Women's Health
LODDON MALLEE

Her Health Matters

A REGIONAL APPROACH TO WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH

2023 - 2026

Acknowledgements

Women's Health Loddon Mallee (WHLM) wishes to thank the many individuals, colleagues and partners who have contributed their time, knowledge, experience and leadership to refresh the Her Health Matters sexual and reproductive health strategy.

Acknowledgement of Country

Women's Health Loddon Mallee acknowledges the Traditional Custodians of the lands on which we live, work and play.

We celebrate and respect the unique cultural and spiritual relationship that Aboriginal and Torres Strait Islander peoples share with the lands, sky and waters and the ongoing contribution their cultures make to the life of the region.

As we pay our respects to Elders past, present and future, we pledge our commitment towards reconciliation and justice.

We recognise the strength and resilience of all Aboriginal and Torres Strait Islander peoples and are dedicated to a future in which they feel connected, empowered and safe within the communities of the Loddon Mallee region.

Women's Health Loddon Mallee (2023). Her Health Matters: A regional approach to sexual and reproductive health in the Loddon Mallee Region 2023-2026. Bendigo, Victoria.

About

WHLM is a not for profit (but for purpose) independent, regional service run by women, for women, based on the social model of health. We engage with women and gender diverse people, communities, service providers and Local Governments to promote and enhance the health and wellbeing of women across the Loddon Mallee Region. WHLM works within a feminist framework. We are committed to a rights-based approach in advocating for women. We focus on the role of gender regarding traditional roles and stereotypes that lead to disadvantage, discrimination, and violence against women. We are invested in advocating for positive change for all women and girls across the Loddon Mallee Region.

WHLM has five key focus areas:

1. Advance gender equality and respect
2. Improve sexual and reproductive health
3. Primary prevention of violence against women
4. Improve women's mental health and wellbeing
5. Women in a changing society

This strategy has been developed to focus the resources and effort required to achieve the goal of focus area 2 to improve sexual and reproductive health:

We will ensure communities have access to informed and appropriate sexual and reproductive health services that are provided free of judgement and discrimination. Individuals should be empowered to have safe, respectful, and pleasurable relationships and a positive approach to sexuality and its expression.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
BBV	Blood-Borne Viruses
DV	Domestic Violence
FGM	Female Genital Mutiliation
HIV	Human Immunodeficiency Virus
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual
LMPHU	Loddon Mallee Public Health Unit
LMR	Loddon Mallee Region
MBS	Medicare Benefits Schedule
MTOP	Medical Termination of Pregnancy
PCOS	Polycystic Ovarian Syndrome
PD	Professional Development
PHN	Primary Health Network
Q&A	Question and Answer
RTI	Reproductive Tract Infections
SRH	Sexual and Reprodutive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infections
WHLM	Women's Health Loddon Mallee

CONTENTS

1. STRATEGY SNAPSHOT

Vision

Women* across the Loddon Mallee Region can access supportive, evidence-based, and culturally responsive sexual and reproductive health services, provided free of judgement and discrimination. Communities support and promote positive approaches to sexuality and its expression which enables and empowers women to enjoy safe, respectful and pleasurable relationships and to have their voices heard.

DEFINITION OF SEXUAL AND REPRODUCTIVE HEALTH

Good sexual and reproductive health (SRH) is important for women's general health and wellbeing. It is central to their ability to make choices and decisions about their lives, including when, or whether, to consider having children. Sexual and reproductive health is not only about physical wellbeing – it includes the right to healthy and respectful relationships, health services that are inclusive, safe, and appropriate, access to accurate information, effective and affordable methods of contraception and access to timely support and services in relation to unintended pregnancy.

STRATEGIC PRIORITIES

Living a sexually healthy life: Individuals are empowered to have safe, respectful, and pleasurable relationships

Knowing your body: Individuals understand and are supported to manage their own health, particularly conditions and transitions related to their reproductive health system

Having reproductive choices: Individuals have an improved understanding of and access to contraception, termination of pregnancy, fertility and birth services

Finding the right care: Sexual and reproductive health information and services are provided in a manner that is non-judgmental, easily understood, free from discrimination, geographically and financially accessible, and sex-positive

Working together: Communities and health services collaborate to ensure sexual and reproductive health information and services are appropriate, flexible, innovative and effective

DEFINITION OF WOMEN

This document refers to 'women' to include anyone who lives and identifies as a woman.[1] In reference to 'women' this document also extends to include all transgender, non-binary, and gender diverse people who may access women's sexual and reproductive health services including, but not limited to, abortion, contraception, assisted reproductive technology, and screening for sexually transmissible infections/blood-borne viruses (STIs/BBVs).

WHLM acknowledge that neither sex nor gender are binary in nature and that socially constructed understandings of what it means to be woman or man do not reflect the gender diversity of our community. As a rights-based organisation, championing gender equality and social justice, WHLM firmly believes in everyone's right to self-determine and to safely express their gender. This strategy is developed for women of all ages and life stages.

2. BACKGROUND AND CONTEXT

2.1 The Loddon Mallee Region

The Loddon Mallee Region (LMR) of Victoria is located in the north-west of the state and includes the local government areas of Buloke, Campaspe, Central Goldfields, Gannawarra, Greater Bendigo, Loddon, Macedon Ranges, Mildura, Mount Alexander and Swan Hill. The region covers over 58,000 square kilometres stretching from Gisborne, north to Echuca and follows the Murray River to Mildura. The population of the Loddon Mallee region is estimated to be 348,397, 177,089 of whom identify as women(Australian Bureau of Statistics, 2021).

The LMR is predominantly rural in nature which presents particular challenges in sexual and reproductive health related to service availability, confidentiality, choice and appropriateness of service delivery. These challenges pose a further barrier to service access for diverse population groups including young people, Aboriginal and Torres Strait Islander people, gender diverse people, sexuality diverse people, people with a disability, and people from refugee and migrant backgrounds.

2.2 What Is Sexual And Reproductive Health?

Good sexual and reproductive health (SRH) is important for women's general health and wellbeing. It is central to their ability to make choices and decisions about their lives, including when, or whether, to consider having children. Sexual and reproductive health is not only about physical wellbeing – it includes the right to healthy and respectful relationships, health services that are inclusive, safe, and appropriate, access to accurate information, effective and affordable methods of contraception and access to timely support and services in relation to unintended pregnancy.

The ability of an individual to achieve sexual health and wellbeing depends on their:

- awareness of, and access to comprehensive, good-quality information about sex and sexuality
- knowledge about the risks they may face and their vulnerability to adverse consequences of unprotected sexual activity
- ability to access sexual health care
- living in an environment that affirms and promotes sexual health

Sexual health-related issues are wide-ranging, and encompass sexual orientation and gender identity, sexual expression, relationships, and pleasure. They also include adverse consequences or conditions such as:

- infections with blood borne viruses (BBVs) and human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and reproductive tract infections (RTIs) and their adverse outcomes (such as cancer and infertility)
- unintended pregnancy
- sexual dysfunction
- sexual violence
- harmful practices (such as female genital mutilation, FGM)

Reproductive health includes all matters relating to the reproductive system and its functions. It is inclusive of stages such as puberty and menopause, fertility, reproductive control, and conditions that affect the reproductive system such as endometriosis and polycystic ovarian syndrome (PCOS).

Sexual and reproductive health plays a fundamental role in the overall health and wellbeing of women, influencing health at every life stage. Like other areas of health, sexual and reproductive health is interlinked and influenced by many factors including physical, emotional, environmental and social determinants. The impacts of sexual and reproductive health are human and economic, and direct and indirect. Unintended pregnancy, sexual violence, sexually transmissible infections (STIs) and infertility are major contributors to morbidity and associated costs in Australia. The incidence and impacts of poor sexual and reproductive health in turn varies among different population groups and according to age, sex, socioeconomic background and geographic location.

2.3 Review And Refresh Of The Her Health Matters Strategy

Women's Health Loddon Mallee (WHLM) engaged HealthConsult to review and refresh 'Her Health Matters: a regional approach to sexual and reproductive health in the Loddon Mallee region.'

HealthConsult engaged with a variety of stakeholders throughout the review and refresh process including:

- Women's Health Loddon Mallee staff, executive management and members of the Board of Management
- Service providers from across the Loddon Mallee region
- Representatives from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

Women's Health Loddon Mallee also completed stakeholder engagement with consumers in the Loddon Mallee region through three focus groups and an online survey. The voices and experiences of the women consulted by Women's Health Loddon Mallee are highlighted in Chapter 3.1 of the strategy.

3. WOMEN

This document refers to 'women' to include anyone who lives and identifies as a woman.[2] In reference to 'women' this document also extends to include all transgender, non-binary, and gender diverse people who may access women's sexual and reproductive health services including, but not limited to, abortion, contraception, assisted reproductive technology, and screening for sexually transmissible infections/blood-borne viruses (STIs/BBVs).

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To improve the sexual and reproductive health of communities across the LMR it is recognised that the health of all persons needs to be addressed. This strategy predominantly focuses on women (as defined above) as girls and women continue to experience a higher burden of sexual and reproductive ill-health, including:

- women predominantly bear the primary responsibility for reproductive choice, including contraception
- the impact of poor reproductive health is greater on women, due to both biological and social factors
- many women experience significant diagnostic delays for conditions that affect the reproductive system
- women are more often the victims of family violence and sexual assault which has direct impacts on women's sexual and reproductive health outcomes

Although the terminology used throughout the Strategy generally refers to women and girls, this is not intended to exclude women with diverse sexualities, intersex women, transgender women, transgender men, or non-binary people.

3.1 Voices, Experiences And Stories

The voices, experiences and stories of women are at the heart of this strategy.

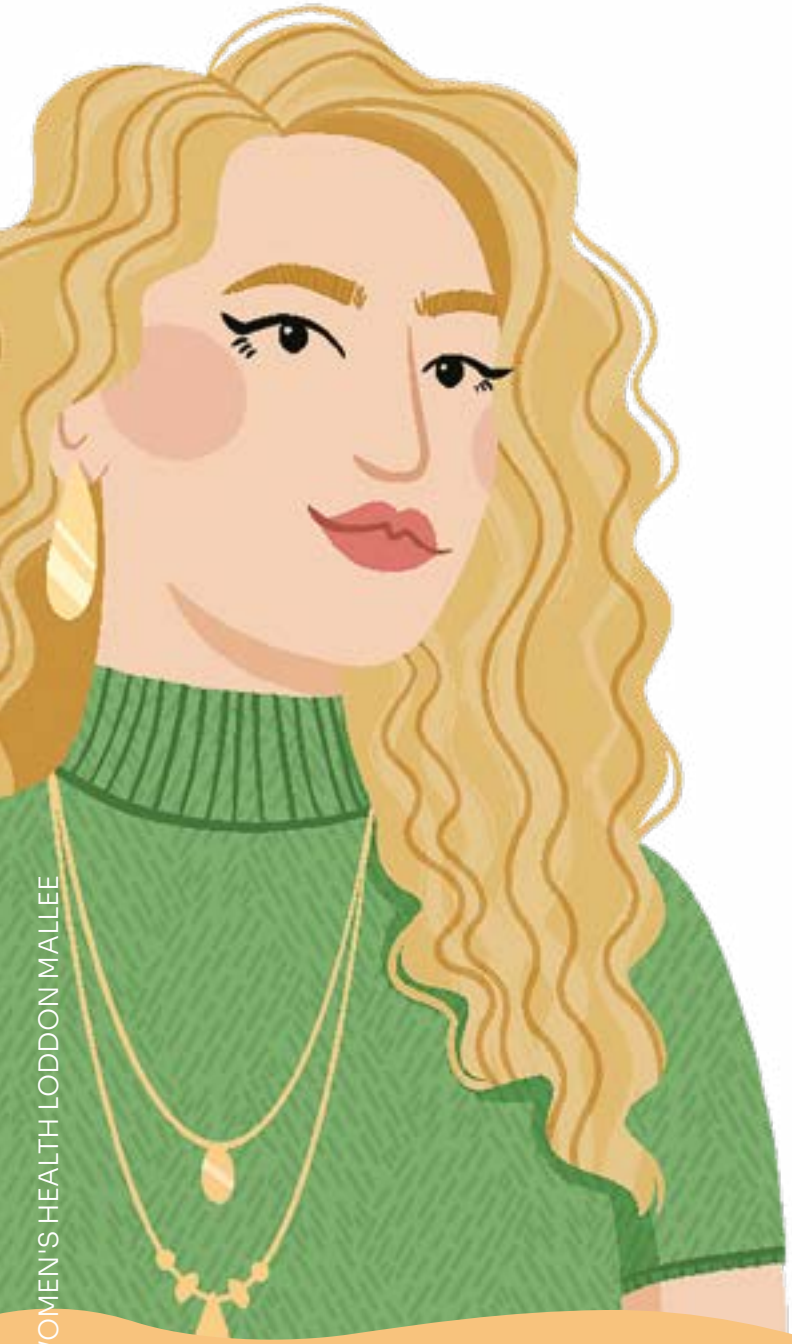
- "I am positive that **women's health is just not taken seriously**. I don't feel heard at all. You're made to feel like either you're complaining or mad, or perimenopausal"
- " It comes down to that thing you know, 'women are hysterical'. **A lot of people don't understand how in tune women are with their bodies, because they have to be"**
- **"I went to a doctor, and I said I think I have an ovarian cyst, and he said 'do you spend much time watching TV?** It took me a little while to twig what he was talking about and that he said why do you think that? and I described the pain in my right ovary, and he said 'well you've got a lot of other things down that way.'". Anyway, **it was an ovarian cyst but that was the response I got, stupid man, I was so angry"**
- "When you look at trials, **clinical trials, the people who take part are men**, men in their twenties and thirties that are looking for money. It's not women, it's not Filipinos, it's not Africa women, it's white men, and **we know their bodies don't react the same"**
- "We need more awareness within women themselves to **speak up, and to be more confident and strong about what we want"**
- "I used to love the pap smear clinics here.....**I was quite traumatised having to go to a male doctor and having to strip off...** whereas having a clinic where you are local and you can just book in with a female, it's much better"
- **"Information for young people**... it is really hard to get health professionals to come into the school and hard for them to access services, because **we don't have a clinic or a doctor that can provide these services, prescribe anything or give further information** in the area – particularly the youth, **they can't drive, they are stuck in the limits of the town unless their parents drive them**, but also access to information and efficient services"

- "My daughter is 7, almost 8 is talking about nipple pain - who do I ask? do I go to the doctor or is that over utilising the medical service, am I hypothesising something based on Google or **is this (puberty) happening? Where is that information other than on the internet? Where is that space within the community (for support)?"**
- "(SRH) is like a mountain....**there's a lot of work that could be done in the preventative space that could be really empowering"**
- "Younger people are often more receptive to new knowledge and ways of doing things and it's **often the older generations that need to be educated as well.** It's all well and good to have respectful relationships in schools but **if the parents or grandparents of those kids have the same dreadful values then how much change is going to happen?"**
- **"My 8 year old daughters asked me the other week what a slut was,** it was big. At that age it is about giving her enough information to understand but not too much. **It was awful.** It's not just losing that innocence but just that feeling of I'm going to need to manage this stuff before it happens"
- "The main problem I have is that I'm mentally ill before I am sexually active, or I am mentally ill before I am female or **I am mentally ill before anything else and that steps on accessing services and having good quality conversations"**
- **"I recently had a DV [domestic violence] experience** and I found the services really, really good at responding to that quickly. **I feel grateful that I could reach out and that I got a response that was really quick and the care was sensitive and I felt supported, and not shamed.** That was a really important experience in my journey"
- **"I feel like there's a baseline of if everyone is ok then we are doing our job. It's not like if everyone is thriving, and doing amazing, and we have resolved all these problems, then we are doing a good job.** I feel like the baseline, like the aim is let's just make everything functional and workable, and I feel like **there is an opportunity for a paradigm shift in how we approach healthcare"**

"The health services are not in town, so **we rely a lot on our friends and our families to provide support and information**...apart from that, I don't feel very supported professionally, apart from my GP"

"I'm really happy with the prep[aration] for Puberty because I feel really confident now about her journey. Those are really helping...**she had those classes and she was really excited.** She has all her pads and stuff in her bag, she's all organised and **I could tell she felt really empowered**...she feels really comfortable with herself now"

"The nurse-practitioner did come to [town name], but only if enough people book in...it used to be once a fortnight or a month, on a more regular basis... but if you don't know that... **I didn't know that"**



- **"Getting a GP is hard,** and seeing the same GP week to week, month to month, year to year. They only work two days a week often and **you've got to kind of go in and explain everything over and over and over again"**
- "The taboos, we like to think they aren't still there but they are still prevalent. **We all think that we are equal, and you know boys and girls and equal but nah, that stuff is still so ingrained in the playground and in the politics of being a child"**
- **"It's so complex now.** It's more diverse with the non-binary push, which is great, but it's also quite confusing for a lot of kids and there's a lot of emphasis on that non binary world which is another element of complexity in an already complex situation of transitioning from childhood into adulthood"

3.2 Priority Populations

The incidence and impact of poor sexual and reproductive health on women and girls varies between different population groups, and is influenced by factors such as socioeconomic status, geographic location, and age. In addition, intersectionality, the understanding of how aspects of someone's identity interact to shape a person's experience, is an important consideration in the context of sexual and reproductive health. Interventions need to balance universal strategies with specialist, tailored approaches for women who experience intersectional disadvantage.

A life course approach recognises the impact of a person's life stage and prior experiences on health outcomes and behaviours. Taking a life course approach means health is viewed across a whole life and interventions should consider the past, current and future needs and experiences of the target group.

The following population groups were identified as a priority through the stakeholder and community consultations and following analysis of population health data. Health equity and a right-based approach are key drivers of this strategy, and alongside the priority populations listed below, there will be a continued focus on affordability, accessibility and acceptability of initiatives and services.

3.2.1 First Nations Communities

The impacts of intergenerational trauma, racism within health and other systems, and a lack of cultural safety remain barriers to improving health outcomes for First Nations people.[2] Aboriginal and Torres Strait Islander peoples have historically been subjected to sexual violence from early colonisers, who used this to debilitate First Nations communities in Australia.[3]

3.2.2 Migrant And Refugee Groups

Women from culturally and linguistically diverse backgrounds, particularly women from migrant and refugee backgrounds, are at a greater risk of developing adverse health conditions than Australian-born women.[4] Culturally relevant and multilingual sexual and reproductive health information and available services are not easily accessible for migrant and refugee women, who find the Australian health system difficult to navigate and understand. Furthermore, we recognise that past experiences of war, violence and stigma create further intersectional disadvantage for migrant and refugee women.

Seasonal and temporary workers within the Loddon Mallee region are also subject to limited access to healthcare based on visa status. This adds to the complexity of providing care to this population group as the person incurs fees for non-medicare eligible service provision.

3.2.3 Gender And Sexuality Diverse People

Gender refers to socially constructed roles, behaviours and attributes that any society considers appropriate for girls and women, and boys and men.[5] However, although they are used interchangeably, gender is not the same as sexuality. Sexuality refers to whom a person is attracted to, which can include various sexual orientations.

The health experiences of people from gender and sexuality diverse communities are shaped by oppressive and discriminative structures that endorse heteronormativity and cis-normativity.[4] As a result, they experience poorer health and sexual outcomes compared to heterosexual and cis-gendered peers, such as higher rates of sexual violence, unsafe sex, and poorer sexual and reproductive health literacy.[4]

3.2.4 People With Disability

People are considered to have a disability "if they have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities." [5] Women with physical, cognitive or psychiatric disabilities are a substantial and diverse population in Victoria, with nearly one in five women and girls having a disability.[4] They, and their carers, have a higher risk of mental ill-health, early onset of chronic conditions, and social and economic disadvantage than the general population.[6]

Individuals with disabilities have the right to information, education and resources to make informed choices about their sexuality and sexual and reproductive health. However, the sexual and reproductive needs of persons with disabilities are often overlooked and neglected.[4] Women with disabilities are two times more likely than women without disabilities to have experienced sexual violence and intimate partner violence.[7] The compounded effect of gender inequality also means that women and girls with disabilities are more likely than men with disabilities to be unemployed, live in poverty, or be engaged in unpaid care work.[4]

3.2.5 Young People

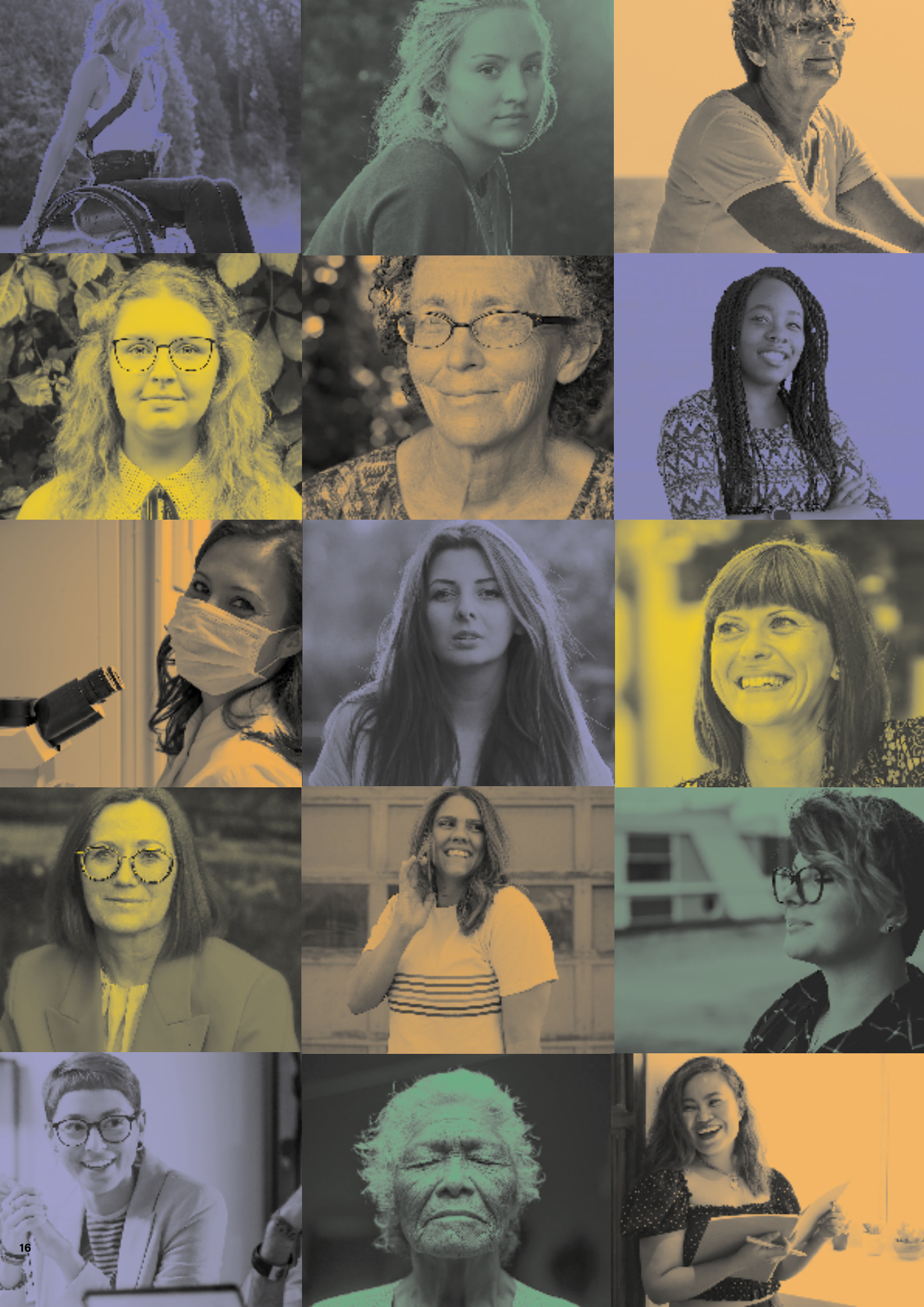
Youth health focuses on young people aged 12-24 years of age. Youth is a key transition stage in life, with the health of young people influencing future educational outcomes, transitions into full-time work, developing healthy adult lifestyles and difficulties with forming families and parenting.[8]

The sixth National Survey of Australian Secondary Students and Sexual Health in 2018 found that about half the students in Years 10, 11 and 12 had engaged in sexual intercourse (47%).[8] However, evidence suggests that young women may have an unmet need for contraception, inability to access contraception or may not be using contraception properly, with women aged 24 years and younger accounting for 43% of abortions.[4] Factors influencing young women's contraceptive choices and access to STI screening include cost, lack of experience with sexual and reproductive health services, lack of trust, low health literacy, side effects, cultural norms, fear of judgement, stigma, and social conditions.[4,9] These factors can contribute to low usage of contraceptives and STI testing, increasing the risk of unintended pregnancy and STIs. This complex mix of factors and attitudes can lead to sexual ambivalence among young women.

3.2.6 Older People

The World Health Organisation explains that healthy ageing is about creating environments and opportunities that enable people to be and do what they value throughout their lives so people can continue to enjoy a good quality of life as they age.[10]

Structural ageing of the population indicates that sexual health issues in older people could become an increasing public health issue. Currently, there is a lack of government sexual healthcare policies specifically targeting older adults. In addition, ageing is also related to reproductive health stages such as menopause, which can cause debilitating symptoms in some people. Some may consider a career break or retiring when their work is affected by menopausal symptoms such as hot flushes, sweats, sleep disturbance and mental health issues. In the workplace, difficulties with memory and concentration may be particularly difficult. A 2021 study found 83% of people experiencing menopause were affected at work, but only 70% would feel comfortable speaking with their manager about it.[11]



4. THE HER HEALTH MATTERS STRATEGY 2023-2026

4.1 Overview

The Her Health Matters Strategy and implementation plan will prioritise primary prevention approaches and initiatives that work to:

- address the social determinants of sexual and reproductive health
- prevent ill health
- promote health equity

The strategy is informed by local evidence and was prepared in consultation with the local sexual and reproductive health workforce, primary prevention practitioners and the voices of women* in the Loddon Mallee region. These voices, experiences and stories must remain central to all related activity.

The Her Health Matters Framework 2023-2026 (Figure 1) is a conceptual and planning tool designed to guide collaborative action across the Loddon Mallee region. It summarises the strategic priorities, priority populations, and actions that will be implemented through the strategy.

FIGURE 1: THE HER HEALTH MATTERS FRAMEWORK 2023 – 2026

VISION:

All women across the Loddon Mallee region can access supportive, evidence-based, and culturally responsive sexual and reproductive health services provided free of judgement and discrimination. Communities support and promote positive approaches to sexuality and its expression which enables and empowers women to enjoy safe, respectful and pleasurable relationships and to have their voices heard.

STRATEGIC PRIORITIES

- Living A Sexually Healthy Life
- Knowing Your Body
- Having Reproductive Choices
- Finding The Right Care
- Working Together

VOICES, EXPERIENCES + STORIES OF WOMEN

PRIORITY POPULATIONS

- First Nations People
- Migrant And Refugee People
- Gender + Sexuality Diverse People
- People With Disability
- Young People
- Older People

ACTIONS

- Create Connections
- Grow Capacity
- Build Knowledge
- Amplify Voices
- Develop Solutions

4.2 Strategic Priorities

4.2.1 Living A Sexually Healthy Life

Overview: A sexually healthy life includes sex positivity, pleasure, respect and access to evidence-based information about sexual education and consent.

What we heard:

A body-positive, sex-positive integrated approach to sexual health is required. Sexual health was described by service providers as "not merely the absence of diseases and infections, but consent, relationships and pleasure as well." This includes "healthy relationships with ourselves and our bodies, and as a result of that we can relate to others in good health as well." Greater awareness of sexual health will allow "women themselves to speak up, and to be more confident and strong about what we want."

The current system is not sex-positive "There's still a shaming style outlook on young girls and their behaviour, and how that affects how they are treated when in actual fact it's the choice of the person when it comes to sexual assault or anything like that. Just because a young teenager goes out and gets drunk doesn't mean they should be shamed by their family or adults around them. It is very harmful and it is still something that goes on. It's very upsetting." Using a sex-positive approach will remove stigma and support women in achieving fulfilling, and pleasurable sex lives.

There needs to be more education around informed consent. It was reported that "there are still a lot of people that don't know what consent means," and that "at the core...there is a system that condones violence against women and does not respect informed consent or informed decline." While respectful relationship education in schools is required, there is a need for this to be "expanded out into adult settings where you could access information that was more relevant for whatever life stage you are at."

Education in schools needs to improve. It was reported that "you are always hearing lack of sex education in schools...people are not promiscuous- there is just a lack of education." Service providers highlighted that there needs to be "targeted, simplified education starting from the beginning "basic anatomy" and "small sessions more regularly to provide opportunity to take in the information...rather than one big session." There also needs to be upskilling of staff "to feel confident in delivering respectful relationship education." Furthermore, consumers stated that "young people are receiving zero LGBTI+ education in school, when they are a captive audience - there is a lack of access to reputable information and resources".

What can be done:

1. **Provide recommendations to schools and stakeholders regarding quality SRH education programs and provide linkages to support their implementation** (i.e. linking the school with a local SRH nurse or health promotion officer)
2. **Affirmative consent training and education for priority groups** (i.e. seek local partnerships and tailor education sessions for target populations)
3. **LGBTIQA+ sex education for young people** (i.e. provide advice to education and youth services regarding appropriate training programs and organisations)
4. **Facilitate access to e-sexual health clinics, including screening services** (i.e. promote existing clinics to priority groups through partner organisations)
5. **Facilitate access to sexual health resources in languages other than English** (i.e. work with local service providers to confirm languages and culturally safe and appropriate resources)
6. **Advocate for standardised STI testing during antenatal care** (e.g. focus on areas with high rates of STIs and mother-baby transfer).

Outcome: Individuals are empowered to have safe, respectful and pleasurable relationships.

4.2.2 Knowing Your Body

Overview: Knowing your body includes an understanding of reproductive health across different life stages and transitions, including puberty, menopause and ageing.

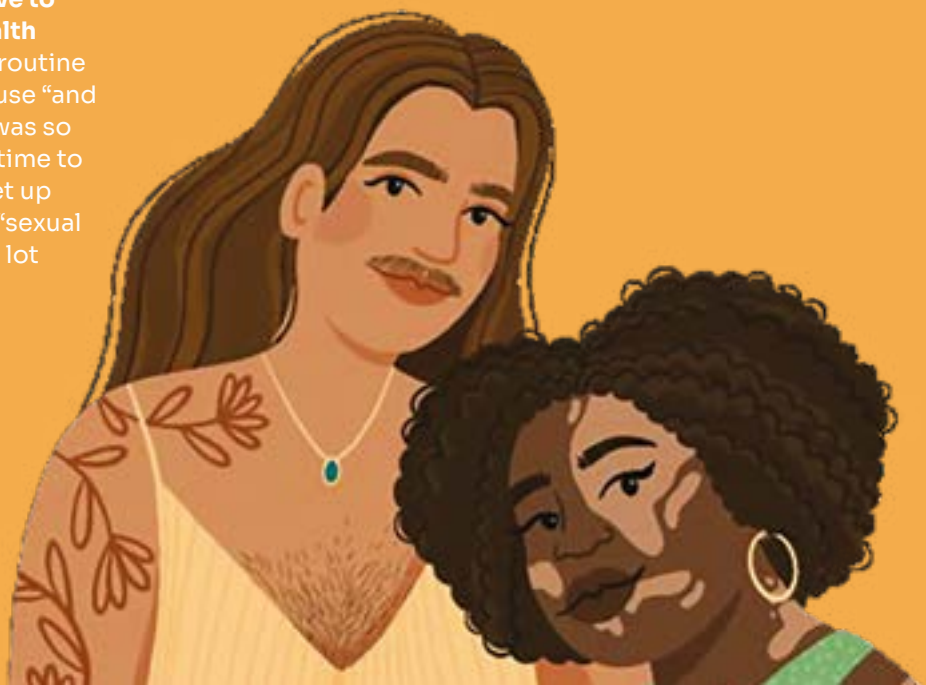
What we heard:

- **Sexual and reproductive health needs to be redefined for older people.** It was identified that there is a preconception that older people do not have sex, where in fact "older people still have sex during, before and after menopause"
- **There is a lack of understanding about menstruation, perimenopause and menopause.** Women felt that "when you add anything to do with hormones or cycles there's this thing of 'suck it up'... there's this continuum of lack of understanding, or lack of empathy, which is a larger social issue." This can impact the ability to access culturally safe services or appropriate medication
- **There is little to no information available on puberty for gender and sexuality-diverse young people.** It was identified that the school-based programs were based on a traditional view of male and female sexual identity and relationships (cis-normative). "Everything they hear is from a cis normative perspective"
- **The current medical model is not conducive to talking about sexual and reproductive health issues.** One woman reported that during a routine health check she asked about perimenopause "and I just got the impression that she [the GP] was so under the pump that she didn't really have time to go into it." Current GP appointments are set up around 15-minute appointment times, but "sexual and reproductive health discussions take a lot of time"

What can be done:

1. **Review resources and programs and provide recommendations regarding inclusive puberty and sex education tools for local schools and organisations** (e.g. content meets best practice regarding gender-inclusive puberty and health education. Actions include collaborations with key education stakeholders)
2. **Develop and run peri-menopause and menopause information sessions targeting priority populations and rurally isolated women** (e.g. online presentation and Q&A session with GP/s and/or other health care professionals)
3. **Develop and implement workplace policies for reproductive health (including menopause)**
4. **Readily available information sessions or resources relating to sexual health for ageing populations** (e.g. expert-led sessions for primary care and aged care workforce)
5. **Explore partnership opportunities to provide local leadership and equity for the free period products in public places initiative** (e.g. train stations, hospitals, public libraries, schools)

Outcome: Individuals understand and are supported to manage their own reproductive health.



4.2.3 Having Reproductive Choices

Overview: It is vital that all women have reproductive choices including preventing pregnancy through contraception, abortion access and access to appropriate care during pregnancy.

> "It's a minefield to know what your options are, where to go...what does it feel like if you have an abortion? What's it going to be like if you don't?"

What we heard:

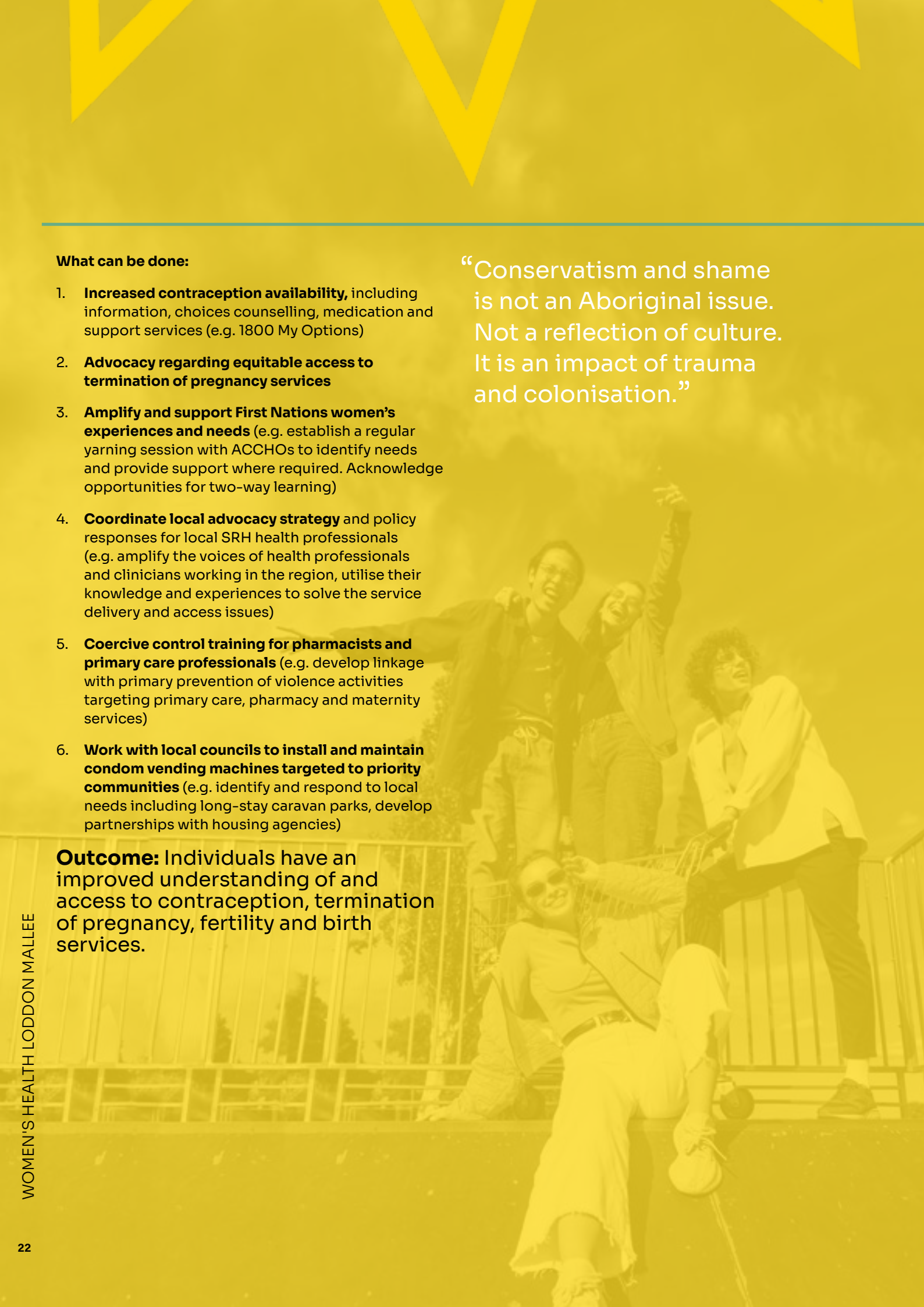
- **Access to contraception is vital to leading a sexually healthy life.** It was reported that it is often hard to access products for free such as dams or condoms in regional and rural communities. Local community health services are "not wanting to promote or provide condoms." Schools are also "often too nervous to supply [products], and if they do they are not promoted." This was reinforced by service providers, who have heard young people say they do not have "free, anonymous access to contraception." However, some initiatives, such as condom vending machines have "helped to reduce unplanned pregnancies and STIs"
- **There is a lack of information regarding abortion access.** One woman identified that "it's a minefield to know what your options are, where to go... what does it feel like if you have an abortion? What's it going to be like if you don't?" Important information regarding reproductive choices, including access to abortion clinics, is "still under the cover"
- **Supportive health care professionals are required to help assist with reproductive choices.** A variety of experiences with health care professionals were reported, with some women reporting they experienced "phenomenal care" during pregnancy. However, others "wonder about the discrimination in terms of accessing fertility and reproductive health" and state that there is "medical gaslighting that goes on around childbirth and all sorts of women's issues"
- **Reproductive options are required for all age groups.** This includes "abortion access, and unplanned and unwanted teenage pregnancies"

What can be done:

1. **Increased contraception availability,** including information, choices counselling, medication and support services (e.g. 1800 My Options)
2. **Advocacy regarding equitable access to termination of pregnancy services**
3. **Amplify and support First Nations women's experiences and needs** (e.g. establish a regular yarning session with ACCHOs to identify needs and provide support where required. Acknowledge opportunities for two-way learning)
4. **Coordinate local advocacy strategy** and policy responses for local SRH health professionals (e.g. amplify the voices of health professionals and clinicians working in the region, utilise their knowledge and experiences to solve the service delivery and access issues)
5. **Coercive control training for pharmacists and primary care professionals** (e.g. develop linkage with primary prevention of violence activities targeting primary care, pharmacy and maternity services)
6. **Work with local councils to install and maintain condom vending machines targeted to priority communities** (e.g. identify and respond to local needs including long-stay caravan parks, develop partnerships with housing agencies)

Outcome: Individuals have an improved understanding of and access to contraception, termination of pregnancy, fertility and birth services.

"Conservatism and shame is not an Aboriginal issue. Not a reflection of culture. It is an impact of trauma and colonisation."



4.2.4 Finding The Right Care

Overview: The provision of sexual and reproductive health services needs to take into account geographical location, affordability, culturally safe and appropriate care and culturally appropriate resources.

What we heard:

- **It is difficult to access SRH services.** The ability to access affordable sexual and reproductive health services in a timely manner is described by service providers as "almost non-existent" for people living in regional and rural communities. Furthermore, most specialist sexual health centres are in Melbourne. This is seen as a "huge barrier" and requires people to often travel up to eight hours by public transport to access sexual and reproductive health services
- **The community is not always aware of the services available to meet specific needs.** There is a lack of awareness of specific services available which may lead to unmet expectations. One service provider stated that "Loddon Mallee region is incredibly multicultural, but SRH services are often stigmatised, shamed or unheard of." Furthermore, consumers highlighted that "it doesn't feel centralised or easy to find information about services that are available in the region"
- **There is a need for Aboriginal-specific SRH information and care.** This extends to LGBTIQA+ information and education. Service providers highlighted that "rainbow mob is scared, they don't know what sex is for them". Mainstream services also need to understand the relationship between colonisation in SRH care and service access. "Conservatism and shame is not an Aboriginal issue. Not a reflection of culture. It is an impact of trauma and colonisation"
- **There is a need for culturally safe and gender appropriate care**. Service delivery needs to be targeted to priority populations, such as LGBTIQA+ populations, Aboriginal and Torres Strait Islander peoples, and young people. Service providers stated that they should be appropriately trained and upskilled to "ensure that health care is equitable and accessible by everyone"
- **There is a need for access to appropriate information on sexual and reproductive health.** Several women identified that most of the information they receive on sexual and reproductive health is "from Google" or social media sources, where it is easy to "go down rabbit holes" and be misinformed. Access to knowledge was reported by service providers as being the "key to building confidence, as it is reducing the barriers to accessing services." Service providers also highlighted the need for information catered to one's health literacy, as "patients may not understand what is being explained to them...they may feel overwhelmed with information overload"
- **There is a need for culturally appropriate sexual and reproductive health resources.** Several women identified that there are not enough resources translated into other languages, and current resources "assume that there is a level of understanding about the body...that just doesn't exist." Women should also have access to interpreting services when required
- **There is a need to access appropriate sexual and reproductive health services for other priority populations,** including women with disabilities

What can be done:

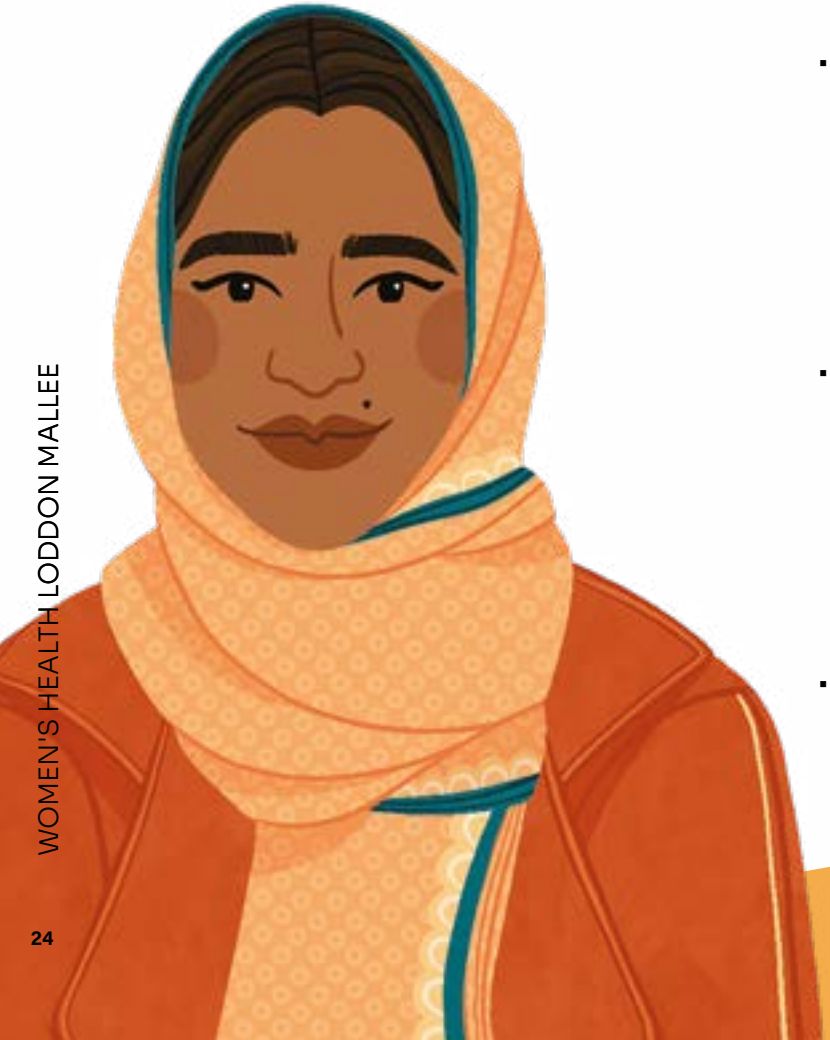
1. **Provide better care options for people without Medicare eligibility** (e.g. explore subsidised care opportunities with philanthropic or humanitarian organisations)
2. **Improve sexual and reproductive health literacy in the region** (e.g. promote SRH services, eligibility and access across the region, promote 1800 My options as an information service)
3. **Explore regionally available SRH training for primary care professionals** (e.g. develop partnership with Primary care team at Murray PHN to deliver SRH training to local general practices)
4. **Advocate for more localised SRH services** (e.g. SRH clinic hub and spoke model)

5. **Review current e-health services to establish supported access** (e.g. pharmacies, telehealth, community health) across the region

6. **Advocate for mandatory training for the health workforce,** including cultural safety training and LGBTIQA+ inclusion training

Outcome: Sexual and reproductive health information and services are provided in a manner that is non-judgmental, easily understood, free from discrimination, geographically accessible, and sex-positive.

> "There is a poorly coordinated approach between council, health services, health professionals and schools."



4.2.5 Working Together

Overview: There needs to be partnerships between different SRH service providers, including with those that serve priority populations (including Aboriginal and Torres Strait Islander people). WHLM is in a unique position to coordinate relationships between these providers.

What we heard:

- **There is currently fragmentation of care between service providers.** One woman commented that "care across the pregnancy and birth continuum is currently fragmented." This does not allow the "creation of opportunities for meaningful relationships to be formed with care providers, which is known to be a key factor in birth outcomes". The fragmentation of care can also lead to service providers often having "difficulty finding details of [sexual and reproductive] services available" for referral

- **There is currently poor coordination of sexual and reproductive health services in the community.** One woman reported that "there is a poorly coordinated approach between council, health services, health professionals and schools." This was reinforced by service providers, who believe that "communication and a consistent approach across the region as well as regular information flow" is vital between community services

- **Integrated and preventative care are fundamental to sexual and reproductive health.** It was identified that "stand-alone sexual health services are not sustainable," and that instead an integrated and holistic approach to healthcare is required. Preventative care and lifestyle approaches, instead of pharmaceutical solutions are preferred by women and feel "accessible, workable...and empowering as well"

- **Health professionals and clinicians struggle to find time to do the policy and advocacy work.** "I'd like to get involved in more political stuff but I don't have the time, I don't get invited to share what I know, and I probably don't have the skills to do it"

What can be done:

1. **Develop a partnership with Murray PHN regarding GP clinic training in SRH and LGBTIQA+ health and inclusive SRH primary care services**
2. **Determine partners for development of SRH service hub and spoke model. Utilise existing structures such as Victorian Government Health Service Partnerships. This includes advocating for further funding and expansion of services within the Victorian SRH hubs. For the Loddon Mallee Region, the SRH hub is a part of Bendigo Community Health Services (BCHS)**
3. **Develop a joint plan and integrate activities with the Loddon Mallee Public Health Unit**
4. **Re-establish (or refresh) Communities of Practice for SRH nurses**
5. **Establish formal partnerships between ACCHOs and mainstream services to build SRH capacity within ACCHOs** (e.g. clinical supervision or mentoring)
6. **Renew partnerships with Local Council regarding the provision of SRH consumables** (e.g. condoms, sanitary products etc.)
7. **Develop and execute an advocacy plan for the region in collaboration with key stakeholders and service providers**

Outcome: Communities and health services collaborate to ensure sexual and reproductive health information and services are appropriate, flexible, innovative, and effective. Implementation of the strategy will be guided by the following influences and approaches.

4.3 Approaches And Influences

4.3.1 Intersectionality

The consideration of how people experience multiple and intersecting forms of discrimination and disadvantage is referred to as 'intersectionality'.

Intersectionality describes the understanding of underlying systems and structural conditions, and their impacts on lived experiences, including sexual and reproductive health and wellbeing.[4] It is a tool that assists with understanding how aspects of our identity, including gender identity, race, religion, socioeconomic class, sexual orientation and disability interact to shape the social, cultural and economic experience.[12]

Those who experience disadvantages when it comes to power, privilege, and access to resources, have an increased risk of poorer health outcomes. Taking an intersectionality approach means going beyond explanations or solutions that use single categories to describe people or issues and acknowledging the impact of many factors interacting together.[13]

4.3.2 Advocacy

Advocacy for SRH, including reproductive rights, involves a collection of strategies that can be used to achieve social, economic, political, cultural, legal and civil change in the sexual and reproductive health sphere.[14] Advocacy is important because:

Issues related to sexual and reproductive health are **often stigmatised by society and de-prioritised by governments**

- Sexual and reproductive health strategies need political support, and advocacy is often required to **motivate governments towards change**
- Advocacy is well placed to **identify and challenge root causes and systematic barriers to sexual and reproductive health**

4.3.3 Life Course

Australian women are living longer, healthier lives, with healthy ageing concepts (including successful and positive ageing, ageing well and ageing productivity) evolving due to a changing population demographic.[6] Healthy ageing begins at preconception, and continues through life stages such as birth, puberty, fertility, motherhood, perimenopause, and menopause. Different life transitions are associated with different health needs, risks and interventions that are required to ensure optimal physical health, mental health, and social and emotional wellbeing.

Taking a lifecourse approach means health is viewed as a whole, rather than a series of disconnected and unrelated stages.

4.3.4 Rural And Regional Health

Women in the Loddon Mallee region are shown to have poorer health outcomes than those who live in major cities. Poorer health outcomes in rural and regional regions are due to:

- **Greater health risk factors.** Rural and remote women experience poorer birth outcomes than their urban counterparts.[15] Expectant mothers living in very remote areas of Australia are 4.6 times more likely to smoke during pregnancy than those in major cities.[16] 8.5% of babies born in major cities are pre-term compared with 13.4% of babies born in very remote locations of Australia.[16] The Australian Institute of Health and Welfare also highlighted that people in regional, remote and rural areas are 24 times more likely to be hospitalised for domestic violence as those in major cities[17]
- **Poorer access to, and use of, health services.** Availability, cost, distance, travel time to services and privacy are significant barriers to accessing sexual and reproductive health services in regional and rural Victoria.[15,18] This includes access to and availability of contraception, surgical and medical termination of pregnancy and related ultrasound scans and colposcopies
- **Cultural and social characteristics.** Living in small communities may reduce the ability for women to access private, respectful and culturally safe sexual health services for testing, treatment and support. This includes access to services that are culturally sensitive, youth friendly, and LGBTIQA+ inclusive, and services that cater for non-Medicare card holders

4.3.5 Sex Positivity And Pleasure

Sex positivity refers to 'an ideology that promotes, with respect to gender and sexuality, being open-minded, non-judgemental and respectful of personal sexual autonomy, when there is consent.'[19]This encompasses pleasurable sexual experiences that are safe, and are free of coercion, discrimination or violence.

Positive sexual health is essential to the overall health and wellbeing of individuals, couples, families and communities.[20] It relies on people being able to have access to evidence-based information about sex and sexuality, an understanding of the risks of unprotected sexual activity, equitable access to sexual health care, and a society that affirms and promotes sexual health.

5. STRATEGY IMPLEMENTATION

Implementation of the Her Health Matters Strategy requires the development of an operational plan, or action plan, that includes the tasks, resources, deliverables and key stakeholders required to successfully implement the strategic priorities outlined above. It is advised that action plans are updated annually for the duration of the strategy. The **action plan** should provide clarity on what the team will be doing on a daily or weekly basis, a benchmark for expected deliverables to keep the team on track and, a list of day-to-day operations your team members need to take to accomplish long-term goals.

Action planning should include the following steps:

- **Narrow down the scope:** To create a detail-oriented operational plan, the scope needs to be narrowed to a focus area and/or priority group to ensure the goals are achievable within time and resource allocations
- **Identify key stakeholders:** Determine who is required to contribute to completing the tasks and achieving the goals
- **Create the plan:** Define the objectives, tasks, resources, responsibilities, and metrics for success. Include a list of well-defined deliverables
- **Share and update the plan:** Share the plan with stakeholders and monitor implementation. Update the plan to capture progress and changes

5.1 Monitoring For Success

This section provides a proposed outcomes framework and a list of suggested performance measures to monitor the impact and success of the Her Health Matters Strategy. The Her Health Matters Outcomes Framework (the Framework, Figure 2) presents a high-level overview of the potential outputs and outcomes that can be monitored.

The **social determinants of health** are included to indicate needs and highlight areas of priority (e.g. health, social, or place-based need) and the **strategic priorities** are included to ensure the Framework remains focused on the goals of the strategy. The **outputs** summarise what can be easily monitored through the action plan activities, such as reach and participation in professional development sessions, whether or not joint plans were created, and whether or not individuals report increased knowledge or improved experiences following an intervention.

Output measures are usually short-term. **Outcome measures** include longer-term impacts such as reduced incidence of health conditions, improved service access (i.e. new or expanded service availability), and improved population health literacy, including empowerment, and access to SRH information, support and care.

In addition, suggested indicators and data sources for monitoring the impact of the strategy are provided in section 5.2.

FIGURE 2: HER HEALTH MATTERS OUTCOMES FRAMEWORK

EQUITY			
Social Determinants Of Health	**Sexual And Reproductive Health Strategic Priorities**	**Outputs**	**Outcomes**
▪ Socio-economic factors ▪ Gender equity ▪ Health behaviours ▪ Social, built and natural environments	▪ Living a sexually healthy life ▪ Knowing your body ▪ Having reproductive choices ▪ Finding the right care ▪ Working together	▪ Reach ▪ Increased knowledge and confidence ▪ Consumer experiences and stories ▪ Collaborations ▪ Joint plans	▪ Reduce ill-health ▪ SRH literacy ▪ Service access ▪ Changed behaviours ▪ Population health
ROLE OF WHLM	▪ Create Connections ▪ Grow Capacity ▪ Build Knowledge ▪ Amplify Voices ▪ Develop Solutions		

5.2. Indicators Of Success And Outcomes

This section presents suggested indicators and data sources to monitor the implementation of the strategy. It is anticipated that the indicators and measures are updated following the generation of annual action plans.

Table 1: Suggested Indicators Of Success

Outcome	Indicators of success	Data sources
Living a sexually healthy life Individuals are empowered to have safe, respectful and pleasurable relationships	Monitor rates of: ▪ sexual violence ▪ sexually transmitted infections ▪ BBV infections ▪ mother-baby STI transmission Increased knowledge of consent Increased sexual health literacy Women report increased confidence in seeking sexual health information and care Women report increased satisfaction with sexual health care Increased confidence to apply women's SRH knowledge	Women's Health Atlas Reach: ▪ Number of professional development sessions (incl. modality) ▪ Number of participants ▪ Number of organisations Reported increase in knowledge Women's experiences and stories
Knowing your body Individuals understand and are supported to manage their own reproductive health	Increased access to period products for priority populations Increased reproductive health literacy Education sessions delivered through multiple partners and modalities Increased cancer screening rates (breast, cervical and bowel) Increased rates of women accessing 45 and 75 year health checks Increased confidence to apply women's SRH Knowledge Organisations implement supportive measures for people experiencing menopause	Period product availability audit (mapped to areas frequented by priority groups) Number and type of stakeholder engagement Reach (PD sessions) Number of organisations that have implemented reproductive health-related policies Reported increase in knowledge Women's experiences and stories MBS data reports

Outcome	Indicators of success	Data sources
Having reproductive choices Individuals have an improved understanding of and access to contraception, termination of pregnancy, fertility and birth services	Monitor reproductive choices trends: ▪ Number of MTOPs by LGA ▪ Contraceptive implants ▪ Contraceptive IUD Monitor birth trends[34]: ▪ Birth rate ▪ Young mothers/teenage births ▪ Fertility rate Increased knowledge regarding contraception and reproductive choices Increased availability of contraception and reproductive choices Increased knowledge about intimate partner violence and coercive control Increased confidence to apply women's SRH knowledge	Women's Health Atlas Reach (PD sessions) Reported increase in knowledge Women's experiences and stories Number of joint initiatives/ collaborations with stakeholders
Finding the right care Sexual and reproductive health information and services are provided in a manner that is non-judgmental, easily understood, free from discrimination, geographically accessible, and sex-positive.	Priority groups can access informed, appropriate SRH care SRH care is available across multiple modalities and is relevant to the local context and population groups A model of care is developed for SRH services in the region Local health services provide contemporary and evidence based SRH care Increased confidence to apply women's SRH knowledge	Feedback from community groups Audit of SRH service availability targeting priority groups Women's experiences and stories Number of joint initiatives/ collaborations with stakeholders

Outcome	Indicators of success	Data sources
Working together Communities and health services collaborate to ensure sexual and reproductive health information and services are appropriate, flexible, innovative, and effective	Development of regional SRH advocacy plan Increased number of collaborative projects/activities between WHLM and partners Increased number of shared initiatives across WHLM focus areas Development of sustainable regional SRH Communities of Practice SRH priority areas integrated with LMPHU regional planning Increased confidence to apply women's SRH knowledge	Number of joint initiatives/ collaborations with stakeholders Annual activity reporting (across WHLM portfolios) Local/regional plans

Monitoring trends over time, and by LGA, will provide information regarding access to reproductive choices, however, increases or decreases may be due to increased knowledge about the service, fluctuation in need, service availability, or other factors. Data should be interpreted with input from local services.

Birth rates should be monitored to ensure service needs and appropriateness (e.g. teenage friendly) and is not intended to assign a negative value proposition (such as the teenage birth rate should be decreased).

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APPENDIX A: DEFINITIONS

A.1 Sex

Sex refers to "the biological differences between males and females. This includes the reproductive organs and sex-specific hormonal activity. Individuals may identify as being a sex other than the one they were assigned at birth or as being intersex or of indeterminate sex."[13]

A.2 Sexuality

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."[13]

A.3 Sexual Health

Sexual health is defined as "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."[21]

A.4 Reproductive Health

Reproductive health is "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people can have a 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."[21]

A.5 Sexual And Reproductive Health Rights

Sexual and reproductive health rights (SRHR) are firmly based in human rights. The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Rights critical to the realisation of sexual and reproductive health include:

- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security
- the right to 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
- the right to decide the number and spacing of one's children
- the rights to information, as well as education
- the rights to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights[21]

A.6 Gender

Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for women and girls, boys and men. Ideas associated with gender play a strong role in determining what society permits, expects, and values in women and men, and impact the economic, social, and power relations between the sexes. These opportunities and expectations are not always equal. As gender is culturally determined, societal expectations of gender will change over time and place.[22]

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