contribution to evolving understandings of sexual health and include the right to:

- Life, liberty, autonomy and security of the person
- Equality and non-discrimination
- Be free from torture or to cruel, inhumane or degrading treatment or punishment
- Privacy
- The highest attainable standard of health that includes sexual health and social security
- Marry and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- Decide the number and spacing of one’s children
- Information and education
- Freedom of opinion and expression

Reproductive rights pertain to the basic rights of all couples and individuals to:

- Freely and responsibly decide the number, spacing and timing of their children (WHO, 2010a)
- Access good quality information to make reproductive decisions
- Achieve the highest sexual and reproductive health possible, including the right to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents (WHO, 2006 updated 2010).

To achieve reproductive health, the WHO (2010a) states that people need to exercise control over their sexual health and achieve healthy sexuality. As such, sexual and reproductive health are conceptually interlinked (WHO, 2010a). However, inequities exist for individuals and populations in attaining and realising sexual and reproductive rights, including inequities based on gender norms and gender inequality. Gender inequality, based on traditional societal gender norms and expectations that privilege men’s power, can have harmful and negative impacts on women’s sexual and reproductive health and rights (International Planned Parenthood Federation, 2015; MacPherson et al., 2014). The WHO emphasises the importance of understanding the key roles discrimination and inequality play in an individual’s ability to attain and maintain their sexual health (WHO, 2015a). The WHO explains that the ability of women and men to achieve sexual health and wellbeing can depend on a number of factors relating to: their access to comprehensive, good-quality information about sex and sexuality; knowledge about the risks they face and their vulnerability to the adverse consequences of sexual activity; their access to sexual healthcare; and an environment that affirms and promotes sexual and reproductive health (WHO, 2010a; WHO, 2015a).
Methods

A systematic search of Australian academic research and health promotion interventions was conducted. International evidence was also drawn upon. The following databases were searched through EBSCOhost, a platform that houses multiple databases:

- Academic Search Complete
- AgeLine
- CINAHL Complete
- eBook Collection
- Global Health
- Health Policy Reference Center
- Health Source: Nursing/Academic Edition
- LGBT life with Full Text
- MEDLINE Complete
- SocINDEX with Full Text.

Evidence published in English between 2005 and 2015 was included. Academic evidence not relevant to the Australian context or published prior to 2005 was excluded.

Concepts of sexual health (such as sexual rights, STIs, HIV/AIDS and sexuality), reproductive health (including termination, maternal health, pregnancy, postnatal and family planning), health inequity, economic position, resource or service utilisation, health and wellbeing, mother, gender or sex, childlessness, education, employment, violence, discrimination, pornography, health promotion, health literacy, sex education, determinants of health, policy, social, cultural, economic, political, age, life course and sexual orientation were searched.

Searches were specific to the following population groups: Aboriginal and Torres Strait Islander people, refugee, asylum seeker, culturally and linguistically diverse (CALD), people with a disability, prisoners, drug users, young people (defined as 12 to 24 years as per the Australian Institute of Health and Welfare age range), gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) and sex workers.

The search strategy was conducted in phases:

1. Each concept was searched individually. This resulted in a combined total of 1,226,465 journal articles
2. Each concept was searched in combination with each of the population groups separately. This resulted in a combined total of 397,068 journal articles
3. Each individual concept and population group was run in combination with the concept of ‘research methods’. This resulted in a combined total of 298,228 journal articles
4. Each concept, each population group and ‘research methods’ was run in combination with the concept of ‘health inequity’. This resulted in a combined total of 5,520 journal articles.

Abstract analysis of these 5,520 articles was undertaken. Those that did not meet the inclusion criteria (n = 5,289) were excluded. The remaining 231 articles were then categorised into four groups that represent the layers of influence in ‘Fair Foundations: The VicHealth framework for health equity framework’ (socio-economic, political and cultural context; daily living conditions; individual health-related factors; and difference in health and wellbeing outcomes) and subjected to full review (VicHealth, 2015).
In addition, the Cochrane library, Google Scholar and Google advanced searches were conducted. Grey literature was searched using Google advanced site: gov.au and site: org. This enabled search output from government agencies and other organisations. The concepts of health inequity, sexual health and reproductive health were combined. A total of 167 website results were found for .org, while 30 websites were found through gov.au. The following websites were searched:


From these websites, 22 documents were retrieved. These articles were then categorised into four groups, representing the layers of influence as per ‘Fair Foundations: The VicHealth framework for health equity framework’ (VicHealth, 2015).

After reviewing and identifying gaps from the conducted search strategy, a series of final searches were conducted for information from countries that are contextually similar to Australia, such as the United Kingdom, the United States of America and New Zealand. The following population groups were also searched in combination with the concept of sexual and reproductive health inequities: women and girls, pornography and raunch culture, prison populations, and people living with a disability. As a result of these searches, an additional 21 articles and 14 documents were included in the literature review.

The 252 journal articles and 36 documents underwent full review in relation to the inclusion and exclusion criteria. As a result, 122 articles and documents were excluded, resulting in a total of 166 articles and documents included in the final review and documented in this literature review.
Socioeconomic, political and cultural context

The literature on sexual and reproductive health inequalities can be explored across multiple levels, ranging from macro to micro influences. Analysis of the literature at the macro layer identified six key themes: gender norms; cultural and societal norms and values; violence, discrimination and stigma; public policy and law; socio-economic status; and access to culturally appropriate, accessible healthcare and services. These key themes are consistent with social determinants of sexual and reproductive health outlined by the WHO (2010b), as well as by Women’s Health West’s work to inform the Action for Equity framework that was modelled on the WHO, as relevant to the Victorian policy and practice context. Within these themes, research draws on different population groups and groups with varying social positions.

Gender norms

Gender norms is a term used to describe the socially constructed norms, roles and responsibilities and expectations that shape societal understanding of what it means to be a woman or a man within any given society (Women’s Health West, 2014). Inequities based on gender and gender-based norms were evident in the literature, including expectations based on gender identity, normative concepts of masculinity and femininity, and power imbalances between women and men (Trevor & Boddy, 2013). These inequities negatively influence sexual and reproductive health.

Sen and Östlin (2008) explored how gender acts as a social determinant of health that affects women and girls across the world. Gender norms and unequal power relations between women and men were acknowledged as a root cause of gender inequality and a significant social determinant of health that determines if an individual’s health needs are recognised, whether they have control over their lives and health, and whether their rights are realised. Gender inequality benefits men through power, resources, authority and control, yet Sen and Östlin explained these benefits also impact on the emotional and psychological health of men. They further explained that gender norms in health are based on values and attitudes regarding the relative importance of girls versus boys and women versus men. This highlights the need to take action on gender equity in health in order to redress health inequities overall and in particular to improve the health status of women and girls (Sen & Östlin, 2008).

Research has explored young people’s experiences of a range of sexual and reproductive health topics, including sexual and gender identity, in relation to their everyday interactions in school settings. Keddie (2009) undertook a longitudinal ethnographic case study to explore masculinity in schools. The study found schools could be places where prevailing heteronormative discourses of gender, power and sexuality privilege male heterosexuality over the detriment of female students. Dominant male power and perceptions of entitlement could contribute to negative experiences, such as sexual harassment, for female students. This had the potential to negatively impact on the female students’ social and emotional health and wellbeing as well as educational progress, with consequences including missing school to avoid harassment. Female students also discussed how many instances of harassment would go unreported because of negative ramifications such as intimidation by male peers, thus perpetuating the status-quo. The study is a single case study in one setting. However, Keddie stated the experiences of the female students are not unique or isolated to this setting, but rather provide further evidence of what she describes as a ‘serious and enduring problem’ of sexual harassment that ‘prevails despite decades of feminist educational reform and the long-term institution of sexual harassment policies in schools’ (2009, p. 13), which needs redressing.

Power imbalance among women and men is a common theme across the literature in relation to attitudes towards sexual and reproductive health, and these power imbalances are embedded and stem from cultural attitudes and beliefs. The attitudes of young Aboriginal women about decisions regarding sexual relationships and pregnancy in a remote Australian Aboriginal community were explored in an ethnographic study. The study found the town was marked by power differentials, with women expected to be submissive and subservient, which was even more so the case for younger adult women (Senior & Chenhall, 2008). This research demonstrates the influence gender-based inequalities in power and attitudes about gender have on women's sexual identity and the way they express their sexuality. Similarly, a qualitative study with Sudanese and Eritrean women found the relationship dynamics between women and men presented challenges to acquiring knowledge and healthcare in relation to topics such the use of contraceptives and the ability to negotiate safe sex (Rogers and Earnest, 2015). This led to women believing health education needs to be provided separately to women and men. These examples from the literature demonstrate the implications of gender-based inequalities in power and the negative impact on the sexual and reproductive health of women and girls.

Qualitative research also explored masculinity and the representation of masculine traits specific to gender norms with a sample of 63 men aged 19 to 100 years of various classes and socio-economic backgrounds, to explore their perceptions of ‘acceptable’ masculinity (McCann et al., 2010). This research found homophobic humour emerged as central to the formation of Australian male identity and masculinity, which highlights the policing and scrutiny of non-conformity to gender norms, with humour used as a means to control and humiliate men who do not comply. The men in this study stated...
Socioeconomic, political and cultural context

Research has explored traditional gender norms and challenges to these norms, with a focus on transgender people. A literature review of transgender people and social work highlights the importance and need to generate a positive transgender discourse in Australian social work as a means of working with and advocating for individuals who have non-traditional gender identities. In particular, the review highlighted the minority status of transgender people, where their views are largely absent from the literature, and the need for an approach to practice that is responsive to gender diversity (Trevor & Boddy, 2013).

Cultural and societal norms and values

The impact that dominant cultural and societal norms and values have on health inequities is represented in the VicHealth framework. These dominant norms and values provide the context in which policies are developed and implemented (VicHealth, 2015). In addition, cultural and societal norms give rise to social stratification based on sexuality, gender, disability, race or ethnicity (VicHealth, 2015). This results in the unequal distribution of power, money, resources and, as such, differential exposure and vulnerability to poor health outcomes (Solar & Irwin, 2010).

Research focusing on women (Bishop, 2012; Caxaj & Berman, 2010) and men (McCann et al., 2010) has explored how sexuality is presented and represented, experienced and managed. It has also explored the gender differences that exist (Bishop, 2012), the impact the contemporary ‘hypersexualised’ landscape has on women and girls, geographic location (Bishop, 2012), migration (Caxaj & Berman, 2010) and the concept of the ‘traditional family’ (Correia & Broderick, 2009; Short, 2007).

Australian (Bishop, 2012) and international (Caxaj & Berman, 2010) qualitative research has explored how young women manage cultural and societal norms about their sexual experiences. Bishop (2012) examined representations of youth sexuality and how young people interpreted their sexual experiences, with the aim of exploring how young women chose to discuss and represent their sexual experiences. The sample consisted of 31 young adults aged 18 to 26 years from Tasmania. All had spent their childhood and adolescence in a rural area, yet most now resided in one of three Tasmanian cities. Caxaj and Berman's (2010) discourse analysis of 25 purposively selected written online texts (blogs and electronic forums) and pre-existing transcripts from the United States, United Kingdom and Australia, explored the socio-political context of belonging to a migrant community and the impacts on their health and wellbeing.

In both studies, women felt their reputations could be impaired based on others’ perceptions of and/or their actual sexual experiences, requiring these reputations to be managed (Bishop, 2012; Caxaj & Berman, 2010). Bishop (2012) found the women presented one or more of four overlapping narratives: idealist, prudent, hedonist and transcending adversity, based on how the women spoke of their experiences and practices of sex in light of relationships, rural upbringing, norms and gender differences. For the women in this study, overtly sexual behaviour and casual sex had not become normalised. Rather, the majority of the women downplayed their casual sexual practices due to cultural and societal norms, whereby the women were aware of the ease of being negatively labelled if their sexual encounters were publicised, which would have been met with disapproval by others and caused them to feel shame (Bishop, 2012). A similar finding was evident in Caxaj and Berman’s (2010) study, with migrant women who identified overwhelming amounts of surveillance from family and community members in relation to their sexual practices. Many voiced concerns and fears for their reputation due to the pervasive rumours within their neighbourhoods and communities. For the women in this study, the scrutiny they experienced was permitted and endorsed by gender norms within their culture. The women in Bishop’s (2012) study also highlighted the gender differences that relate to how women were perceived and their need to negotiate and present themselves differently due to cultural and gender norms relating to the behaviours of women and men.

In light of recent increases in the availability of violent and sexist mainstream pornography, Walker and colleagues (2015) conducted 33 in-depth interviews with young people aged 15 to 20, to explore their views on the nature, origins and effects of sexting. Their findings highlighted an important link between sexting and pornography, with pornography viewing a factor influencing sexting. This research further revealed a link between pornography exposure, young men's sexual expectations and pressure on young women to conform to what is being viewed. Young people expressed growing concern for gendered norms that continue to reinforce men's power and the subordination of women. This research could not prove pornography causes men's violence against women. However, it suggested that pornography use has the potential to become a mediator of young people’s sexual understanding and experiences. Therefore pornography that involves sexual aggression and violence towards women reinforces a sexual script that promotes gender inequality and men's subordination over women, rather than promoting women's equality, agency and pleasure. It has been posited that raunch culture and
the hyper-sexualisation of girls and women creates a burden of expectation with potentially negative sexual and reproductive health consequences; however, to date there is no research evidence of such contributions to sexual and reproductive health inequities. For a discussion of raunch culture and hyper-sexualisation, see studies by Bishop (2012) and Jackson and Goddard (2015).

Investigating the sexual health of young Muslim women who have immigrated to Australia, Wray and colleagues (2014) conducted in-depth interviews with ten women aged 18 to 25. Findings revealed sexuality was constructed in terms of ‘purity versus corruption’. Similar to Caxaj and Berman’s (2010) study, young women’s cultural communities were identified as regulating sexual experiences and knowledge in an effort to maintain ‘purity’. Maintaining sexual ignorance (for example by avoiding gaining any knowledge of sex or sexual health) and avoiding sexual expression (for example, regulating sexual desires through positioning these desires as sinful due to their cultural teaching) were mechanisms the young women utilised to position themselves as ‘pure’. These findings demonstrated that participants’ avoidance of sexuality is associated with a limited knowledge of their own bodies, which can lead to misinformed sexual health choices and a limited understanding of safe sexual practices. In addition, poor sexual health knowledge is most strongly influenced by community regulations and a woman’s self-policing, rather than an inability to attain information within the Australian education and healthcare systems (Wray et al., 2014).

Cultural attitudes and beliefs also have implications for access to sexual and reproductive health information and services. A qualitative study with 42 Assyrian and Karen women, who had arrived in Australia as refugees, examined the constructions and experiences of sexual and reproductive health and associated services. The study found the cultural prohibition of heterosexual sex before marriage and the taboo of same-sex relationships had implications for unmarried women’s access to sexual health services, including contraception, cervical screening, and termination of pregnancy. Additionally, these cultural attitudes resulted in a ban on sex education, as well as talking about sex, and failed to acknowledge or recognise non-heterosexual identities (Ussher et al., 2012). Furthermore, sex and motherhood were seen as ‘mandatory within marriage’. These cultural beliefs lead to women’s inability to refuse marital sex and is compounded by limited knowledge about contraception and sexual pain. Given the importance placed on mothering and the possibility that a husband would leave if his wife could not have children, Karen and Assyrian women had knowledge about, and acceptance of, assisted reproductive technologies (ART). This research further found that the high value placed on motherhood resulted in a lack of recognition of postnatal depression (Ussher et al., 2012). A qualitative study with 51 immigrant Iranian women found pregnancy, contraception, menstrual problems and menopause were of concern. However, sexual violence, sexual orientation, sexual difficulties or dissatisfaction were not mentioned (Merghaty Khoei & Richters, 2008). Together, these findings indicate that, for some cultural groups, sexual and reproductive health is confined to reproductive function. Furthermore, there is a belief among many communities that sexual health is not for public discussion (Merghaty Khoei & Richters, 2008).

The presence of the ‘traditional family’ in reproduction has been identified within the available research (Correia & Broderick, 2009; Short, 2007). This included discourses about the role and presence of fathers, whereby there has been a resurgence of patriarchal values, including the position and presence of a father, which highlights the impact of ‘biologism’ rather than social relationships. There is the dominant blueprint of a family — a partnered heterosexual mother and father. For lesbian mothers in a study by Short (2007), this meant there were times and places when their families or relationships were not recognised or permitted. Research exploring access to medically assisted reproductive technology (MART), regardless of marital status, also highlighted the persistence of the ‘traditional’ family norm (Correia & Broderick, 2009). Analysis of letters to the editor identified the common belief that access to MART should be restricted to the ‘traditional’ family structure of a mother, father and children. This family structure was seen as ‘natural’ and ‘good’, whereby the role of the father is unique and irreplaceable, which highlights the importance of the father making essential and unique biological and social contributions to a child’s development. Family types that do not meet this composition are not considered eligible for MART or broadly accepted within Australian social and cultural norms relative to family and parenthood.

Violence, discrimination and stigma

The WHO (2010b) describes violence against women and discrimination as important social determinants of sexual and reproductive health, given the association these have with short- and long-term health outcomes.

There has been substantial research investigating men’s violence against women. However, there is a dearth of research that explores violence against women and sexual and reproductive health inequities. The United Nations Development Fund for Women (UNIFEM) (2010) posit that violence against women has deep roots in discrimination and inequality between women and men, and its eradication requires the empowerment of women and gender equality, particularly through education, reproductive health rights and economic and political empowerment. By compiling international data from the WHO, the International Violence Against Women Survey, Demographic and Health Surveys (DHS) and the World
Socioeconomic, political and cultural context

Reports that focus on violence against women ascribe particular importance to promoting gender equity in order to prevent men’s violence against women and promote equal and respectful relationships between women and men (VicHealth, 2007). From a socio-economic-political stand point, action needs to focus on societal factors relating to culture, values and belief that shape community, organisational, individual and relationship factors that combine to influence violence against women. Cultural foundations are an important point of action because it is in these beliefs about the perpetration of violence against women are justified, excused, trivialised, minimised and where blame can be shifted to women (VicHealth, 2014).

Our Watch (2015b) similarly defined gender inequality as a cause of violence against women. Our Watch noted the complexities of gender inequality in public and private life explaining that gender inequalities operate in a multitude of ways. A number of factors interact with gender inequalities to reinforce violence against women, and forms of social, political and historical discrimination and disadvantage intersect with drivers that reinforce violence against women (Our Watch et al., 2015a). To act on gendered drivers of violence against women, an intersectoral approach must be taken, whereby the significance of sexism, misogyny and gendered relations of power must be highlighted as drivers of violence against women (Our Watch et al., 2015b).

Quantitative research conducted by Miller and colleagues (2010) explored young women’s experiences of reproductive control by men, finding pregnancy coercion and pregnancy sabotage (that is, birth control sabotage) were commonly experienced by young women aged 16 to 29 (n = 1,278) using family planning clinics in the United States. In particular, young women experiencing intimate partner violence were at an increased risk of unintended pregnancy as a result of pregnancy coercion and/or pregnancy sabotage. This research demonstrated young women who experience intimate partner violence were seeking care at family planning and sexual health clinics, and as such, intervention programs should be provided in these clinics to reduce harm-related reproductive control and partner violence. In addition, the authors suggested clinicians should screen young women for pregnancy coercion and birth control sabotage by asking specifically about these experiences, and be prepared to connect women with violence-related support services (Miller et al., 2010).

Cultural norms leading to violence, discrimination and stigma have been examined, focusing on the experiences of lesbian mothers, gay men, gay fathers, pregnant women, migrant communities, and people with a disability. Short (2007) explored the discourses about the role and presence of fathers, biology and lesbian-parented families, and how women negotiated and engaged with these discourses. Given the resurgence of patriarchal values, including the position and presence of a father and ‘traditional’ families, lesbian families reported feelings of not meeting the traditional perceptions of ‘family’ still exist. This discrimination impacted their choice to participate in particular activities, with women reporting experiencing interactions or reading media comments that led to feeling ‘discounted’, ‘invisible’ and being the object of ‘scrutiny’ or ‘judgement’ (Short, 2007). As a result of the time and attention required to navigate these difficulties, women reported ‘tiredness’, ‘irritation’, ‘distress’ and ‘anger’. Similarly, research exploring the experiences of gay fathers found negative, discriminatory and conservative social attitudes presented a challenge in their day-to-day lives (Tuazon-McCheyne, 2010). The men in this study reported a perceived pressure to do well at everything to avoid criticism. Further, the men highlighted the unfounded social and cultural belief that paedophilia and homosexuality is somehow connected, which was a source of frustration for gay fathers.

The psychosocial wellbeing of gay men has been examined using a nationwide survey of 840 gay men aged 40 to 78 (Lyons et al., 2013). The study found approximately 32 per cent of gay men reported being unfairly treated in the past two years as a result of their sexual orientation, with the percentage of men reporting discrimination decreasing as age group increased. Only 43 per cent indicated they felt the general public felt positively toward them. A study by Aaron and Ragusa (2011) of gay men’s experiences in the workplace as public servants in Canberra found perceived and experienced invisibility for participants in their workplaces. Edwards and Cheers (2007) also discussed the invisibility experienced by same-sex attracted women in various aspects of daily life in rural South Australian communities.

Pregnant women have reported experiences of discrimination as a result of their past behaviour (Yelland et al., 2012). Women who reported three or more stressful life events or social health concerns had a two-fold increase in adjusted odds of perceived discrimination compared to those who reported none (41.1 per cent versus 20.4 per cent). Young women (defined as 25 years and under) and those
who smoked during pregnancy were also at increased risk of experiencing perceived discrimination (Yelland et al., 2012).

Discrimination, harassment and social stigma is also experienced by women who wear the hijab, which is a symbol of religious and cultural difference, and an alternative to Western heteronormativity (Caxaj & Berman, 2010). Qualitative research has also explored the stigma experienced by migrant women, who had resettled in Australia and experienced pregnancy outside of marriage due to sexual violence or engagement in survival sex, or who had left a relationship due to family violence (Bartolomei et al., 2014).

There is a paucity of research that examines the sexual and reproductive health inequities of women living with a disability, and even less which considers the socio-cultural context of these women’s lives. Drawing on Australian and international research provided an overview of the sexual assault and victimisation, homophobia and gender-based discrimination for people with a disability, and highlighted the broader concerns relating to sexuality for people with a disability, specifically safety and freedom from sexual violence. Findings suggest that socio-structural disadvantage places people with a disability at greater risk of exposure to child sexual abuse and adult sexual assault (Higgins, 2010).

Research has also focused on the discrimination and stigma people experience when they challenge cultural and societal norms. This included a focus on health outcomes that include HIV (Fielden et al., 2011; Jeffreys et al., 2010), herpes simplex virus (HSV) (Shearer et al., 2012) and BBVs (Hien Thi & Maher, 2008); associations with policy, practice and services (Short, 2007, Yelland et al., 2012); and different population groups including lesbian mothers (Short, 2007), pregnant women (Yelland et al., 2012), communities that have immigrated (Guerin et al., 2006), and people with a disability (Higgins, 2010).

Qualitative research explored the experiences of discrimination and stigma for people with HIV and BBVIs (Fielden et al., 2011; Hien Thi & Maher, 2008; Jeffreys et al., 2010). For example, HIV experiences have been explored through a needs assessment and interviews conducted with sex workers living with HIV in Australia, with a sample of 13 participants, of which nine were from capital cities, and four from outside capital cities (Jeffreys et al., 2010). HIV stigma and its management for young women living with HIV has been explored via interviews with professional adolescent service providers from Australia, Canada, the United Kingdom and the United States (Fielden et al., 2011). The influence of cultural beliefs and practices on the risk of BBVIs among ethnic Vietnamese injecting drug users has also been explored, using observational fieldwork and in-depth interviews (n = 58) to identify barriers to accessing health and preventive programs (Hien Thi & Maher, 2008). This body of research provides evidence of the discrimination and stigmatisation of people living with HIV and BBVIs by the community and healthcare providers (Cama et al., 2015; Fielden et al., 2011; Hien Thi and Maher, 2008; Jeffreys et al., 2010).

Qualitative research that explored chlamydia found the perceived barrier to patients disclosing their STI status to their partners was stigma (Pavlin et al., 2010). Stigma and discrimination was also reported as a barrier to accessing services for those with BBVIs (Hien Thi & Maher, 2008). Research has explored how stigma impedes HIV positive young people from disclosing their status, and creates isolation and fear among them and their families. To manage stigma, safe spaces need to be created where young people are able to discuss HIV (Fielden et al., 2011). Fielden and colleagues (2011) suggested that by integrating HIV-positive young people with peers who have various conditions, providers can create a normalising environment where symbols of stigma can be erased, allowing no one condition to be singled out. Research has also found that sex workers living with HIV experience discrimination from within their community, are criminalised for sex work, are subject to disclosure laws in some states and territories, and face stigma perpetrated by the media (Jeffreys et al., 2010). This research highlighted the levels of institutionalised marginalisation and stigmatisation that sex workers experience. Jeffreys and colleagues (2010) suggested that the criminalisation of sex work, of people living with HIV and of sex workers living with HIV is at the centre of this discrimination and needs to be challenged.

Quantitative research has also explored the frequency and patterns of discrimination and harassment of women in the workplace, specific to those reported to the Queensland Working Women’s Service between 2001 and 2004 (McDonald & Dear, 2008). The Queensland Working Women’s Service is a community-based organisation specialising in advice, assistance and advocacy for working women. The sample for the research included 9,015 cases, with the majority of women seeking assistance aged between 25 and 44.

Findings of this research include:

- 5,000 women reporting workplace harassment or bullying
- 1,243 reporting sexual harassment
- 1,447 reporting discrimination on the grounds of sex, pregnancy and family responsibilities.
Less frequently reported were racial discrimination (263 cases), discrimination based on age (337 cases) and disability discrimination (451 cases) (McDonald & Dear, 2008). Women aged 18 to 25 were more likely to report sexual harassment and pregnancy discrimination, and women over 45 were more likely to report age, disability and racial discrimination and workplace bullying. Women aged 25 to 44 were over-represented in cases of discrimination relating to family responsibilities, as consistent with their prime childbearing years. This research indicated that the discrimination women experience in the workplace changes across their lifespan (McDonald & Dear, 2008).

Public policy and law reform

Sexual and reproductive health behaviours are uniquely regulated by society through legislation relating to marriage, abortion, FGM/C sexual intercourse, education and access to sexual and reproductive health services without parental consent. Public policy and the law is a social determinant of health that plays a significant role in upholding or denying sexual and reproductive health (WHO, 2010b). Sexual and reproductive health inequalities have been explored in the literature specific to policy, including policy within the education sector, policy specific to sexual and reproductive health, and healthcare practices and services.

Education sector

Sexual and reproductive health policy was evident in education policies for students (Goldman, 2010; Goldman, 2013), and teachers, with research exploring the experiences of GLBTIQ teachers in the education system (Jones et al., 2014).

Goldman (2010) reviewed Queensland education documents to explore how sexual and reproductive health is included in the curriculum, compared to other states. This review found Queensland schools lacked concise information about what should be taught, lacked programme development and effective implementation for such teaching, and also lacked support for teachers and school communities. As a result, it is expected that many, if not most, Queensland school students do not engage in this vital area of learning throughout their schooling. The review of all states and territories found New South Wales and Victoria have curriculum documents ‘of exceptional quality’, clarity, and worth in their representation of sexuality education and reproductive health education. The new documents developed for Queensland sexual and reproductive health education were found to be more explicit, clear and comprehensive within the curriculum. However, the authors recommended further review of the Victorian and New South Wales models for elements of good practice to incorporate into the Queensland documents. More recently, Goldman (2013) reported on a review of Queensland primary school documents in terms of inclusion of sexual and reproductive health education, knowledge and teaching for junior school students aged five to eight years. It evaluated the sexuality educational framework for junior school students recommended by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) and compared it to the existing state-designed Health and Physical Education curriculum that includes sexual and reproductive health for the same cohort. The comparative results showed that the sampled curriculum was inadequate for the task of teaching puberty, sexuality and reproductive health and safety. The Queensland documents generally had a lower level of vocabulary, awareness, cognition and capability about sexuality topics, even though previous research has shown that children of this age are able to comprehend and reason about sexual and reproductive knowledge.

Mixed method research explored the experiences of GLBTIQ teachers in the education system (Jones et al., 2014) drawing on a policy review, a survey and interviews. The sample consisted of over sixty Australian law and education policy documents related directly or indirectly to GLBTIQ teachers. Sixty-three GLBTIQ teachers completed an online survey and nine interviews were conducted with teachers who identified as lesbian, gay, transgender and/or queer. The policy review uncovered a range of protections for GLBTIQ teachers. At the national level, there is no education policy protecting GLBTIQ teachers in support of the legislative protections. Victoria had the most policies specific to supporting GLBTIQ teachers, while Western Australia had a more modest policy protection for staff, banning discrimination on the basis of their sexual orientation and gender history. In New South Wales, discrimination complaints on the basis of homosexuality or transgender status were directed towards legal services and policy directly discouraged teachers from voicing their own opinion on controversial topics while teaching. South Australia had government policies that supported the diverse sexual orientations of staff, while Tasmania had three relevant indirect government education policies focusing on discrimination. In the Australian Capital Territory, there were three indirect policies; however, these focus more on promoting protection from harassment for all people in schools. Queensland and the Northern Territory had no specific direct or indirect state-wide level protections for GLBTIQ teachers in state schools. However, similar to New South Wales, the Northern Territory had a policy preventing teachers promoting their own political or personal views on matters considered controversial (Jones et al., 2014). Despite the existence of some policies, many of the teachers surveyed (42 per cent) were unaware if their school had a policy protecting GLBTIQ staff against discrimination on the basis of sexual orientation or gender diversity. Only 27 per cent indicated that their school had policy protection, even though over half were under state-level protection, which indicated that state policies are not promoted. The majority of schools did not support and allow staff to be ‘out’ as GLBTIQ (56 per cent),
Sexual health

Research exploring public policy has had a specific focus on sexual health, including a case study of child sexual abuse among Aboriginal children (as a result of a government report and responses), the policy context of different states in Australia for sex workers, and a review of policy specific to the sexual health of midlife and older adults.

Fawcett and Hanlon (2009) provided a discussion of a case study of the release of a 2007 report and government responses specific to child sexual abuse among Aboriginal children in the Northern Territory. The authors stated that the government strategy prioritised an invasive and non-participatory form of intervention, which was justified by the protection of Aboriginal children from sexual abuse. This paper argued that links between current and past government policies can still be made.

Research explored the delivery of health promotion services to sex workers in Perth, Melbourne and Sydney, to assess whether the law has an impact on the delivery of sexual services (Harcourt et al., 2010). These three cities had different prostitution laws: Melbourne brothels are legalised if licensed and criminalised if unlicensed; Perth criminalised all forms of sex work; and sex work in Sydney was largely decriminalised without licensing. The sample consisted of 10 to 12 key informants in each city who completed questionnaires (telephone survey) to represent samples of female sex workers in urban brothels. Key informants included community and outreach workers (including the managers and staff of health promotion programs), police officers, health workers, local government planners and social workers with access to sex workers or responsibility for regulating the sex industry. A survey was also undertaken with a representative sample of brothel-based sex workers while at work in each city to elicit information about their contact with a variety of authorities and health promotion programs. Despite the differing legislation, each state had a thriving and diverse sex industry and a government-funded sex worker health promotion program with shopfront, phone, online and outreach facilities. The research found the legal context did appear to impact the conduct of health promotion programs targeting the sex industry, with more Sydney workers reporting a sexual health centre as a source of safer sex training and information than other cities (Sydney's 52 per cent versus Melbourne's 33 per cent and Perth's 35 per cent). Bates and Berg (2014) also explored policy that impacts sex workers in Australia, and argued that the decriminalisation of sex work is the best practical legislative approach to preventing HIV and other STIs, while also further supporting the rights of sex workers. Lazarus and colleagues (2012) and Duff and colleagues (2015) called for broader policy and societal changes that recognise and acknowledge the legitimate occupational status of sex work to promote more accepting, inclusive and non-judgmental services and improve health equity for sex workers.

A scoping review of Australian federal, state and territory government health policy documents was undertaken to explore the inclusion of sexual health for midlife and older adults (Kirkman et al., 2013). The review found that the sexual health of midlife and older adults is not specifically referred to in the policy documents, whereby there is a focus on risk rather than wellbeing in terms of sexual health, and an emphasis on reproduction that excludes midlife and older adults.

Reproductive health

Research that focuses on policy has had a specific emphasis on reproductive health (including ART), pregnant women, pregnancy coercion, parents (including rights and legislation for gay men who have used surrogacy), and lesbian mothers.

The impact of the Australian policy change to ART in terms of different socio-economic status (SES) has been explored (Chambers et al., 2013). Aggregate annual data on the number of fresh in vitro fertilisation (IVF) cycles between 2007 and 2010 were obtained from a national dataset of all services for which Medicare benefits were paid. This research found women from higher SES quintiles used more ART treatments compared to those in lower quintiles, which reflects a greater ability to afford treatment and a greater need for ART treatment, as highlighted by the later child-bearing trend. In the 12 months after the introduction of the policy, where out-of-pocket costs increased from $1,500 to $2,500 for a fresh IVF cycle, there was a 21 to 25 per cent reduction in fresh ART cycles across all SES quintiles. Higher SES groups experienced an increasingly greater reduction in absolute numbers of fresh ART cycles due to the already higher levels of utilisation. This study highlighted that even in a country with supportive public funding for ART, socio-economic disparities in accessing treatments exist, and while financial factors are important, disparities in utilisation are also likely due, in part, to differences in childbearing patterns and treatment-seeking behaviour (Chambers et al., 2013).
Research has explored MART through a media analysis (Correia & Broderick, 2009). In 2000, the Federal Court of Australia allowed access to MART regardless of marital status; that is, access included single women and lesbians. This decision led to vigorous public debate, whereby this study analysed 180 letters to the editor in two newspapers — the West Australian and The Australian. Analysis identified representation of the ‘traditional’ family structure of a mother, father and children, and arguments that access to MART should be restricted to this family structure, as discussed previously. This representation of the family was characterised as ‘natural’ and ‘good’, highlighting the importance of the father. By this definition, single women and lesbians are excluded from representations of family, with letters indicating the inclusion of these women in defining the family was a threat to the role of men. However, there were some representations of family, based on positive parenting values, independent of gender and number of parents, which suggested political agendas restricting MART to heterosexual family structures were not supported by public consensus. This highlighted the emerging representations of family that include non-traditional parenting structures.

Research conducted in England explored short intervals of pregnancy (i.e. only a short period of time separating consecutive pregnancies), specifically looking at cases where children are removed from their birth mother, with subsequent pregnancies often having the same result (Broadhurst et al., 2015). This study used administrative data from 2007 to 2013 to provide the first national estimate of prevalence of recurrent care proceedings in England. The findings from this research confirmed that birth mothers were caught in a cycle of short interval pregnancies and short interval proceedings, leaving them with little time to make changes to their lives, with a median interval between a first and second care episode being 75 weeks. The authors highlighted the need for government policy to ensure equitable access to healthcare services so these women might exercise their reproductive rights to decide both the number of and spacing between pregnancies (Broadhurst et al., 2015).

Australian research has explored gay men who have used surrogacy to become parents, and their experiences of this within an environment of very limited legal, social, political and cultural support for intentionally gay-led families (Tuazon-McCheyne, 2010). The sample consisted of thirteen men (aged 30 to 55), which comprised of seven couples (in one family just one partner attended) who had all conceived at least one child through surrogacy. Findings indicated that fathers embraced the political reality of their parenting and were stimulated to create improved support structures for themselves and future parents. Though the sample consisted of those from a relatively high SES, with an average income of over $150,000 per annum per couple, it was still a struggle for many of them to afford surrogacy costs. For the men in this study, the process of becoming and being a parent had been politicised.

**Discriminatory laws and practices**

Research has examined discrimination and stigma and its relationship with public policy, the law and associated practices. Together this research highlights the discrimination women experience at the institutional level.

Qualitative research has explored life for lesbian mothers in Australia, including how the policy and social context affects and shapes their decisions around reproductive health, how to conceive, and the structure of their family (Short, 2007). The research was conducted with 68 women aged 25 to 56 from across Australia, of whom 41 were mothers, eight had a child due, and seven were organising or attempting to conceive (either them or their partner). Findings revealed lesbian mothers identified their most important desired resource was laws that recognised the relationship between non-birth mothers and children (Short, 2007). For those living in Western Australia and the Australian Capital Territory, where two women are permitted to be on their child’s birth certificate, this resulted in numerous practical, financial, social, emotional and symbolic benefits. The women’s ability to understand the relationship between discriminatory laws, policies, discourses and attitudes assists those that are mothers. All women in the sample emphasised that lesbian women usually spend considerable time considering their conception options (e.g. sperm-provider, friend) by thinking about current laws, public policies and discourses that do not recognise non-birth mothers as mothers, lesbian-parented families as families, and procedures that give particular importance to children having a father and to biological relationships. The research found that lesbian mothers still face considerable discrimination and heterosexism (the belief or assumption that heterosexuality is the norm in society) in family-related law, public policies and discourses, which creates obstacles and difficulties for these women and their families.

Two studies relating to migrant sexual and reproductive health and experiences of public policy and healthcare — one from Australia (n = 255, 141 were African women and 114 were Middle Eastern women, all aged 19 to 50) and one from New Zealand (n = 64, aged 27 to 48) — found while most women agreed reproductive health was a major concern, they were more inclined to participate in research that explored the broader concerns affecting their resettlement and health and wellbeing (Guerin et al., 2006). The women in this study had a high level of understanding about legislation against FGM/C yet felt there was a need to put FGM/C into perspective. For many, their perceptions of reproductive health were impacted by personal accounts of sexual and reproductive health, including
experience in refugee camps and the need to trade sexual favours for food or medicines for their families as a matter of basic survival. Further, the priorities in their lives, such as providing for their family, the continued racial and social problems experienced by their children due to being a minority group, intergenerational family conflict, and concerns about family still in conflict areas, were more important than their current sexual and reproductive health. The women felt FGM/C-related education programs should target health professionals’ understanding of FGM/C and Somali culture, indicating the need for recognition and inclusion of cultural sensitivity in policy.

**Socio-economic status**

SES is a key social determinant of health. The WHO states that SES, in particular poverty, is both a cause and outcome of poor sexual and reproductive health (WHO, 2010b). Low SES is associated with unequal distributions of resources, services and opportunities (WHO, 2010b; Ward et al, 2011). Across the literature in sexual and reproductive health, experiences of SES disadvantage were identified as a factor associated with experiences of pregnancy care, STI testing, termination of pregnancy and poor access to services for young people. This was influenced by people’s social position and resulted in health inequity.

Sutherland and colleagues (2012) explored pregnancy care experiences of women who accessed publicly-funded antenatal care in Victoria and South Australia. They found the model of care women accessed during pregnancy was related to a range of social indicators of disadvantage. Women who were more disadvantaged in terms of SES, education level, household income, and those born overseas in a non-English speaking country were more likely to access public services than primary midwife care. Participants who accessed public services were less likely to report their care as ‘very good’ compared to women who accessed other models of care. Women who experienced forms of social and economic disadvantage were also more likely to report different access to and utilisation of pregnancy care services, and poorer experiences of pregnancy care, potentially compounding their disadvantage. However, single women and Aboriginal and Torres Strait Islander women were under-represented in the study, while women in private care were over-represented. Women who had experienced a still birth or infant death were excluded. Thus, the pregnancy care experiences of these under-represented groups, who arguably experience disadvantage, as well as the women who have additional specialised support and service needs (such as those who have experienced a stillbirth or infant death) warrants further attention.

A study by O’Grady and colleagues (2015) found similar inequities in healthcare associated with disadvantage. They surveyed perinatal and postnatal Aboriginal and Torres Strait Islander women about their experiences, specifically regarding influenza vaccine uptake during pregnancy. They found many of the participants experienced disadvantage in access to healthcare, which could have impacted upon low rates of influenza vaccine uptake among this group during pregnancy. Only five participants from a cohort of 53 women (9 per cent) had received the influenza vaccine during pregnancy, and 25 participants (47 per cent) reported that they were not offered this form of care. Both studies highlight the need for improved equity of access to pregnancy care services and outcomes for disadvantaged women.

Further, international research conducted with 5,332 women in England demonstrated that, with each decrease in SES, women were 25 per cent less likely to receive any antenatal care and 15 per cent less likely to receive any postnatal care (Lindquist et al., 2014). In addition, women with low SES were more likely to report being disrespected and discriminated against by doctors and midwives (Lindquist et al., 2014). Similarly, in Victoria, Lindquist and colleagues (2015) aimed to quantify the risk factors associated with maternal morbidity, with a focus on the influence of SES in 211,060 women. The research findings demonstrated lower SES is associated with an increased risk of severe maternal morbidity, with women from the lowest SES more likely to experience severe complications in pregnancy than women from the highest SES.

Quantitative research from the UK has explored the effects of socio-economic deprivation on teenage pregnancy (Smith & Elander, 2006). Survey data from 201 young women from high and low SES areas were analysed. Living in a deprived area was found to be associated with early sexual activity and lower life expectations. This research suggests interventions that focus on raising the life expectations of young girls from deprived families is warranted in order to reduce rates of teenage pregnancy.

To explore whether chlamydia testing is reaching the most at-risk populations, Rose and colleagues (2012) analysed 221,110 data records from two private diagnostic laboratories for a seven-year period. Findings demonstrated Maori and Pacific Islander people aged 15 to 19, who experience high socio-economic deprivation, had higher rates of chlamydia yet low rates of chlamydia testing. Similarly, Crichton and colleagues (2015) conducted a systematic review, drawing on 29 studies, to explore the variation in chlamydia prevalence in populations, including in Australia. Overall, SES disadvantage was associated with chlamydia infection in women and men. These findings demonstrate inequities in sexual and reproductive health associated with SES and highlight the need for targeted chlamydia screening interventions.
The health inequities of sexual and reproductive health: A review of the literature

Taft and Watson’s (2007) quantitative study found factors associated with having a termination included a range of socio-economic and relationship factors that indicate social disadvantage, such as having a lower level of education, not having private health insurance, being in a de-facto relationship and experiencing intimate partner violence. Taft and Watson’s analysis was based on data from the Australian Longitudinal Study on Women’s Health cohort of women aged 18 to 27, across the data collection period. This research demonstrates how the inequitable distribution of resources associated with SES, and gender-based inequities associated with intimate partner violence, impact upon women’s sexual and reproductive health, and increase their likelihood of termination of pregnancy.

Demonstrating how services can be inaccessible due to SES, Olsen and colleagues (2012) found service type and SES impacted on the choices young people made when accessing community sexual health services in the United Kingdom. Young females were statistically more likely to use a young person’s sexual health service rather than a mainstream service. However, a young person living in a disadvantaged area was more likely to use a mainstream service if it was closer to home. This research highlighted the need for services that are youth friendly and accessible, located within the most disadvantages areas of a community.

Access to culturally appropriate, accessible healthcare and services

The ability of individuals, particularly women, to access culturally appropriate and accessible health services is an important determinant of sexual and reproductive health. Services might not be accessible to individuals because of SES, racism, language barriers, cultural norms or culturally inappropriate services or support (WHO, 2010b). From the socio-political-cultural context, access to culturally appropriate and accessible healthcare and services can be limited due to governance, policy or dominant cultural and societal norms (VicHealth, 2015).

Across the literature, examples of inaccessible healthcare and services were evident. Asylum seekers and refugee communities resettling in a new country have unique and complex healthcare needs compared to the rest of the population. These are influenced by multiple factors that interact and stem from their home country experiences, their journey of seeking asylum, and their refugee and resettlement experiences (Bartolomei et al., 2014; Hadgkiss & Renzaho, 2014; Murray et al., 2010). However, current service delivery to asylum seekers and refugee communities generally fails to appropriately and adequately meet their sexual and reproductive health needs. Several studies highlighted a range of culturally inappropriate or insensitive practices that negatively influenced the sexual and reproductive health service experiences of asylum seeker and refugee communities, such as language barriers, limited access to interpreters, lack of continuity of care with the same practitioner, inadequate duration of appointments, and service user perceptions of unhelpful or uncaring staff (Murray et al., 2010; Yelland et al., 2014). A lack of resources such as interpreters was reported as a significant barrier to service access, utilisation and quality of care. Guirgis and colleagues (2012) recommended interpreter services as an essential component of health service practice in order to increase accessibility for those who have low English language proficiency.

With a similar focus on the lack of culturally appropriate and accessible healthcare and services, Bartolomei and colleagues (2014) drew on a series of linked studies conducted between 2003 and 2013. The research involved refugee and displaced women in Australia, India, Colombia, Thailand, Finland, Jordan, Zambia and Uganda, and settlement service providers, aiming to develop insight and understanding of the settlement experiences and needs of refugee women. They found that services were ill-equipped to support refugee women and families in a way that takes account of the complex, broader context of their past experiences and current disadvantage and marginalisation. Services were often delivered in silos, rather than responding to the combined needs of the refugee women in an integrated manner, prompting the authors to call for a more coordinated case management approach based on partnerships between different service providers and sectors.

Research has also explored women’s perceived discrimination relating to perinatal care in Australia (Yelland et al., 2012). A multidimensional research approach compared perceived discrimination experiences between women in different models of private and public maternity care. The key findings of this research showed that women attending public models of maternity care were significantly more likely to report perceived discrimination compared to those who had attended a private obstetrician (30.7 per cent versus 19.7 per cent, respectively). In addition, women who reported three or more stressful life events or social health concerns were twice as likely to report perceived discrimination, compared to women who reported no stressful life events or social health problems (Yelland et al., 2012). This research showed that women in Australia experienced unequal treatment in perinatal care, especially women who experienced stressful life events or social difficulties during their pregnancy. Authors warned this can lead to double disadvantage, wherein women who experience complex life events in pregnancy are most likely to also experience poor quality care or care that does not adequately meet their needs (Yelland et al., 2012). These findings highlight the need for the provision of more equitable maternal care across private and public sectors, especially perinatal care, that more adequately meets the needs of women who experience stressful life events during their pregnancy.
Further, the authors stated that a more comprehensive understanding of how and why women report perceived discrimination in perinatal care is essential.

Homophobic and sexist incidences when accessing health services have also been examined. Qualitative research explored the experiences and expectations of older gay and lesbian people and their access to health and aged care services, drawing on nine men and five women aged 58 to 72 (Hughes, 2007). Findings from this research revealed specific homophobic and/or sexist incidents, which impacted on participants’ willingness to access services in the future. The participants also recounted experiences of indirect discrimination in the form of heteronormativity, whereby the general assumption of heterosexuality created a failure to provide lesbian- or gay-friendly services.

The sexual health of people with a disability is commonly overlooked, and research regarding access to appropriate sexual and reproductive health services among this population group is scant. People with a disability face many barriers to care and information, frequently based on the incorrect assumption that they are not sexually active and therefore do not need sexual and reproductive health services. Additionally, services are often inaccessible to people with a disability as a result of physical barriers, a lack of appropriate information and communication materials, the lack of disability-related clinical services, healthcare providers’ negative attitudes, and stigma and discrimination (WHO & UNFPA, 2009). Smeltzer (2007) discussed the importance of clinicians and support workers becoming more equipped to talk to women with a disability about having a child and properly assist them to access pregnancy and parenting information. Thompson and colleagues’ (2014) research demonstrated the barriers to the provision of sexual health information for people with intellectual disability. This qualitative research utilised a constructionist grounded theory approach, conducting interviews with eight disability service managers from government-operated and government-funded services. Interviews were then conducted with 23 clinicians who worked directly with people with an intellectual disability regarding their sexual health. Findings revealed barriers to the provision of sexual health for people with an intellectual disability included a lack of policy, lack of formal requirements to respond to sexual health, negative attitudes from community, family, and staff, and a lack of sexual health education. Interventions are needed to reduce these barriers to ensure disability support workers and clinicians are able to adequately provide sexual healthcare to people living with a disability (Thompson et al., 2014). Thompson and colleagues (2014) further argued that sexual health policy in Australia needs to provide clear and specific directions about sexual health and incorporate all areas of sexual health. They highlighted the need for funding requirements to explicitly incorporate sexual health provision, and ensure the sexual health of all people living with a disability be specifically assessed, to ensure sexual health provision is not limited to only problematic sexualised behaviours.
Daily living conditions

Daily living conditions represent a mid-stream level influence on health and wellbeing in ‘Fair Foundations: The VicHealth framework for health equity’ (VicHealth, 2015). The framework identifies six main determinants — early childhood development, education, work and employment, physical environment, social participation and healthcare services — that contribute to people’s daily living conditions, and the settings in which action can be undertaken. The literature on sexual and reproductive health inequities does not redress each of these areas. Rather, it predominantly focuses on healthcare services, and a small body of research on work and employment, education, and the experiences of parenting. However, there is some overlap between the different areas, such as access to health services which can be related to social participation.

The body of literature related to daily living conditions and lived experiences of sexual and reproductive health inequities also spans a diversity of population groups, including women, men, migrants, refugees, asylum seekers, diverse gender identities, diverse sexualities (including people who identify as GLBTIQ), people working in a range of different employment sectors or occupational settings, and diverse age groups including young people, adults and the aging. Implicit within many of these population groups identified and discussed are intersectionalities of multiple identities or disadvantage that influence and have implications for the lived experiences of sexual and reproductive health. For populations who experience intersectionalities, the complex and unique experiences of each aspect of identity and lived experience needs to be considered, as well as the unique challenges that the interaction of these multiple aspects produce to contribute to inequities.

Work and employment

Work and employment is identified by ‘Fair Foundations: The VicHealth Framework for health equity’ as both a determinant of health equity and a setting for action (VicHealth, 2015). Studies of work and employment have found diverse experiences by employees in workplaces that include the coexistence of positive and negative experiences of workplace culture. Aaron and Ragusa (2011) explored the lived experiences of gay men in their everyday workplace setting in the public service in Canberra, while Willis (2009) explored the everyday workplace setting among young queer workers. Aaron and Ragusa (2011) found some workers reported feelings of a gay-friendly culture in their workplace, while others employed in the same sector reported feelings of covert discrimination. Equal-employment opportunities and anti-discrimination policies existed in workplaces, and some workers in Aaron and Ragusa’s study felt they were effective in creating positive, gay-friendly workplaces. However, the perception about the impact of these policies varied among the cohort, as some workers reported feelings or experiences of existing covert discrimination. Examples included stereotyping, negative comments by colleagues, and withholding of workplace opportunities. Overall, it was concluded that homophobic discrimination in the workplace existed despite policies and legislation to prevent such discrimination. Willis (2009) explored the perceptions and experiences of queer young people regarding sexuality and their workplaces. Their findings revealed diverse experiences. However, while Aaron and Ragusa emphasised the need for whole-of-workplace policies and practices to facilitate more inclusive environments, Willis found ‘micro-practices’ of everyday inclusion for GLBTIQ youth in workplaces were more effective in promoting inclusivity among that cohort.

Education

Education is a key area of daily conditions that influences health equity (VicHealth, 2015), and there was a small body of literature that related to sexual and reproductive health inequities within education. Some of the research that highlighted inequities in education settings was discussed in the section on public policy and the law (page 12).

Smith and Stepanov (2014) discussed school-based youth health nurses (SBYHNs) in Queensland and their sexual and reproductive health advice to students. The authors outlined the key legal principles relevant to nurses working in this field, demonstrating that the law sought to prioritise the concept of confidentiality and aimed to avoid exposing adolescents to harm that may result from unsafe sexual practices. These key principles were: 1) adolescents were interested in their sexual health and would seek advice about fertility, contraception, and STIs; 2) adolescents relied on SBYHNs to be able to recognise when services were needed outside the scope of the SBYHNs, including appropriate referral to external providers for advice and services relating to STIs and termination of pregnancy; and 3) adolescents needed to trust their discussions with SBYHNs were in confidence, and their decisions were respected, particularly when their values and decisions may have conflicted with those of their parents or other adults. As such, there is the need to prioritise the decisions of adolescents seeking medical advice about their sexual and reproductive health, whereby failure to adhere to the principles of confidentiality and privacy can have a negative impact.

Despite the barriers to sexual and reproductive health promotion and equity present in education settings, there is some evidence to support the role or potential role of a school setting to facilitate the
implementation of sexual and reproductive health promotion policies and practices to positively impact the everyday lives and sexual health of young people. Weaver and colleagues (2005) conducted a study to explore the relationship between school-based sexual education policies and youth sexual health outcomes across Australia, the United States, France and the Netherlands. The study found countries with schools that adopted a more liberal approach to sex education (Australia, France and the Netherlands) as opposed to conservative approaches (such as the ‘abstinence-only’ approach in much of the United States) tended to have better sexual health statistics among the youth population. However, direct causality between models of sex education and sexual health outcomes could not be established. Further, the study found liberal school-based sex education programs did not necessarily enhance sexual activity, but rather helped enhance safety and responsibility in sexual encounters. However, programs varied, with some emphasising the biology of sexual health (for instance France), while others covered broader aspects of sexual health, such as sexual identity, diverse sexualities, discrimination and homophobia (Australia and the Netherlands). Further exploration is needed for other potential influencing factors such as the content and model of delivery.

Sexual health promotion research and interventions have explored alternative modes of information and sexuality education provision. A study with 620 people aged 16 to 29 found being aged 20 years or under and living in a major city were associated with more than two hours of social media use per day (Lim et al., 2014). This is important because the growth of social media among young people has led to an increase in health promotion interventions being delivered through these forums. Most participants in Lim and colleagues’ (2014) study reported being more comfortable accessing sexual health information from websites (85 per cent) rather than doctors (81 per cent), school (73 per cent), or mainstream media (67 per cent). However, fewer people were comfortable getting information from social media, such as Facebook (52 per cent), apps (51 per cent), SMS (44 per cent), and Twitter (36 per cent). This study demonstrated that, overall, young people were not comfortable accessing sexual health information through social media (Lim et al., 2014). However, an evaluation of a social marketing campaign for gay men found the use of social marketing, combined with mainstream advertising (billboards and campaign posters on public transport), could be successful in delivering sexual health messages among this population group (Pedrana et al., 2014). Together these findings support the use of several sexual health promotion strategies across multiple platforms.

Healthcare service provision and delivery

There was a substantial body of research on inequities in health services generally, as well as on inequities in specific types of services such as family planning services, assisted reproductive technology services, and perrinal services.

General health services

The literature discussed various aspects of everyday experiences of health services, and related to a range of population groups, including GLBTIQ populations (either broadly or for a particular sub-group within the GLBTIQ population, such as gay or lesbian women); migrant, refugee and asylum seeker communities; Aboriginal and Torres Strait Islander people; young people; and people in regional, rural and remote communities. Themes that emerged in the lived experiences of health service utilisation and access among these groups included experiences of culturally inappropriate services, inappropriate or exclusionary language and communication, and stigma and discrimination.

Culturally inappropriate services and support

Several aspects of culturally inappropriate services and support were apparent in the literature. These included poor cultural understanding or sensitivity in service design and delivery, and poor cultural competency of healthcare practitioners, which can create barriers to service access and contribute to negative experiences of service utilisation.

A systematic review of 32 studies explored health service utilisation and barriers to access among refugee communities in Australian and international contexts (Hadgkiss & Renzaho, 2014). Barriers to healthcare access identified included cultural barriers and culturally inappropriate services, prohibitive financial costs, low health literacy among asylum seeker and refugee communities, and language barriers. Research specific to sexual and reproductive health service utilisation experiences of CALD migrant populations in Australia identified similar barriers. For example, Botfield and colleagues’ (2015) review of 120 studies related to sexual and reproductive health service utilisation by young people of CALD backgrounds in Australia found that this population group has difficulties accessing sexual and reproductive health services due to financial barriers, language barriers, negative perceptions of healthcare providers, and the physical location of services. These barriers can interact with financial issues in accessing suitable transport, and feelings of embarrassment in seeking social support from others to help access services far away. Botfield and colleagues (2015) concluded that it is important for sexual and reproductive care to be relevant to the everyday context of people’s lives in order to be more culturally sensitive and appropriate. The authors highlighted a debate between those who
advocate the need for sexual and reproductive health services to be embedded in, and integrated with, resettlement services to overcome service access barriers, and those who contend that cultural norms and cultural barriers are the primary obstacles that need to be overcome.

An interrelated perceived or experienced lack of cultural competence among health practitioners was also widely reported in the literature, spanning the experiences of multiple population groups. A common finding and recommendation across the literature was the need for more and better cultural competency training of health practitioners to ensure CALD communities have access to health services (Guirgis et al., 2012, Yelland et al., 2012). A study conducted by Yelland and colleagues (2012) explored the responses of maternal and early childhood health services to Afghan refugees resettling in Australia. Their study involved mothers, fathers and health practitioners, to gain a wider and more comprehensive understanding of their perspectives and experiences. Their findings revealed that, while health practitioners were aware of the importance of understanding the influence of cultural factors and the refugee and migration experience on women in order to enhance care, appropriately responding to the challenges to meet women’s needs was difficult. Practitioners faced challenges including limited understanding of Afghan culture and the context of migration. Guirgis and colleagues (2012) stated that the limited cultural competency of practitioners to provide information to CALD service users in appropriate ways, using acceptable and effective methods, combined with the language difficulties experienced by CALD people engaging with health services in Australia, posed a risk of misinformation or misinterpretation by service users. This conclusion by Guirgis and colleagues highlights and reinforces the intersectionality of multiple factors that combine to concomitantly influence experiences of service access and utilisation.

Culturally inappropriate or insensitive service delivery is also experienced by other groups, such as GLBTIQ populations. Hayman and colleagues (2013) explored lesbian mothers’ experiences of healthcare utilisation in a qualitative study involving fifteen lesbian couples. Participants reported experiences of service exclusion based on heteronormative practices (such as female partners being prevented from participating in procedures or care of their partner, or not being permitted access to consultation or treatment rooms to support their female partner, while male partners were allowed such access). Participants further reported assumptions in service delivery, inappropriate questioning by service providers, and other heteronormative and exclusionary practices (such as heterosexual-oriented paperwork). The participants felt such instances represented forms of homophobic discrimination in service delivery. Literature about culturally appropriate service delivery for this population group was very sparse, in contrast to the body of literature pertaining to non-English speaking communities.

Cultural appropriateness and sensitivity in service delivery is also commonly cited as an important factor in women’s experiences of pregnancy care. Two studies explored this topic with regards to the experiences and needs of Aboriginal and Torres Strait Islander women. One study explored Aboriginal women’s experiences of antenatal care, and found women who gave birth in an Aboriginal family birthing program or Aboriginal health service were more likely to report positive experiences of antenatal care compared to those who gave birth in mainstream services (Brown et al., 2015). This was regardless of whether they accessed the service in a metropolitan or regional area. This finding related to women’s perceptions and experiences of the services as being culturally appropriate, thus reinforcing the need for culturally appropriate health services. The authors concluded the positive experiences reported by women could potentially contribute to more positive health outcomes for Aboriginal families. Their conclusion is supported by a systematic review undertaken by Jongen and colleagues (2014) of 23 studies of maternal and child health (MCH) services for Aboriginal and Torres Strait Islander women, which cautiously suggested appropriate and equitable MCH service delivery for this population group could contribute to improving MCH outcomes, such as improvements in infant birth weight. Improved MCH outcomes were consistently identified across the reviewed studies. Furthermore, over half of the studies reviewed were delivered through Aboriginal Community Controlled Health Organisations, or developed in collaboration with Aboriginal community members, to enhance their cultural appropriateness. However, Jongen and colleagues pointed out that while women’s experiences of service delivery and care were explored and reported, evaluating the actual quality of care they received is challenging, due to the lack of national guidelines for antenatal care and the wide variance in recommended antenatal tests and schedules. Inequities in pregnancy-care-related services are discussed in the section specifically about this service type (see page 25).

Language and communication

Language, and particularly low English language proficiency among people of CALD backgrounds, has been widely found to be a barrier to accessing healthcare services and practitioners (Botfield et al., 2015; Guirgis et al., 2012; Hadgkiss & Renzaho, 2014; Murray et al., 2010). What is not as widely or clearly discussed in the literature is whether the nature of the concepts discussed in consultations is also appropriate or has an equivalent concept in the CALD service user’s own culture and language. This aspect of effective communication in healthcare access and utilisation warrants further exploration.
Additionally, language was raised as a potential barrier or negative influence in the experiences of GLBTIQ people in service access and utilisation due to the use of inappropriate, exclusionary, heteronormative language (Hayman et al., 2013; Koh et al., 2014). In contrast, language used by practitioners and services that was inclusive and acknowledged services users’ sexuality contributed to a more positive experience of service utilisation. Examples of exclusionary or inclusive language predominantly referred to verbal or written forms (such as that presented in information pamphlets or on forms), but participants also discussed the important role of non-verbal cues and symbols in their experiences of health service use. For instance, GLBTIQ people who participated in Koh and colleagues’ study (2014) provided examples of images and symbols that spoke to convey a particular message, such as inclusive publications and pictures in waiting rooms, or a rainbow flag on display, which could convey a message of being a ‘gay-friendly’ service. This highlights an example of applied cultural competency and language use in health research, and also more broadly highlights the importance and utility of diverse, culturally specific and appropriate forms of language and communication to positively engage culturally diverse populations.

**Stigma and discrimination**

Various population groups experience real or perceived stigma and discrimination that poses a further barrier to their service access, and exacerbates health inequities. This barrier was discussed most often in research that pertained to the experiences of GLBTIQ people who access healthcare, and their experiences of receiving quality care (Hayman et al., 2013; Koh et al., 2014). The literature commonly reported that GLBTIQ people experienced various forms of direct, perceived and anticipated homophobia and discrimination in service access and utilisation. Interestingly, Koh and colleagues (2014) also revealed the phenomenon of ‘reverse stereotyping’, in which a GLBTIQ service user’s fears or perceptions of experiencing homophobic discrimination are based on assumptions or stereotypes about the service provider, which can inhibit practitioner-client interactions and quality of care.

Experiences of stigma and discrimination are not always overt. Research by Lee (2009) and Hayman and colleagues (2013) reported GLBTIQ service users expressed feelings of marginalisation and the sense of being invisible. This idea of invisibility was repeatedly raised in research related to the broader range of the lived experiences of GLBTIQ people beyond service access and utilisation experiences. Several studies found that, to overcome some of these barriers, GLBTIQ people engaged strategies to negotiate and navigate healthcare access. A strategy of dividing care between multiple service providers was commonly used by women who identify as lesbian, bisexual or queer (Koh et al., 2014; Mulligan & Heath, 2007), and gay men (Koh et al., 2014). However, for GLBTIQ people these strategies can have negative impacts on their sexual and reproductive health, such as fragmented care (Koh et al., 2014). GLBTIQ service users also revealed a strategy of seeking care from practitioners and services that were known to be GLBTIQ-friendly (Hayman et al., 2013; Koh et al., 2014; Mulligan & Heath, 2007). Such practitioners and services were identified by word-of-mouth within the GLBTIQ community, and through services advertising as GLBTIQ-friendly. This suggests social networks are important in facilitating healthcare access for the GLBTIQ community.

Factors that enable GLBTIQ people’s access to healthcare include practitioners’ or services’ recognition and acceptance of their sexuality. This recognition could be symbolic, such as GLBTIQ images, flags or other resources visible in services, and/or by practitioners using language that is non-heterosexist and inclusive. The literature highlighted the need for greater training of health professionals in sexual diversity and cultural competency, and the capacity for changes to service practices to make healthcare more accessible and appropriate for GLBTIQ people. Mulligan and Heath (2007) provided a useful list of points for general practitioners (GPs) to consider in their service delivery for GLBTIQ communities, and resources available to support them in their practice. Further to this, Koh and colleagues (2014) posted that existing guidelines and models on best practice in healthcare for people who identify as GLBTIQ are yet to be widely adopted or implemented. Importantly, the literature highlighted diversity within the GLBTIQ population that needs to be considered in understanding their healthcare experiences and needs. For instance, Mulligan and Heath (2007) highlighted differences in outcomes between participants who identified as lesbian, and those who identified as bisexual, while Hayman and colleagues (2013) found that lesbian women who are also mothers often have unique experiences compared to other lesbian women.

The literature predominantly focuses on stigma and discrimination experienced by GLBTIQ populations. However, some literature revealed similar inequities experienced in the daily conditions of service access and utilisation for other marginalised or disadvantaged groups. For example, Johnston and colleagues (2015), Senior and colleagues (2014) and Lindberg and colleagues (2006) found young people experience fear and perceived or real stigma from service providers when accessing sexual and reproductive health services. This is compounded by other inequities such as regional or remote location (Johnston et al., 2015) or gender (female) (Senior et al., 2014). Johnston and colleagues (2015) found that young people experience a range of structural inequities relating to service access that need to be redressed (e.g. cost, access to transport and service operating hours). However, the young people in their study placed greater emphasis on interpersonal interactions with practitioners and a welcoming, non-judgemental service for facilitating positive conditions and experiences of service
Some literature discussed the stigmatisation of people living with a disability in health services, particularly from a human rights perspective. Higgins (2010) argued that sexuality, relationships and sexual and reproductive health for people living with a disability are often invisible in society, which contributes to great inequities. The literature revealed the negative influences of stigma in daily living conditions are further compounded with other forms of social disadvantage and marginalisation, such as ethnicity, sexual identity, and in particular gender-based inequities (Higgins, 2010). The result is that inequities are disproportionately experienced by women living with a disability (Frohmader & Ortoleva, 2013; Gibson & Mykitiuk, 2012; Higgins, 2010). Gibson and Mykitiuk’s (2012) Canadian study with women living with a disability found that assumptions, negative attitudes and discriminatory practices in health services negatively impacted service access. Discriminatory attitudes and practices included poor availability or accessibility of sexual and reproductive health information and services, differences in service availability based on diagnostic category of disability, and negative attitudes of healthcare practitioners toward women living with a disability, including actively discouraging parenting aspirations. Frohmader and Ortoleva (2013) insisted that discrimination experienced by women living with a disability in sexual and reproductive health services is manifested in the lack of access to and exclusion from these services on the basis of economic, social and cultural factors, and results in a violation of women’s sexual and reproductive health rights.

Research has shown that sex workers experience general stigma and discrimination in society (Abel, 2014; Begum et al., 2013; Duff et al., 2015; Lazarus et al., 2012), which impacts on their daily conditions and experiences of health service access and utilisation. Abel (2014) found that sex workers in New Zealand accessed some types of health services for regular general health and sexual health check-ups. However, despite the decriminalisation of sex work in New Zealand, sex workers remained guarded about their occupation and tended not to disclose it to their health practitioner, which could have resulted in their consultations not comprehensively meeting their health needs. Similarly, Lazarus and colleagues (2012) found that in Canada, where sex work as an occupation is criminalised, sex workers also perceived and experienced stigma that posed a barrier to health service access and utilisation. Abel (2014) found some sex workers accessed sexual health check-ups through services specifically designed for sex workers, which decreased perceived or feared stigma, and that such services could be preferable to increase access to quality care.

Similarly, people living with HIV have described experiencing HIV-related stigma in general society, as well as specifically in their healthcare interactions. Brener and colleagues (2013) found that while HIV diagnosis in Australia disproportionately affects non-heterosexual people, generalised stigma and stigma in accessing treatment more negatively affected heterosexual people living with HIV, compared with non-heterosexual counterparts. Non-heterosexual people in their study were more likely to be receiving treatment for HIV, possibly because heterosexual people with HIV perceived treatment services to be more targeted to gay men, highlighting a perceived inequity and barrier to health services. Women comprised more of the heterosexual proportion of participants, further highlighting a perceived gap and inequity in service provision for HIV-positive women. Despite this, there were no differences in health and wellbeing outcomes between the groups. The authors suggested this could have been due to several factors, including social support networks among the gay community that may have helped ameliorate the negative effects of stigma among a community in which HIV is not uncommon, and also that heterosexual people with HIV may not have experienced some forms of stigma or marginalisation that homosexual people with HIV did, such as sexuality-based stigma and discrimination. Experiences of stigma generally, and in healthcare, are demonstrably complex and multifaceted.

Stigma and discrimination in sexual and reproductive health service access is also a concern faced by substance users, and particularly among women (Edelman et al., 2013; Stengel, 2014). For example, women with problem drug use anticipated a high emotional cost of accessing sexual health services, which posed a barrier to service access. This anticipated emotional cost was based on several factors, including previous experiences of stigma from service providers. Stengel (2014) found that, among pregnant drug users, interactions with sexual health service providers were shaped by service providers’ negative moral judgements, and sexual health service access was delayed or avoided because of fear of stigma. Stigma and discrimination compounded negative health outcomes for this marginalised group, which resulted in great inequity in health service access and utilisation, and sexual and reproductive healthcare. Edelman and colleagues (2013) posited that interventions with drug users to redress anticipated stigma and emotional concerns in accessing sexual health services, and sensitive care and engagement with drug users by practitioners, are needed to overcome this barrier and reduce this health inequity.
Overall, the literature discussing experiences of stigma and discrimination in the daily conditions of sexual and reproductive health service access and utilisation predominantly pertained to the experiences of women, and intersectionalities of gender with other forms of marginalisation, such as stigmatised occupations or behaviours, like sex work or drug use. The literature about experiences of stigma and discrimination in sexual and reproductive healthcare among men was much less prevalent, and highlights an area for further research.

**Family planning and assisted reproductive technology (ART) services**

Examination of the research relating to specific types of health services, such as family planning, ART and termination of pregnancy, identified inequities associated with social position related to age, geographic location and SES.

Herbert and colleagues (2010) examined patterns of use of ART or fertility treatment among Australian women. They found women who live in major cities and have private health insurance are more likely to engage in earlier use of treatment for infertility at women's specialist clinics compared to other infertile women, possibly suggesting positive experiences of service accessibility for these women, and experiences of inequities for other women. This study only included women aged 27 to 33 who were in a heterosexual relationship. Hence, the findings may not be relevant to older women, single women and lesbian women who seek to access ART.

Published data regarding termination services in Australia is limited and not easily accessible. However, Taft and Watson (2008) found that one in four Australian women will access a termination of pregnancy. Abigail and colleagues (2008) further explored pregnancy termination data to investigate trends in women seeking a termination over a ten-year period (1996 to 2006). One key trend identified was a statistically significant increase in women aged 30 to 50 years having a termination. This may be reflective of other social trends that reveal an increasing age of childbearing among both primiparous (first time having a child) and multiparous (having had multiple births) women. Furthermore, they found two-thirds of the terminations were performed on multiparous women. Abigail and colleagues (2008) did not explore reasons for this trend, but it is possible the prominence of terminations performed on multiparous women could be for a range of reasons, such as socioeconomic, lifestyle, relationship, or other personal factors such as desired or ideal family size. This finding could be significant for health services, as it highlights the need for family planning and pregnancy support services (including termination services, counselling and health promotion) targeted at women aged 30 to 50 who are multiparous, and for young women who experience social disadvantage.

**Perinatal services**

Daily conditions and experiences of inequities in perinatal services were reported in the literature and included explorations of women's experiences of perinatal services and conditions in relation to accessing pregnancy care services, quality of care, health and wellbeing outcomes and other social outcomes. Some of this literature was discussed previously as it pertained to socio-economic inequities (see page 16) or cultural appropriateness in health service access (see page 17).

Although relatively small, the body of literature pertaining to pregnancy care services revealed inequities relating to the social and emotional health and wellbeing of women in seeking pregnancy care. Yelland and colleagues (2012) found some women experienced discrimination in perinatal care. In particular, young mothers under 25, and women who smoked during pregnancy, reported experiences of discrimination. Other studies stated that some women reported feelings of isolation throughout their perinatal experience (Murray et al., 2010; O’Grady et al., 2015). Murray and colleagues (2010) found that African women’s experiences of the Australian health system and their engagement with perinatal services resulted in feelings of isolation. Their study aimed to deeply explore individuals’ lived experiences in order to elicit commonalities. They found participants widely experienced isolation through feelings of loneliness and unfamiliarity throughout their perinatal experiences, as many described having no prior contact with the Australian health system, little or no knowledge of how the Australian health system operated, little information or explanation provided, and little understanding of their healthcare rights. Yelland and colleagues (2014), in their study with Afghan refugee women, found that healthcare practitioners did not ask women about their social wellbeing or take steps to attend to their social health needs. These negative experiences of pregnancy care services highlight how the interactions between the daily conditions and experiences of women can negatively influence sexual and reproductive healthcare experiences and outcomes.
Experiences of parenting

Parenting experiences are important to the discussion of daily conditions due to their influence on sexual and reproductive health inequities. Daily life experiences and conditions of parenting are discussed in the literature, particularly in regards to GLBTIQ parents’ experiences within the context of sexual identity and wellbeing.

Two studies explored the daily lived experiences of parenting among gay and lesbian parents. One explored the parenting experiences of gay and lesbian parents (Lee, 2009), and the other explored parenting experiences among lesbian mothers, with a focus on healthcare service access and utilisation (Hayman et al., 2013). Both studies used qualitative research approaches and methods that were inclusive and demonstrated reflexivity in order to engage with the populations of interest around sensitive personal topics. Findings revealed some commonalities with the body of research among the general population, including challenges in balancing paid employment and family responsibilities, and a loss of time available for parents’ leisure activities. However, the research also revealed that gay and lesbian parents face additional unique challenges associated with parenting that relate to their sexuality, such as dealing with sexualised representations of gay and lesbian parents, and negotiating and managing sexual and parental identities (Lee, 2009). Many participants also discussed the challenges of fulfilling their desire to become a parent (Lee, 2009). Unique challenges were similarly faced by lesbian mothers, such as access to appropriate maternity services (Hayman et al., 2013).

Lee (2009) and Hayman and colleagues (2013) discussed strategies that gay and lesbian parents adopted to help them manage or overcome these challenges, such as resilience. Hayman and colleagues found lesbian mothers employed a range of strategies, particularly in accessing healthcare, such as screening potential service providers to determine their attitude toward GLBTIQ people, and advocating for GLBTIQ rights and inclusion in care. Lee highlighted the practice of ‘deseexualisation’ used by gay and lesbian parents that involved hiding or minimising their sexual identities and privileging a heteronormative identity in order to conform to heteronormative ideals and expectations around parenting. The practice of conformity was also discussed by Edwards and Cheers (2007) in their study of same-sex attracted women living in rural communities. They highlighted the possible negative emotional and psychological impacts on homosexual people who practice conformity and suggested the need for comprehensive and integrated sexual and reproductive health services that include emotional and social support related to sexuality, sexual identity and family planning.

Mothers who are sex workers (Duff et al., 2015) and mothers who are drug users (Stengel, 2014) also experienced inequities relating to parenting, due to stigma and discrimination in health services. These studies were discussed in relation to stigma and discrimination in healthcare services (see pages 23 to 25).
Individual health-related factors

Sexual and reproductive health inequities exist at the individual level and are apparent in knowledge, attitudes and behaviours among different population groups. The research particularly highlighted sexual and reproductive health inequities among adolescents and young adults, refugee communities, CALD populations and Aboriginal and Torres Strait Islander people. The research also drew attention to the influence of social and cultural beliefs on individual health-related factors, knowledge, attitudes and behaviours.

Knowledge

Poor levels of sexual and reproductive health knowledge contribute to health inequities between population groups, which is most apparent in relation to STIs and HIV/AIDS, contraception, and access to education and information. These disparities are further compounded by levels of education and literacy, and social and cultural beliefs. Furthermore, much of this research is conducted with adolescents and young adults.

STIs and HIV/AIDS

LaTrobe University’s fourth national survey of secondary students on the sexual health of year 10 and 12 students across Australia found that, while overall knowledge was poor, young women had better knowledge of STIs, hepatitis, Human Papillomavirus (HPV) and cervical cancer compared with young men (Smith et al., 2009).

A qualitative study of sexual health among recently arrived young people from refugee backgrounds in Melbourne found they had limited knowledge of sexual health and STIs, with the exception of HIV/AIDS (McMichael & Gifford, 2010). Similarly, a survey sample of 51 West African women (and 100 Australian-born women for comparison) investigated knowledge of HIV and attitudes towards condom use among West African refugees who had settled in Perth in the past five years. Drummond and colleagues (2008) found most West African women held negative attitudes towards condom use. While West African and Australian women were well informed about HIV modes of transmission, West African women who were less educated had the poorest knowledge of HIV, and those with higher levels of education had misconceptions about how HIV is spread, how to protect against it, and the effectiveness of condoms in protecting against HIV and other STIs (Drummond et al., 2008).

Of particular concern and more challenging to redress are the beliefs embedded within traditional social cultural constructs; for example, the belief among West African communities that having sex with a virgin will cure HIV/AIDS, and that HIV/AIDS is caused by spirits or supernatural forces (Drummond et al., 2008). Similarly, Ireland and colleagues (2015) found cultural beliefs shaped young Aboriginal women’s sexual perceptions and practices, and that some of these cultural beliefs may compound communication problems with health professionals. For example, STIs were believed to be the result of excessive sexual intercourse or sexual intercourse with too many partners. However, black magic sorcery was also believed to be a cause of STIs. Young women in this study were uncertain if condoms could protect against STIs, which placed them at higher risk of STI acquisition and transmission (Ireland et al., 2015).

However, sexual health promotion programs are able to redress these knowledge deficits, as demonstrated by Fagan and colleagues (2015). Between 2007 and 2010, their mixed methods evaluation of a long-term, comprehensive, multi-strategy Aboriginal and Torres Strait Islander sexual health promotion program, Kasa Por Yarn, found an improvement in sexual health knowledge among 15- to 19-year-old women, but not young men. Between 2010 and 2012, the program demonstrated significant sexual health knowledge improvement for young women and men. Knowledge scores were higher for 15- to 24-year-olds who participated in the program compared with those that did not (Fagan et al., 2015).

The Sexual Health and Attitudes of Australian Prisoners (SHAAP) survey of 2,351 prisoners from New South Wales and Queensland found STI history was common, with women more likely than men to report a prior STI (35.1 per cent compared to 20.0 per cent) (Butler et al., 2010). The most common STI among women was chlamydia, while genital warts was most common among men (Butler et al., 2013a). However, further analysis revealed prisoners had significantly better STI knowledge compared with the general population regarding chlamydia, but slightly poorer knowledge of herpes. Additionally, being over 25 years of age, not married, female, homosexual or bisexual, and having a history of STIs was associated with better STI knowledge (Malacova et al., 2011).
Contraception

Knowledge about STIs is related to knowledge about contraception. An ethnographic study undertaken in a remote Aboriginal community aimed to describe and explore young women's behaviour and knowledge in relation to sexual health (Ireland et al., 2015). The study found poor sexual health literacy, particularly in relation to STIs and contraception. For example, the young women did not understand how hormonal contraceptives worked, were unaware of contraceptive methods such as the oral contraceptive pill, diaphragm, vaginal hormonal ring or inter-uterine device, and none of the young women were aware of emergency contraceptive. The young women were aware of methods available to them via the clinic, namely Implanon, depot medroxyprogesterone acetate injection, and condoms (Ireland et al., 2015).

Research by Calabretto (2009) also demonstrated a lack of knowledge about emergency contraception. This study explored Australian first-year university students’ knowledge and attitudes about emergency contraception and their understanding of the risk for pregnancy. Using a convenience sample of 627 first-year, on-campus students from health and non-health disciplines, the study found emergency contraception knowledge was poor in relation to timing, accessibility, action and side effects, but that young women had better knowledge than young men. For example, only 25 per cent of students were aware that emergency contraception was not restricted to the ‘morning after’ unprotected sexual intercourse. Further, less than half of the students knew it is not necessary to wait for twelve hours to take emergency contraception, and less than one in five knew emergency contraception should ideally commence within three days (72 hours) following unprotected sexual intercourse, but can be commenced up to five days (120 hours) following. Calabretto’s (2009) study suggested there was not just a lack of knowledge regarding the use of emergency contraception but a lack of knowledge regarding its availability. Just over one-third of the students knew emergency contraception was available over the counter, another third believed emergency contraception required a doctor’s prescription, and just under one-third knew it was available through a hospital emergency department. However, just over half knew it could be obtained from a registered nurse at a sexual health clinic.

Similarly, a study investigating correlates of contraceptive knowledge and attitudes and describing differences in contraceptive knowledge by contraceptive category among 119 young people aged 14 to 24 found that, while overall contraceptive knowledge was low, young women had greater knowledge than young men (Ritter et al., 2015). Young people’s knowledge of condoms and the withdrawal method was better, but low in relation to the oral contraceptive pill, vaginal ring and long-acting reversible contraceptive methods (Ritter et al., 2015).

Information and education

A barrier to STI and contraception knowledge is limited access to sexual and reproductive health information and education. Information and education is a key determinant of sexual and reproductive health; however, for some population groups, access is restricted, culturally inappropriate or in conflict with cultural beliefs, traditions and norms. The ways in which sexual and reproductive health information and education is provided are therefore important.

A qualitative exploratory study conducted in Brisbane with Sudanese and Eritrean women aged 18 to 55 found that health literacy and cultural competency were key factors for effective sexuality and relationships education, for dissemination of sexual and reproductive health knowledge and for increasing the utilisation of healthcare services by people from minority ethnic communities (Rogers & Earnest, 2015). Further to this, barriers to sexuality and relationships education included gender, culture, finance and language. Younger women also cited concerns of confidentiality and trust as inhibiting their access to contraception and reproductive health services. They expressed the need for increased parental understanding, along with community support for sexual and reproductive health and sexuality and relationships education, to enable young people to receive the education they require to make informed decisions about their sexual health (Rogers & Earnest, 2015). A conflict of culture and beliefs was apparent in the Rogers and Earnest (2015) study, whereby cultural beliefs clashed with sexuality and relationships education provided in schools. Many young people were not allowed to attend school-based sexuality and relationships education and, as a result, were not equipped to negotiate safe sexual practices and were at risk of STI acquisition and transmission and unintended pregnancies.

McMichael and Gifford’s (2009, 2010) studies with recently arrived young people from refugee backgrounds in Melbourne also identified confidentiality concerns, shame and embarrassment as barriers to sexual health information and services. Furthermore, unplanned pregnancy and STIs were tied to the ‘social risks associated with unsanctioned sexual relationships and sexual health problems: [including] parental and familial disapproval, loss of individual and family reputation, social exclusion, reduced marriage prospects and reduced opportunity for work and study’ (McMichael & Gifford, 2010, p. 269).
Rogers and Earnest (2015), in their study with Sudanese and Eritrean women, found that sexual and reproductive health was considered taboo and difficult to talk about, which impacted on access to and utilisation of sexual and reproductive health services and education. Sociocultural pressures, traditions and norms also impacted on sexuality and relationships education discussions within the family environment. For example, a lack of family communication about sexual health was reported, as it is considered culturally inappropriate for children and parents to discuss puberty, sexual activity, contraception, reproduction and sexual health. In addition, cultural and religious beliefs led to expectations of sexual abstinence before marriage, as well as appropriate ways for young women to behave in the presence of men, namely, limiting social contact. This is further supported by the research by McMichael and Gifford (2009), who found cultural and religious expectations of abstinence from sex prior to marriage resulted in difficulties discussing sex within families.

By contrast, Smith and colleagues (2009) found approximately half of the respondents to the fourth national sexual health survey of secondary students reported feeling confident talking to their parents about contraception and STIs, and almost half believed they could confidently discuss matters concerning sex with their parents. Ninety per cent of students in Smith and colleagues’ (2009) study were born in Australia, as were 74 per cent of their parents. This suggests sociocultural differences are likely to play a significant role in young people's sexual and reproductive health knowledge.

Qualitative research explored the potential for sexual health promotion with young people aged 16 to 22 via Facebook and other social media (Byron et al., 2013). Findings showed the complexities of young people's social media use, and the unlikelihood of transmitting traditional take-home messages about sexual health in these spaces, given the participatory culture of social network sites; the stigma of sexual health, especially STI's; young people's careful presentations of self; and privacy concerns. Due to the stigma attached to sexual health, participants indicated it was unlikely that people would share such messages on Facebook. Participants used humour to defuse embarrassment about discussing sexual health, and therefore could be a way of getting young people to share messages about sexual health.

Research has looked at efforts to destigmatise health concerns, specifically HSV (Shearer et al., 2012). Shearer and colleagues’ study aimed to describe the range of destigmatising strategies used by the public via brief online videos (YouTube clips), and to describe videos that were successful or unsuccessful in creating these destigmatising messages. A thematic analysis of 103 publicly produced YouTube videos designed to destigmatise HSV infection was undertaken, and identified five main destigmatising strategies. These included providing information; normalising through familiarity; promoting disclosure; negating a negative perception; and expressing moral indignation. Most YouTube clips used multiple strategies, and were classified as unsuccessful, successful, mixed or neutral. These destigmatising strategies were similar to those identified in hepatitis C research, which highlighted that education, information and personal experiences were a means of challenging attitudes (Cama et al., 2015). Analysis of YouTube clips also explored the use of humour, which suggested attention must be paid to the balance of content in such clips, and using when attempting to convey destigmatising messages, which may then reduce the stigma attached (McCann et al., 2010; Shearer et al., 2012). This research found it may be possible to destigmatise HSV infection using a range of strategies, including short clips.

**Attitudes**

Attitudes are often related to knowledge, considered to predict subsequent behaviour, and are influenced by a range of social and cultural factors. This section discusses attitudes towards sexual and reproductive health in relation to unintended pregnancy, STIs, contraception, and violence against women within the context of social and cultural influences on individual-health related behaviours.

Gender power imbalance is a common theme related to sexual and reproductive health attitudes, which are embedded within cultural attitudes and beliefs (discussed in depth on pages 6 and 7). Attitudes that reflect gender-based power inequities persist, with 19 per cent of Australians holding the view that ‘men should take control in relationships and be the head of the household’ and 28 per cent agreeing that ‘women prefer a man to be in charge of the relationship’. Of particular concern, is that these attitudes are more likely to be supported by young people (VicHealth, 2014).

Ireland and colleagues (2015) found many young Aboriginal women's sexual relationships had unequal gender-based power dynamics, which caused sexual coercion, harassment from partners for money or substances, refusal to use condoms, violence, and substance use. These young women were ambivalent about having sex, with most saying they were frightened of having sex, but believed if they did not have sex with a boy he would leave her for someone who would. A Canadian study conducted with sex workers found reduced control over sexual-decision making played a critical role in intimate partner violence (Muldoon et al., 2015).
Another study with young Aboriginal and Torres Strait Islander people suggested young women were not always able to negotiate sex with or without a condom and young men believed it was their female partner who needed to be responsible for safe sexual practices. This study found a clear gender dynamic indicating that young women still felt responsible for insisting on protection during sex, but were often challenged by men’s dislike for condoms, refusal to use them, or ambivalence towards safer sexual practices (Mooney-Somers et al., 2012). Similarly, a study with recently arrived refugee young people found young men believed women should take greater responsibility for protection as they are more concerned with avoiding pregnancy than men (McMichael & Gifford, 2010). Attitudes towards contraceptive use and risk were examined in the fourth national survey of secondary students and sexual health, which found that less than one in ten students believed they were at risk of HIV/AIDS, an STI, hepatitis B or C (Smith et al., 2009). However, students who were sexually active, had more sexual partners and who were same-sex-attracted were more likely to believe they were at risk of HIV/AIDS and STIs. Further, not using a condom during sex was only associated with increased perceived risk of infection when a student’s sexual partner was someone they had met for the first time (Smith et al., 2009). Ritter and colleagues’ (2015) study of 119 young people aged 14 to 24 found almost half of participants believed ‘contraceptives make sex seem less romantic’ and more than half agreed that ‘contraceptives are difficult to use’. However, while young women and men had positive attitudes to contraception, young women’s attitudes were more positive than their male counterparts. It is possible that this greater positive attitude towards contraception held by females may be attributed to the perceived risk of unwanted pregnancy.

Senior and Chenhall’s (2008) study found that teen pregnancy was the norm in some Aboriginal communities and most young women who participated in their research believed pregnancy was a way to marry the partner of their choice (Senior & Chenhall, 2008). Similarly, Ireland and colleagues found ‘children may also have added authenticity and legitimacy to a young woman’s claim to a male relationship’ (2015, p. 6). The Rogers and Earnest (2015) study with Sudanese and Eritrean women found teen pregnancy was common and gender power imbalances meant it was difficult for young women to refuse sexual intercourse.

Research suggests there is an accepted belief in Aboriginal and Torres Strait Islander communities that becoming a mother is how girls become a woman. Women are therefore expected to have a baby at 16 or 17, which is considered age appropriate and culturally acceptable. Ireland and colleagues suggested the ‘perceived economic and social cost of childrearing is of low impact on young women’s lives’ (2015, p. 6). Women in this study had access to informal childcare within the community, with children being raised by a peer-supervised model, and children were perceived by young women to provide more, rather than less, access to money in their welfare economy.

Violence against women causes poor sexual and reproductive health, and as such, is an important consideration. The 2013 National Community Attitudes towards Violence Against Women Survey (VicHealth, 2014) provided evidence of pervasive and persistent social-cultural attitudes of gender inequality that perpetuate violence against women. The findings suggested that knowledge about violence against women was generally good within the Australia community, and most Australians did not approve of attitudes that were supportive of violence against women. However, there were a number of areas of concern and this pattern was gendered (male), age related (young people aged 16 to 24 and people aged over 65), and culturally differentiated. Between four and six per cent of Australians agreed that violence is justified in some circumstances, while many more believed that there are circumstances in which violence against women can be excused. For example, 21 per cent of Australians agreed that partner violence can be excused if the person is genuinely regretful afterward or if they temporarily lost control (22 per cent), while 43 per cent agreed that ‘rape results from men not being able to control their need for sex’. Aboriginal and Torres Strait Islander people and CALD populations were more likely to agree that violence can be justified. Young men were more likely than young women and all men to agree that violence could be justified in some circumstances. One in ten Australians agreed that ‘if a woman doesn’t physically resist – even if protesting verbally – then it isn’t really rape’, with this attitude being more commonly held among people aged over 65 years. Violence-supportive attitudes were further evident, with 11 per cent of Australians agreeing that domestic violence can be excused if the victim is affected by alcohol and 19 per cent stating that sexual assault can be excused if the victim is affected by alcohol and drugs.
Behaviours
Sexual and reproductive health knowledge and attitudes have positive and negative consequences on people’s behaviours. Five themes were apparent in the literature: preventive health; condom use and safe sexual practices; substance use; sexuality; and consent and violence.

Preventive health
Preventive health screening programs are an important public health initiative for identifying those at risk, as well as facilitating early diagnosis and intervention. However, there are health inequities in relation to the uptake of screening programs. For example, Western Australian 2005-06 prenatal screening data showed uptake of prenatal screening is lowest among Aboriginal women, women living in remote areas, women under the age of 25, women in the lowest quintile of the socioeconomic indexes for areas, and women with three or more children, which indicates inequities in screening uptake and service access (Maxwell et al., 2011). Similarly, an audit of hospital records to assess adherence to the guidelines recommending universal antenatal testing for chlamydia, and additional testing for women in the STI endemic regions of Western Australia, found chlamydia was higher among Aboriginal women (Kwan et al., 2012).

Screening for STIs among drug users, men who have sex with men (MSM), and young people has also been researched. A study using a convenience sample of 741 ecstasy users to examine the risk of transmission of HIV and other BBVI through injecting drug use or risky sexual behaviours found that inconsistent condom use in the past is associated with being male, heterosexual and reporting sex under the influence of a substance in the preceding six months (Dunn et al., 2010). After controlling for all other factors, inconsistent condom use with a casual partner in the past six months was predicted by heterosexuality. Yet, while past-six-month injecting drug use and currently being in drug treatment were predictors of past-year HIV testing, identifying as heterosexual predicted a lower likelihood of past-year HIV testing (Dunn et al., 2010). A mixed method study with MSM to determine whether interventions to increase testing for syphilis and enhance partner notification are acceptable, found that more than one-third of men believed they should get a STI test more frequently. A greater willingness for increased testing was observed among men who had recent unprotected anal intercourse with casual partners and men who reported a higher number of partners. The main barrier to testing reported by these men was inconvenience (due to time, difficulty finding a convenient doctor, and difficulty in getting an appointment) and, while partner notification was mainly acceptable, perceived stigma was a potential barrier (Down et al., 2012).

A study with 24 young women from across Victoria found a high level of acceptance for an age-based screening program for chlamydia in general practice during sexual health and non-sexual health related consultations (Pavlin et al., 2008). The women believed chlamydia screening should be offered to all young women rather than targeted at ‘high risk’ women based on their sexual history, as the young women in this study did not want to provide a sexual history in order to be screened. Furthermore, the young women strongly believed chlamydia screening should be normalised and destigmatised (Pavlin et al., 2008).

A systematic review of intervention programs aiming to reduce the incidence and transmission of HIV and STIs among young people aged 12 to 25 found the highest participation rates for STI testing took place in non-clinical and non-general practice healthcare settings (Kang et al., 2010). This is important, as a study exploring STI prevention in general practice found the provision of STI information is low within general practice clinics (Khan et al., 2008). Female GPs were more than twice as likely to be proactive in STI prevention and assist patients to understand safe sex as a high priority. GPs were also more likely to offer printed materials and pamphlets to patients about STIs if they had a shorter duration of practice, had a recent STI diagnosis experience, or practiced in a nonmetropolitan area. However, metropolitan GPs were almost twice as likely to always offer information to patients on STI transmission modes, compared with non-metropolitan GPs. GPs who trained overseas were almost four times more likely to offer information on STI prevention and the importance of partner treatment compared with locally trained GPs. Time and funding were cited as the main barriers to sexual health promotion in general practice (Khan et al., 2008). A cross-sectional study of a community pharmacy-based chlamydia screening program, that offered a $10 cash incentive, found participants were highly satisfied with the pharmacy-based screening service. Participants reported feeling comfortable talking to pharmacy staff about chlamydia. However, they also indicated the lack of privacy in the pharmacy setting was a barrier (Parker et al., 2015).

Evaluations have been conducted on health promotion programs designed to increase the rate of STI testing. A media campaign targeting men and women in Victoria aged 16 to 29 was evaluated to determine its effectiveness in increasing chlamydia awareness and testing (Chen et al., 2007). Gender-specific campaign advertisements were placed in 30 bars, 34 hotels, eight nightclubs, and eight tertiary institutions, as well as major newspapers, popular women’s magazines, and in local press publications. The campaign was later expanded to include several non-metropolitan regions, online advertisements...
and advertisements in buses and trams en route to university campuses. The campaign cost $197,000 total over two years. During the campaign, chlamydia testing rates increased significantly among women and men, but were higher among women. Testing rates increased during the campaign, yet chlamydia testing rates through Medicare were still low at 4.3 per cent of women and 1.9 per cent men aged 16 to 30 (Chen et al., 2007). Kang and colleagues (2010) conducted a systematic review of interventions to reduce the incidence and transmission of HIV and STIs among young people. They found media campaigns that promoted STI testing had a positive impact on testing rates, and that internet and short messaging services (SMS) were useful additional strategies to influence condom use and STI testing. Chlamydia screening and treatment through sporting clubs was also been found to be feasible and acceptable (Kong et al., 2009).

Condom use and safe sexual practices

The fourth national survey of secondary students and sexual health found more than one quarter of students reported having sex without a condom in the past year (Smith et al., 2009). Students in year 10 were more likely than their year 12 counterparts to use a condom and young men were more likely than young women to always use condoms when they had sex in the previous year (Smith et al., 2009). However, a study with young Aboriginal women found condoms were rarely used, with younger women reporting that young men preferred sex without a condom (Ireland et al., 2015). Research has found a negative association between consistent condom use and number of sexual partners. Students who had a greater number of sexual partners were less likely to report always using a condom when they had sex, compared to those with less sexual partners (Smith et al., 2009). Young women were more likely than young men to report trusting their partner and knowing their partner's sexual history as reasons why a condom was not used the last time they had sex (Smith et al., 2009). Inconsistent condom use puts young people at risk of STIs and unwanted pregnancies. Year 10 students were more likely than year 12 students to report having sex that resulted in a pregnancy (Smith et al., 2009). Casual sex was more common among young men than young women, with young men more likely to have sex with someone they did not know (Smith et al., 2009).

A community-based participatory research project conducted with young Aboriginal people revealed that young people talked about the importance of using condoms to protect themselves from STIs, along with establishing a trusting relationship with one’s partner and having STI tests (Mooney-Somers et al., 2012). However, while young men and women agreed free condoms were widely and readily available, protected sex was not always practiced. Some women suggested it was easier to have unprotected sex with their partner and later seek screening, which indicated that the risk of infection and pregnancy was preferable to negotiating condom use. For young women, being in a relationship was equated with trust and therefore there was a perception that there was no need to use condoms (Mooney-Somers et al., 2012). Mooney-Somers and colleagues’ (2012) study with Aboriginal and Torres Strait Islander young people found being under the influence of drugs or alcohol increased the difficulty of enacting intentions to use condoms during sex.

Research about the contraceptive behaviours of same-sex-attracted people is limited, particularly for women. A peer-developed safer-sex website, Girl2girl.info, was developed to promote riskreduction alternatives to latex-based barrier use, as well as traditional (latex-based) safer-sex practices for women who have sex with women. Evaluation of the site and its development revealed the misperception that women who have sex with women are at no or low risk of STIs. As a result of reported aversion to using latex for safer sex, non-latex safer-sex alternatives were welcomed by participants in a study by Cox and McNair (2009). These included short fingernails, taking off jewellery and using lubricant to avoid internal scratching, chewing gum rather than brushing teeth before sex, using tampons to reduce contact with blood during menstruation, and abstaining from oral contact when there were symptoms of cold sores (Cox & McNair, 2009). This is supported by findings from an online survey by Schick and colleagues (2012) with 3,116 women who have sex with women, examining their sexual repertoires and methods used to reduce the likelihood of STIs. Schick and colleagues found that, despite reporting a large variety of sexual behaviours, few women practiced safe sex, putting them at risk of STIs. For example, barrier methods of contraception were not used during scissoring (rubbing of genitals against another woman’s genitals) and few women used or changed a barrier over dildo or vibrator toys during sexual encounters (Schick et al., 2012).

Research has been conducted to examine the potential population impact and cost savings likely from modifying HIV risk factors among MSM. For example, a study conducted in Sydney with a sample of 1,426 HIV-negative MSM found the prevalence of unprotected anal intercourse with a known HIV-positive partner was low (five per cent) (Guy et al., 2011). However, if this behaviour was not present in the population, 34 per cent of infections would not occur. The average lifetime HIV-related healthcare cost attributable to unprotected anal intercourse among MSM is $102 million; ‘no other single behaviour or sexually transmissible infection contributes to a greater proportion of infections and HIV-related healthcare costs’ (Guy et al., 2011, p. 1).

Limited research has examined safe sex practices among prison populations. A retrospective medical record audit of 946 individuals admitted to Western Australian prisons to evaluate selfreported
unprotected sex, found that in the previous twelve months this behaviour was reported among 48 per cent of prisoners, with adults more likely than juveniles to report unprotected sex (Watkins et al., 2011). A mixed methods study exploring how dental dams are used in New South Wales women’s prisons found that, despite 36 per cent of women reporting having sex with another inmate, only four per cent had ever used a dental dam (Yap et al., 2010).

Substance use
Limited research has been conducted on the impact of substance use on sexual and reproductive behaviours. Data from the Sydney gay community periodic survey study and the positive health cohort study were used to examine changes over time in use of crystal methamphetamine and sexual behaviours. Crystal methamphetamine users reported a greater number of sexual partners, had sex in more types of venues, and were more likely to engage in unprotected anal intercourse with casual partners and esoteric (niche) sex practices compared to non-users (Rawstorne et al., 2007). Despite this, while crystal methamphetamine use was associated with unprotected anal intercourse with casual partners, after adjustment for other factors, it was not possible to conclude that it caused an increase in unprotected anal intercourse with casual partners. This was due to the finding of an increase in the prevalence of crystal methamphetamine use over time along with a decrease in unprotected anal intercourse with casual partners (Rawstorne et al., 2007).

STI diagnoses have also been associated with illicit drug use. Data from the Australian Longitudinal Study on Women’s Health found young women aged 22 to 27 had a higher risk of chlamydia, herpes and genital warts if they had ever used illicit drugs. Interestingly, smokers had a reduced risk of herpes compared with non-smokers, but current and past smokers had an increased risk of genital warts compared with non-smokers (Asaaduzzaman et al., 2005). The use of marijuana among young Aboriginal women was common in the study by Ireland and colleagues (2015), and young women were at increased risk of non-consensual sexual intercourse and unwanted pregnancy while under the effects of marijuana. Further to this, some young women used transactional sex to obtain marijuana, usually with older men. A qualitative study with women opioid users found the women believed heroin and methadone use had a negative impact on their sexual functioning and some women actively used heroin as a form of contraception (Banwell et al., 2009).

Alcohol and other drug use has been found to be a barrier in taking antiretroviral medications (ARTM) for HIV. Data from a national cross-sectional survey of 1,106 people living with HIV infection found 867 (78.4 per cent) were taking ARTM at the time of the study and more than one-third (39.1 per cent) of these respondents reported difficulty taking ARTM (Grierson et al., 2011). Difficulty taking ARTM was associated with younger age, alcohol and drug use, poor or fair self-reported health, diagnosis of a mental health condition, living in a regional centre, taking more than one antiretroviral dose per day, experiencing adverse physical side effects or health service discrimination, type of antiretroviral regimen and specific attitudes towards ARTM and HIV (Grierson et al., 2011).

Sexuality
Sexuality has been explored in relation to sexual behaviours and differences in age, education level and occupation. Computer-assisted telephone interviews were used to collect data from a representative sample of 20,094 men and women aged 16 to 69, who were recruited via landline and mobile phone random-digit dialling, to investigate sexual identity, the sex of people with whom they had ever had sexual contact, and whom they found sexually attractive (Richters et al., 2014). The study found patterns of sexual identity differed between men and women. Most identified as heterosexual (97 per cent for men and 96 per cent for women). However, women were more likely than men to identify as bisexual, with women being less likely than men to report exclusively other-sex or same-sex attraction and experience. For instance, nine per cent of men and nineteen per cent of women had a history of same-sex attraction and/or experience. Homosexual identity was more common among men with tertiary education and living in cities, and less common among men with blue-collar jobs. Bisexuality was more common among men aged under 20 years and monosexuality and heterosexuality was less common than among older men. Among women, the association between age and bisexual identity was stronger than for men, peaking in the 20s, followed by a fall in every subsequent age group. Sexual identity was associated with occupation level, with a high proportion of women identifying as heterosexual and bisexual having white-collar occupations, and a large proportion of lesbians holding managerial positions (Richters et al., 2014). This study demonstrates sexual identity and sexual behaviour are not always consistent.

Further to this, research has explored the role of online communities as a source of sexuality-related support. A qualitative study with 14 queer Australian young people found that online communities provided a sense of belonging that reduced their experiences of isolation. Further, engagement in online communities enabled queer young people to understand they are not the ‘problem’, but rather that heteronormative society has caused their exclusion. In this way, the online community provided young people with the necessary ‘emotional resources and social capital to do something to address their marginalisation’ (Hanckel & Morris, 2014, p. 872).
Consent and violence

Scant research attention has been paid to consent and violence with regard to sexual and reproductive health inequities. Research has shown that violence against women is attributed to gender inequity, as detailed throughout this literature review. This section identifies population groups most at risk. The intention is not to ‘blame the victim’ of violence, but rather explore the complexity of the contexts in which consent and violence occurs.

The Australian Longitudinal Study on Women's Health (2000) data analysis of 9,683 women aged between 22 and 27 found early first sexual intercourse was strongly associated with partner violence, with the earlier the age of first sexual intercourse, the stronger the association. Women reporting intercourse before the age of 14 were 7 to 14 times more likely to report partner violence, compared with those reporting first sex at 17 years or older (Watson et al., 2007). What is not clear from this analysis is the context in which the first sexual intercourse took place, insofar as was it consensual, non-coerced sexual intercourse. Ireland and colleagues (2015) found that violence from sexual partners was common among young Aboriginal women and was often considered an acceptable form of intimate partner communication. Data from the fourth national survey of secondary students and sexual health found unwanted sex was more common among young women than young men, with the most common reasons reported as ‘being too drunk’ and ‘pressure from their partner’ (Smith et al., 2009). These findings further highlight the gendered power dynamics and imbalance between women and men.

A mixed methods impact evaluation with 153 young women and men aged 16 to 26 from Australia and New Zealand who participated in the Sex and Ethics Violence Prevention Program, found young women and men who participated were better able to communicate, negotiate consent, interpret body language, voice their wishes and desires, place parameters on sexual activities and challenge potentially sexually coercive situations after the completion of the program. However, there were gender differences. The young women ‘learnt new ways of caring for themselves that include the possibility of an active sexuality. By doing so, they demonstrate an active resistance to traditional gender norms’ (Carmody & Ovenden, 2013, p. 805). The young men ‘increased their awareness of understanding the impact of their desires on their partner and the need to listen actively to their partner’s needs. By these actions, they resisted the dominant discourses of male sexuality as a self-focused sexual pursuit with little regard for the needs of a partner. Through ethical reflection, gaining an understanding of the impact of these sexual scripts on others and learning new negotiation skills, they performed a different kind of masculinity based on ethical mutual concern. They were fashioning new identities as ethical sexual citizens’ (Carmody & Ovenden, 2013, p. 805).
Differences in health and wellbeing outcomes

The inequities identified in the socio-economic, political and cultural context, daily living conditions and individual health-related factors culminate in differences in health and wellbeing outcomes. Within Australia, poor sexual and reproductive health has been found to disproportionately affect certain population groups, including young people, Aboriginal and Torres Strait Islander people, people living with a disability, people residing in rural and remote areas, CALD communities including asylum seekers and refugees, GLBTIQ populations, sex workers, prisoners and people experiencing homelessness (O’Rourke, 2008). However, for some population groups (e.g. people experiencing homelessness, sex workers, and people living with a disability) no or limited research was available that specifically examined sexual and reproductive health inequities. Two main sexual and reproductive health themes emerged from the literature in relation to differences in health and wellbeing outcomes: general health and wellbeing status; and intimate partner violence (IPV), violence, coercion and discrimination.

General health and wellbeing status

Differences in general health and wellbeing outcomes resulting from the socio-economic, political and cultural context, daily living conditions and individual health-related factors differ across population groups and have negative consequences for sexual and reproductive health outcomes. This section discusses health and wellbeing outcomes among GLBTIQ populations, young people, sex workers, prison populations, and people with a disability.

GLBTIQ populations

Health status has been found to vary by sexual identity. Data from the Australian Longitudinal Study on Women’s Health (2003) cohort aged 25 to 30 found women who identified as lesbian, bisexual, and ‘mainly heterosexual’ were more likely than heterosexual women to report poorer mental health (McNair et al., 2011). This research builds on previous cross-sectional analyses of the Australian Longitudinal Study on Women’s Health with women aged 22 to 27 and 50 to 55, which found that younger, mainly heterosexual, bisexual and lesbian women had poorer mental health outcomes compared with exclusively heterosexual women after controlling for age, geographic region and education (McNair et al., 2005). The older mainly heterosexual women had poorer mental health and bisexual women had a greater risk of self-harm than exclusively heterosexual women. However, the effect was weakened after controlling for stress, abuse and social support. Levels of stress and lifetime abuse were higher among all non-heterosexual women (McNair et al., 2005). Similarly, higher levels of psychosocial distress and fair or poor self-rated health have also been found to be associated with non-heterosexual identity (de Visser et al., 2007).

A national online survey to examine differences in mental health, resilience, stigma-related challenges, and social support among 1,034 Australian gay-identified men aged 18 to 39 found that rural men had lower self-esteem, life satisfaction, and social support, and were more likely than urban men to experience psychological distress, to be concerned about acceptance from others, and to conceal their sexual orientation (Lyons et al., 2015). Examining predictors of psychological distress among rural men suggested lower education levels and less tangible support predicted greater levels of psychological distress (Lyons et al., 2015). The rate of major depressive disorders has been found to be higher among HIV-positive gay men than among HIV-negative gay men, with major depressive disorders associated with socio-economic deprivation, interpersonal isolation, personal withdrawal and recent sexual problems. Notably, HIV-status was associated with major depressive disorders (Mao et al., 2009). Similarly, a survey of 253 transgender people from Australia (n = 229) and New Zealand (n = 24) found participants had poorer health ratings than the general population based on the SF-36 health scale, with high rates of depression reported, with assigned males at birth twice as likely to experience depression as assigned females at birth (Pitts et al., 2009). Powdthavee and Wooden (2015) suggested that being a sexual minority is indirectly associated with lower levels of wellbeing through a set of economic, social and personal factors that also predict life satisfaction. These studies drew on large representative samples and suggested the social determinants of health (economic, social, discrimination and inclusion) contribute to health inequity experienced by sexual minorities (McNair et al., 2011; Powdthavee & Wooden, 2015). This requires further exploration.

Lifestyle risk factors such as tobacco, alcohol and other drug use are known to be causes of poor health. The third national study on the sexual health and wellbeing of 3,134 same sex-attracted and gender questioning (SSAGQ) young people found drug use was higher among this population compared to their peers. Young SSAGQ women were more likely to use drugs than young SSAGQ men and drug use was most likely a form of self-medication (Hillier et al., 2010). A national crosssectional study of 1,034 Australian gay men aged 18 to 39 found, after adjusting for differences in age and body mass index, Twink-identified men had the highest risk profile, with higher rates of smoking tobacco and alcohol consumption. Cannabis use was higher among Twink-identified compared with non-identified men (Lyons & Hosking, 2014).
Using data from two national, cross-sectional surveys of people living with HIV, Koelmeyer and colleagues (2014) examined the independent association of key social determinants of health among HIV-positive gay and bisexual men in Australia. The study found being employed, reporting recent sexual activity, a greater number of sources of social support and a higher weekly after-tax income were independently associated with better self-rated health (after controlling for potential confounders, including length of time untreated, HIV infection type, ARTM experience, number of HIV-related adverse events and the presence of other major health conditions).

Similarly, a mixed methods study of 72 men living with HIV found they experienced lower quality of life compared with Australian population norms, and this was particularly the case for the social and emotional domains of quality of life (Millard et al., 2014). Together, findings from these studies suggest redressing barriers to employment, sexual activity, and mechanisms to increase social support, might have positive health effects (Koelmeyer et al., 2014), as would targeting the social and emotional domains of the daily lives of men living with HIV (Millard et al., 2014). Additionally, a national cross-sectional study of 1,034 Australian gay men aged 18 to 39 found no differences between sexual minority sub-cultures (e.g. Twink, Cub and Non-identified) in relation to psychological distress, self-esteem, feeling positively toward their sexual orientation, feeling connected with the gay community, and experiences of discrimination (Lyons & Hosking, 2014). A nationwide online survey, consisting of 1,135 Australian gay men aged 40 years and older, found factors contributing to poor mental health included low income, unemployment, living alone, treatment for a major physical health condition, experiences of discrimination and regarding one’s sexual orientation as an essential part of self-identity (Lyons et al., 2012).

Young people

Much of the research that focuses on health differences relating to sexual and reproductive health has been on rates and prevalence of STIs, particularly chlamydia, among young people. A cross-sectional study of sexually active 16- to 29-year-olds attending Australian general practice clinics found an overall chlamydia prevalence of almost five per cent, with similar rates for both women and men (Yeung et al., 2014). However, gender differences have been observed in relation to chlamydia health-seeking behaviour, with women more likely to be tested as a result of screening, while men were more likely to be tested once symptoms presented or as a result of contact tracing (Stephens et al., 2010). Yeung and colleagues (2014) found 73.4 per cent of chlamydia infections were diagnosed in participants who attended the clinic for other reasons, suggesting testing only those with symptoms or a partner with an STI will fail to detect almost three quarters of chlamydia cases. Additionally, Yeung and colleagues (2014) found a higher prevalence of chlamydia among young people from rural and regional areas, and Asaduzzaman and colleagues (2005) found women from rural or remote areas had higher odds of chlamydia than urban women. However, data from Tasmania indicated rates of chlamydia were higher in urban areas (Stephens et al., 2010). A higher prevalence of chlamydia was also reported among Aboriginal and Torres Strait Islanders (5.8 per cent) (Yeung et al., 2014). It is possible these differences are a result of selection bias in Yeung and colleagues’ study, as the sample was not drawn from a population sample and over represents rural and regional areas, females and Aboriginal and Torres Strait Islanders. However, while Asaduzzaman and colleague’s (2005) study was based on a large (n = 9,582), nationally representative sample of women, and despite oversampling women for rural and remote areas, it relied on self-reported diagnosis.

Chlamydia diagnosis has been found to be associated with an increasing number of sexual partners in the previous twelve months for men and women (Yeung et al., 2014). Data from a representative sample of women aged 22 to 27 found having ten or more male sexual partners increased the likelihood of chlamydia - as well as herpes and genital warts - compared with women with one or no male sexual partners (Asaduzzaman et al., 2005). Age has also been associated with likelihood of chlamydia diagnosis; being aged between 25 and 29 was associated with a decreased risk of chlamydia diagnosis compared with 16- to 19-year-olds (Yeung et al., 2014). An inverse association between age, chlamydia and genital herpes has also been observed, indicating an increased risk among younger women (Asaduzzaman et al., 2005). Age at first sexual intercourse has been associated with increased risk of genital warts. Women 18 years or older at first intercourse had 1.6 times higher odds of genital warts than women aged 15 or younger (Asaduzzaman et al., 2005).

Contraception use has also been associated with STI risk. Chlamydia diagnosis among men has been found to be associated with inconsistent condom use with most recent partner; however, this was not the case for women (Yeung et al., 2014). Use of the oral contraceptive pill has been associated with herpes and genital warts. For example, women who had used the oral contraceptive pill for five years or more had double the odds of getting herpes compared with non-users or those who used the pill for one year or less (Asaduzzaman et al., 2005). It is possible these findings reflected women’s use of contraception to prevent unwanted pregnancies rather than the use of contraception to prevent STIs. Interestingly, a diagnosis of herpes has been reported to be higher among men who experienced violence and women with a higher mean stress score than women who did not have these experiences (Asaduzzaman et al., 2005). The data from the Australian Longitudinal Study on Women’s Health is
based on a large representative sample of Australian women; however, it is possible the findings only provide a conservative estimate of STI diagnosis. Furthermore, they were not able to examine STI diagnosis by a range of population groups, including same-sex attracted women, Aboriginal and Torres Strait Islander women and so forth (Asaduzzaman et al., 2005).

However, further analysis of data from the Australian Longitudinal Study on Women's Health (2003) cohort on women aged 25 to 30 found bisexual and ‘mainly heterosexual’ women were more likely to report STIs, abnormal Pap tests and hepatitis B or C infection. Of note, is that lesbians were more likely to have never had a Pap test or to have under-screened (McNair et al., 2011). Similarly, a cross-sectional study of Australian men aged 18 to 39 found men who did not identify with gay subculture were significantly less likely to report receiving an STI test in the past twelve months (Lyons & Hosking, 2014). A study which aimed to determine the prevalence and risk factors for HPV among female senior high school students that were sexually active found the prevalence of HPV DNA was 11.2 per cent; however, no associations between HPV DNA and the number of male partners, age at first sexual intercourse, time since first sexually active, condom use, smoking or alcohol intake were found (O’Keefe et al., 2006). This study provides a useful insight into HPV prevalence among young adolescent females. However, the findings cannot be generalised to the broader population due to the small (n = 161) convenience sample. It does suggest further research is warranted in order to inform vaccination recommendations.

**Sex workers**

Sex workers are recognised to be at high risk of STIs, yet less is known about their different sexual practices and healthcare needs. An analysis of clinical data from 185 self-identified female sex workers in western Sydney found sex workers from non-English-speaking backgrounds were more likely to be older, have STI symptoms, have had a hepatitis B diagnosis in the previous year and work more shifts per week, compared with sex workers from English-speaking backgrounds (Kakar et al., 2010). Furthermore, sex workers born overseas were more likely to have STI symptoms than Australian-born sex workers who, in turn, were more likely to have a hepatitis C diagnosis in the previous year. Hence, sex workers from non-English-speaking backgrounds would potentially benefit from evidenced-based, culturally and linguistically appropriate interventions and targeted health promotion (Kakar et al., 2010).

**Prison populations**

Prison populations are at a higher risk of poor sexual health compared with the general population (Butler et al., 2010; Butler et al., 2013a; Douglas and Pluggle, 2008). A computer-assisted telephone surveys conducted in 2007 and 2008 with 900 men and 134 women in Queensland prisons found age of first sexual intercourse was lower for men (15 years) and women (16 years) compared with the general population (Butler et al., 2010). Within this prison population, 10 per cent of men and 21 per cent of women had been paid for sex, and 13 per cent of men and 60 per cent of women reported they had been forced or frightened into some type of sexual activity at some point in their lives, which were much higher rates than those for the general population. Seven per cent of men in Queensland and New South Wales prisons reported they had been threatened with sexual coercion while in prison with non-heterosexual identifying men more, Aboriginal and Torres Strait Islander people, those who were Australian born, in a Queensland prison, first time prisoners, had spent more than five years in prison and have a history of sex work were more likely to have been threatened with sexual coercion (Simpson et al., 2015).

Further to this, 68.4 per cent of men and 60.2 per cent of women did not tell anyone or seek help following the incident(s). These findings highlight the high rates of sexual assault and coercion among prison populations, and particularly for women. Rates of forced sexual activity while in prison were much lower, at 3 per cent of men and 4 per cent of women (Butler et al., 2010). Butler and colleagues (2013b) found no evidence that condom provision increased consensual or non-consensual sexual activity in prison. Nonetheless, if condoms were freely available, they were much more likely to be used during anal sex.

The majority of prisoners in Butler and colleagues (2010) study rated their health as ‘excellent’, ‘very good’ or ‘good’, with ten per cent of prisoners reporting a health condition or disability that limited their mobility. A cross-sectional study conducted in a Western Australian regional mixed medium-security prison with 185 prisoners (170 men and 15 women) found 52 per cent of prisoners had at least one chronic health condition (Gilles et al., 2008). Notable were the high rates of poor psychological wellbeing, with 32 per cent of men and 45 per cent of women reporting an emotional or mental health problem, including depression, schizophrenia, psychosis, anxiety disorder, personality disorder, ADD/ADHD, or substance-use dependence. However, it was likely that these rates represented an underestimation of the extent of poor psychological wellbeing within this population (Butler et al., 2010). A qualitative study in the United Kingdom with detained juvenile women identified mental health problems, substance misuse and sexual health as priority health concerns. Additionally, the study identified that for these young women, ‘youth, gender and social exclusion intersect to impact upon not only their offending but also their health’ (Douglas & Pluggle, 2008, p. 75).
The socio-demographic characteristics of prison populations is suggestive of the role of social positioning as a determinant of incarceration. One quarter of the sample in Butler and colleagues’ study (2010) identified as Aboriginal or Torres Strait Islander, representing their disproportionate rates of incarceration. Gilles and colleagues’ (2008) study of Western Australian prisoners found 84 per cent of prisoners were Aboriginal and Torres Strait Islander people. Education levels were low, with 72 per cent of men and 63 per cent of women not having completed secondary school. Approximately one quarter (27 per cent of men and 25 per cent of women) of the sample were unemployed prior to their incarceration (Butler et al., 2010). Watkins and colleagues (2011) also identified distinct socio-demographic patterning of high-risk behaviours among prisoners in Western Australia, including age, sex and Aboriginality.

People living with a disability

People living with a disability, and in particular women and girls, face systemic prejudice and discrimination that results in ‘multiple and extreme violations of their sexual and reproductive rights, through practices such as forced and coerced sterilisation, forced contraception and limited or no contraceptive choices, a focus on menstrual and sexual suppression, poorly managed pregnancy and birth, forced or coerced abortion, termination of parental rights, denial of and forced marriage, and other forms of torture and violence, including gender-based violence. They also experience systemic exclusion from sexual and reproductive healthcare services’ (Frohmader & Ortoleva, 2013, p. 2). These practices highlight the pervasive gendered and disability-based norms and stereotypes that exist within society. Despite this, there is very little research that specifically examines the health and wellbeing outcomes of people living with a disability in relation to sexual and reproductive health inequities.

People living with a disability, and in particular women and girls, are more likely than people without a disability to be victims of physical and sexual abuse and rape (Frohmader et al., 2015; WHO & UNFPA, 2009; Woodlock et al., 2014). Furthermore, people living with a disability fit the common pattern of structural disadvantage, such as high rates of poverty, high rates of illiteracy, lack of access to health resources, and lack of power when negotiating safer sexual practices to prevent against HIV/AIDS and other STIs (WHO & UNFPA, 2009). The intersectionality of being a woman with a disability creates additional marginalisation that further compounds poor health and wellbeing outcomes (WHO & UNFPA, 2009).

Intimate partner violence, coercion and discrimination

Intimate partner violence (IPV), coercion and discrimination are known to be determinants of poor health and wellbeing. The Australian Bureau of Statistics’ Personal Safety Survey (ANROWS, 2015) found women were more likely to be sexually assaulted by a boyfriend or date than by a male cohabiting partner. However, women were equally likely to have been sexually assaulted by a partner they lived with as by a stranger. In regards to women’s most recent sexual assault by a man, three quarters of women reported the assault occurred in a private residence, over half of women indicated drugs or alcohol contributed to the incident, and one third of the women were sexually assaulted by a man known to them and thought the sexual assault was a crime (ANROWS, 2015). This research also indicated that one in four women have experienced at least one incident of violence by an intimate partner and one in three have experienced violence by a non-cohabiting partner. Furthermore, analysis of IPV data from Demographic and Health Surveys across 19 countries, including Australia, found IPV is common during pregnancy, ranging from two per cent in Australia, to 14 per cent in Uganda among ever-pregnant, ever-partnered women. Furthermore, the prevalence of IPV during pregnancy appeared to decline with age (Devries et al., 2010).

However, less is known about these important determinants in relation to sexual and reproductive health inequities that lead to greater health inequalities. Most of the existing research has focused on women and same-sex-attracted men. An eleven-year prospective cohort study of Australian-born women aged 45 to 55 found 27 per cent of women reported experiencing physical, emotional and/or sexual IPV, which was associated with poorer mental and sexual health (Schei et al., 2006). A representative sample of 9,134 Australian women aged 16 to 59 found 21 per cent of women had been sexually coerced, which was associated with poorer psychological, physical, and sexual health (de Visser et al., 2007).

A qualitative study with service providers who assist male victims of IPV, found all service providers believed IPV occurred in male same-sex intimate relationships at rates similar to or higher than heterosexual relationships. They also believed that male same-sex IPV was underreported, and hence an invisible problem. Service providers reported that IPV in male same-sex intimate relationships took similar forms to that found in heterosexual IPV, including emotional, sexual, and physical violence (Kay & Jeffries, 2010). The Kay and Jeffries study (2010) is useful; however, it does not consider the experience of men themselves.
Sexual IPV among MSM has been reported to be more than double the rate of Australian men who reported fewer experiences of homophobic discrimination (Finneran et al., 2012). Psychological ill health, substance use, economic power imbalances, and ideals pertaining to hegemonic masculinity were believed to play a role in IPV among MSM (Finneran et al., 2012). Societal homophobia and heteronormative barriers were believed to prevent male victims of IPV seeking help (Kay & Jeffries, 2010). IPV services have been set up to support women as victims rather than men, and most GLBTIQ-specific services are not designed to deal with same-sex IPV (Kay & Jeffries, 2010).

A South Australian survey with a convenience sample of GLBTIQ people found discrimination via the law and in daily life were significant determinants of health (Rogers, 2007). Similarly, experiences of discrimination were more commonly reported by gay men living in rural areas, with rural men more likely than urban men to feel their sexual orientation was not accepted by others (Lyons et al., 2015), which resulted in negative consequences for health and wellbeing. Similarly, a study with 1,306 lesbian, gay and bisexual Australians found those residing in rural-remote localities were more likely to conceal their sexuality from friends, were more concerned about disclosing their sexuality, had less lesbian, gay and bisexual community involvement, fewer friendships with other lesbian, gay and bisexual people, and (among men) had higher levels of internalised homophobia than those residing in inner metropolitan areas (Morandini et al., 2015).

Research with MSM in the United States, Canada, Australia, the United Kingdom, South Africa, and Brazil found the most commonly reported form of IPV was physical violence, with nine per cent of Australian men in the sample reporting that they had been a victim of physical violence, while 2.5 per cent had experienced sexual violence (Finneran et al., 2012). Perpetrating physical violence against a partner in the past year was reported by 3.9 per cent and perpetration of sexual violence was reported by 0.56 per cent of the Australian men who participated in the study. Additionally, among the Australian men, lower levels of education and history of behavioural bisexuality were associated with experiencing physical IPV, and experiences of IPV were less likely to be reported by older men. Heterosexist social pressures were found to increase IPV, which highlighted the role of heteronormativity as a risk factor for violence among MSM (Finneran et al., 2012).

The third national study on the sexual health and wellbeing of SSAGQ young people found SSAGQ young people experienced substantial verbal and physical homophobic abuse in the community, and in particular within the school environment (Hillier et al., 2010). For example, 61 per cent of young people reported verbal abuse and 18 per cent reported experiencing physical abuse related to homophobia, with young men and gender-questioning people reporting more abuse than women (Hillier et al., 2010). Furthermore, homophobic abuse was associated with feeling unsafe, excessive drug use, self-harm and suicide attempts. SSAGQ young people who had been physically abused reported poorer mental health compared with those who reported either verbal abuse or no abuse (Hillier et al., 2010). Importantly, schools with a supportive environment resulted in less harm or suicide attempts among SSAGQ young people (Hillier et al., 2010). Being in a relationship with a man and having a large network of gay and bisexual friends was a protective factor against internalised homophobia (Chard et al., 2015). A study of transgender people found one in four participants reported suicidal thoughts in the two weeks before they completed the survey (Pitts et al., 2009).

Experiences of social exclusion were common among SSAGQ young people who were religious (Hillier et al., 2010). Young men were more likely to disclose and be supported than young women, particularly by parents. Friends appeared to be the first people SSAGQ young people confided in. However, young people with a religious background, while just as likely to disclose, were less likely to be supported by family and teachers. These young people were more likely to report having to tolerate homophobic language, feelings of compromised safety at home and were more likely to selfharm and have suicidal ideations (Hillier et al., 2010). Young people from CALD backgrounds were less likely to disclose to their parents and, if they did, were less likely to get family support (Hillier et al., 2010). Young SSAGQ people in rural and remote areas also reported experiences of isolation and discrimination that resulted in higher rates of self-harm, and feeling less safe at school and social occasions, compared to young people in urban settings (Hillier et al., 2010). Gender questioning young people were more likely than their same sex-attracted peers to have disclosed, yet even less likely to be supported, and had a greater risk of homelessness, physical abuse, self-harm and suicide (Hillier et al., 2010).
Conclusion and recommendations

Sexual and reproductive health inequities cause poor health and wellbeing and are apparent across all levels of ‘Fair Foundations: The VicHealth framework for health equity’ (VicHealth, 2015). The review of the literature shows that sexual and reproductive health inequities are apparent in policy, institutional structures, the social and cultural context of people’s everyday lives, healthcare services, employment, and education. The review highlights the sexual and reproductive health inequities experienced by various population groups, which are compounded by social position, gender, age, sexuality, culture and ethnicity, and location.

However, as evident in the review of existing literature, there are still substantial gaps. Much of the previous research has focused on young people, same-sex-attracted people, and refugee, CALD and Aboriginal and Torres Strait Islander people, with scant attention paid to substance users, prison populations, sex workers and people living with a disability. Those in mid-life and older adults, and those who identify as exclusively heterosexual, are also absent from the body of research on sexual and reproductive health inequities. Exclusive heterosexuality, presented as the ‘norm’, has only been considered for the purpose of comparison and as such assumes homogeneity. Most of the available evidence specific to sexual health has focused on STIs, while reproductive health has focused mainly on contraception and pregnancy. A smaller body of research has examined violence, coercion and discrimination. However, little attention has been given to aspects of sexual health such as pleasurable, satisfying sexual encounters and experiences, and sexual rights. Hence, current research fails to consider all aspects of sexual health and sexuality as identified by the WHO (2006 updated 2010; 2015a).

Further research is required to redress the identified gaps in the literature. Future research needs to be cognisant of socio-economic, social, cultural, political and geographical differences between and within population groups across the breadth of sexual and reproductive health and the life course. Research is needed to:

• Understand the specific needs, priorities and consequences of sexual and reproductive health inequities among population target groups, including young people, people with a disability, people in or released from incarceration, sex workers, people who inject drugs, mid-life and older people with a diversity of sexualities and the implications for their health and wellbeing across the life course
• Explore the barriers to participation in research for underrepresented population groups and explore the development of culturally appropriate research methods to engage particular subgroups
• Design health promotion interventions that respond to intersectionalities; for example, the sexual and reproductive health needs of migrant and refugee people living with a disability, who are aging and GLBTIQ
• Explore experiences and implications of discrimination for sexual and reproductive health and how this effects health and wellbeing, including help-seeking behaviours, service use and experiences, preventive health programs, and medication compliance
• Understand the experiences and implications of legislation, laws and policy on sexual and reproductive health and how this effects the health, safety and wellbeing of various communities
• Identify the needs of specific population groups, which are used to drive research and health promotion interventions for specific population groups
• Explore experiences of physical, sexual and emotional violence and its impact on sexual and reproductive health among diverse population groups. This includes the identification, implementation and evaluation of strategies to prevent or reduce rates of early violence and sexual assault
• Identify effective strategies to raise awareness of cultural constructions of sex and sexuality, gendered roles, health, illness and risk among health service providers
• Explore the facilitators and barriers to the adoption of inclusive healthcare services
• Explore contextual influences on pregnancy decision-making and the use of termination services among diverse groups of women (of different ages, social and family contexts) in order to inform appropriate design and delivery of targeted services to meet the specific needs of each cohort. Further to this, research is required to explore the lived experience and impact of pregnancy decision making and outcomes.
In addition, there is currently a lack of health promotion program evaluation aimed at reducing sexual and reproductive health inequity. It is therefore recommended health promotion programs are evaluated and report findings made publicly available.

Women’s Health West’s ‘Sexual and reproductive health promotion framework’ (Taylor, 2011) recognises the multiple and interacting factors that contribute to sexual and reproductive health (including the individual, community and societal level influences) and is aligned with ‘Fair Foundations: The VicHealth framework for health equity’ (VicHealth, 2015). Cutting across both frameworks is a focus on the social determinants of health inequity – identifying social, cultural, political, economic and behavioural determinants that contribute to poor health outcomes and inequity. ‘Fair Foundations: The VicHealth framework for health equity’ identifies the need for universal and targeted approaches to redress health inequity, and promotes working within settings as opposed to priority population groups. However, the ‘Sexual and reproductive health promotion framework’ provides a comprehensive approach that identifies priority target population groups, settings for action, and areas for health promotion action to redress sexual and reproductive health inequity (Figure 1). This report has been structured based on the layers of ‘Fair Foundations: The VicHealth framework for health equity’. However, given its congruency with the ‘Sexual and reproductive health promotion framework’, the recommendations of this report are presented according to the layers of this framework.

Figure 1: Women’s Health West’ Sexual and reproductive health promotion framework. Source: Taylor, 2011; Taylor & Vu 2013.

The review findings support the scope and focus of the ‘Sexual and reproductive health promotion framework’. However, a number of recommendations can be made to enhance direction and action within each of the layers of the framework. The recommendations are synthesised to highlight the relevance to the layers of the framework, rather than setting out recommendations specifically under each individual action area within the framework layers. Thus, an integrated, cohesive set of recommendations have been made that recognise the overlap between the layers and each action area to facilitate intervention design, delivery and evaluation that tackles the widespread, core inequities across multiple levels and sectors of society.
Social determinants of sexual and reproductive health equity

It is recommended that:

- Public policy is inclusive and responsive to diverse population groups, and as such, language and subsequent policy interventions move beyond the heteronormativity that leads to persistent and pervasive gender and sexuality norms (Sen & Östlin, 2008; Thompson et al., 2014)
- Diverse populations are engaged in public policy review and law reform processes in order to ensure cultural and gender appropriateness is embedded, institutional and structural violence and discrimination are prevented, and access to affordable and culturally appropriate health services is enhanced (Short, 2007; Yelland et al., 2012)
- Interventions are designed to redress pervasive gender norms and stereotypes and promote diverse understandings of gender, sexuality and sexual identities (Bishop, 2012; Caxaj & Berman, 2010; Wray et al, 2014)
- Sexual and reproductive health service provision is accessible, affordable and culturally appropriate and is informed by, and meets the needs of, diverse population groups’ cultural and religious beliefs, attitudes, behaviours and lived experiences (Caxaj & Berman, 2010; Guirgis et al., 2012; Ussher et al., 2012; Wray et al., 2014; Yelland et al., 2014).

Behavioural determinants of sexual and reproductive health equity

It is recommended that:

- Contraceptive knowledge and safe sexual behaviours are increased via tailored programs and services that respond to the specific needs of population groups, particularly those who are perceived to be at no or minimal risk of STIs and BBVI
- Sexuality education and health information is implemented in various formats across population groups, and is appropriate to age, sexual orientation and culture in order to improve contraceptive practices1 (Fagan et al., 2015; Rogers & Earnest, 2015)
- Sexual and reproductive health services and programs are responsive to and overcome barriers posed by cultural and gendered social determinants and religious and other behavioural determinants to ensure equitable health outcomes (Caxaj & Berman, 2010; Drummond et al., 2008; Ireland et al., 2015; Rogers & Earnest, 2015; Ussher et al., 2012; Wray et al., 2014).

Population target groups

It is recommended that:

- All population groups are engaged in service planning, design, delivery and evaluation to enhance the cultural appropriateness and accessibility of program and service models for each group (Bartolomei et al., 2014; Fawcett & Hanlon, 2009; Hadgkiss & Renzaho, 2014; Murray et al., 2010)
- Policy makers, health promotion practitioners and service providers consult with priority population groups to develop shared cultural understandings and to reduce and prevent stereotyping and reverse-stereotyping, exclusion and discrimination in policy, practice and service provision (Koh et al., 2014; Thompson et al., 2014)
- Organisational policies and practices promote and enable flexibility for diversity, to redress multiple social and behavioural determinants of health for priority population target groups.

---

1This may involve a needs assessment with various community groups to determine their preferred method of engagement with sexual and reproductive health information, such as flyers in various languages, the use of online/social media, or workshops.
Health promotion action

It is recommended that:

- Advocacy is undertaken to influence policy and legislative reform to redress direct and indirect discrimination and promote sexual and reproductive health inequity (Correia & Broderick, 2009; Jones et al., 2014; McDonald & Dear, 2008; Short, 2007)
- Opportunities be identified and barriers to implementing and operationalising workplace antidiscrimination policies and practice be redressed (Aaron & Ragusa, 2011; Yelland et al., 2012)
- Health sector workforce and development training, including gender and sexual diversity training and cultural competency training and development, be implemented in a range of settings to facilitate change across multiple determinants of health2 (Guirgis et al., 2012; Short, 2007; Trevor and Boddy, 2013; Yelland et al., 2012)
- Services, programs and practitioners tailor practice to acknowledge the diversity of sexual orientation and sexual practice across the life course and recognise the fluidity of sexual practices (Richters et al., 2014)
- Practitioners are provided with sexual and reproductive health literacy training to increase awareness and recognition of different forms of violence and victims of violence, discrimination (including covert and institutional discrimination practices), and how to implement primary prevention strategies to prevent violence and discrimination (Bartolomei et al., 2014; Cama et al., 2015; Caxaj & Berman, 2010; Goldman, 2010; Guerin et al., 2006; Hayman et al., 2013; Jeffreyes et al., 2010; Miller et al., 2010; Short, 2007; Taft & Watson, 2007)
- Health services work in partnership to provide integrated sexual and reproductive healthcare, services, health promotion programs and information, and inclusive models of practice, with flexibility to accommodate diverse family types and cognisant of inclusivity in language and non-verbal interactions (Botfield et al., 2015; Hayman et al., 2013)
- Women’s equal representation in leadership positions be enhanced to create public and private domains that promote gender inclusiveness, equity empowerment and leadership, and to contribute to the gender agenda in training and curriculum.

1For instance, diversity training for organisations and practitioners is needed across multiple aspects of diversity, including gender diversity, sexual diversity and cultural diversity. Importantly, diversity training should encompass identification, recognition and acknowledgement of diversity not only between groups, but also within groups. There is also a need for recognition of the diversity within the heterosexual population and their needs, and the heterogeneity within CALD communities and the unique and contextual needs of individuals and population groups within the CALD community (such as asylum seekers, refugees, longer-term resettled migrants, first- and second-generation migrants, males and females, youth and older people). Recognition of these diversities could help to target and redress several social determinants of health, including violence and discrimination, cultural norms, gender norms, and behavioural determinants such as sexual practices, religious beliefs, reproductive and contraceptive practices. Cultural competency training should highlight and develop a broader understanding of the concepts of ‘culture’, ‘cultural diversity’ and ‘culturally inclusive practice’ to better recognise the range of population sub-cultures and their needs (that is, not just people of CALD background, but youth cultures, GLBTIQ populations and Aboriginal and Torres Strait Islander people) (Guerin et al., 2006; Guirgis et al., 2012; Koh et al., 2014; Mulligan & Heath, 2007; Murray et al., 2010). A wider implementation of cultural competency training (particularly that which takes account of diversity within cultures) among the health sector and workforce could also help to redress the barriers faced by multiple groups in relation to accessing affordable, culturally appropriate health services.

2It is important to acknowledge that sexual identity and sexual behaviour do not always align, and determining ways to reach individuals who may not ‘fit the mould’ is essential to inclusive service delivery. There is a need for greater recognition of heterogeneity within GLBTIQ communities and the compounding and unique challenges faced by particular sub-groups within this population cohort; for example, older/aging people who identify as GLBTIQ and GLBTIQ parents (Correia & Broderick, 2009; Hughes, 2007; Short, 2007). Cultural competency of service providers could facilitate this, as could the inclusion of GLBTIQ people in organisational reviews and policy developments to inform their diverse needs (Koh et al., 2014).

3Integrated service delivery should redress sexual and reproductive health in the context of broader social and behavioural determinants of health, in particular those which build upon existing program and service opportunities. For instance, the integration and embedding of sexual and reproductive health information and education in the provision of current programs and services for alcohol and other drugs is recommended to reduce inequities in sexual and reproductive health by targeting this behavioural determinant of health. Sexual and reproductive health services for people from migrant and refugee backgrounds should also be delivered in an integrated manner which considers their sexual and reproductive health context and needs within the broader context of their daily lives (in particular their migration and refugee experiences), rather than in an isolated manner, for more culturally appropriate and holistic care (Usher et al., 2012).
Settings for action

It is recommended that:

- Training and/or curriculum on gender equity and sexual diversity is embedded within settings for action, particularly those which focus on sexuality, gender diversity and sexual diversity (Trevor & Boddy, 2013)

- Programs and services across all settings for action are cognisant of gender norms and challenge stereotypical ascribed gender roles (Rogers & Earnest, 2015; Senior & Chenhall, 2008)

- Sexuality and respectful relationships education programs, which include modules on sexual consent and what constitutes coercion, are implemented across relevant settings, such as education and training institutions, sports and recreation clubs, and workplaces (Walker et al., 2015)

- Sexual and reproductive health education and screening is provided to people in prisons (Butler et al., 2010; Butler et al., 2013a; Douglas & Plugge, 2008)

- All settings for action engage in meaningful and strategic partnerships with organisations or individuals who can assist in cultural competency and inclusivity training or have experience of delivering programs in a way that can be modified and replicated across the sector

- Health and other government and non-government sectors include the diversity of population groups in service and program planning, delivery and evaluation to ensure its cultural relevance, sensitivity and modes of delivery are acceptable to the intended target group.
References


Byron, P, Albury, K & Evers, C 2013, ‘“It would be weird to have that on Facebook”: young people’s use of social media and the risk of sharing sexual health information’, Reproductive Health Matters, vol. 21, pp. 35-44.


Hillier, L, Jones, T, Monagle, M, Overton, N, Gahan, L, Blackman, J & Mitchell, A 2010, Writing Themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.


Keddie, A 2009, ‘“Some of those girls can be real drama queens”: issues of gender, sexual harassment and schooling’, Sex Education, vol. 9, pp. 1-16.


Koh, CS, Kang, M & Usherwood, T 2014, ‘“I demand to be treated as the person I am”: experiences of accessing primary healthcare for Australian adults who identify as gay, lesbian, bisexual, transgender or queer’, Sexual Health, vol. 11, pp. 258-264.


McMichael, C & Gifford, S 2009, ”‘It is good to know now... Before it’s too late”: Promoting sexual health literacy amongst resettled young people with refugee backgrounds’, Sexuality & Culture, vol. 13, pp. 218-236.


References
References


Our Watch, ANROWS & VicHealth 2015a, Change the story: A shared framework for the primary prevention of violence against women and their children in Australia, Our Watch, Australia’s National Research Organisation for Women’s Safety (ANROWS) and VicHealth, Melbourne, Australia.

Our Watch, ANROWS & VicHealth 2015b, Framework foundations 2: Think pieces, stakeholder consultations, issues, implications and approach, Our Watch, Australia’s National Research Organisation for Women’s Safety (ANROWS) and VicHealth, Melbourne, Australia.


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


VicHealth 2007, Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women, Victorian Health Promotion Foundation, Melbourne.


WHO 2005, Addressing violence against women and achieving the Millennium Development Goals, Department of Gender, Women and Health Family and Community Health, World Health Organization, Geneva.


WHO 2012, World conference on social determinants of health, World Health Organization, Brazil.


Women’s Health West 2014, Shared understandings: Women’s Health West guide to health promotion and gender equity, Women’s Health West, Footscray.
References


