Women's Health Issues Paper
No. 2

Women's Health
Victoria

Women and Sexual and Reproductive Health

April 2009

ISSN: 1837-4417

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Women and Sexual and Reproductive Health
(Women's Health Issues Paper No. 2)

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Published April 2009

ISSN: 1837-4417

This paper is also available at:
http://www.whv.org.au/publications-resources/issues-papers

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1. Acronyms

AHMF	Australian Herpes Management Forum
AMA	Australian Medical Association
APA	American Psychological Association
APS	Australian Psychological Society
ARCSHS	Australian Research Centre in Sex, Health and Society
ATSI	Aboriginal and Torres Strait Island
BBV	Blood borne virus
BHC	Better Health Channel
BV	Bacterial vaginosis
CALD	Culturally and linguistically diverse
CYH	Children, Youth and Women's Health Service
DHS	Department of Health Services
FGM	Female genital mutilation
GP	General Practitioner
HIV	Human immunodeficiency virus
HCV	Hepatitis C virus
HPV	Human papillomavirus
HSV	Herpes simplex virus (1 and 2)
IUD	Intrauterine device
MSHC	Melbourne Sexual Health Centre
PID	Pelvic inflammatory disease
SSA	Samesex attracted
STI	Sexually transmitted infection
TOP	Termination of pregnancy
WGNRR	Women's Global Network for Reproductive Rights
WHO	World Health Organisation

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2. Introduction

There are many definitions of sexual and reproductive health, and while most retain similar essential elements, they have developed and expanded in their scope over the years.

In their 1995 report on the National Commission on Adolescent Sexual Health, the Sexuality and Education Council (SIECUS) of the United States (US) combined sexual and reproductive health in their definition:

> Sexual health encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values[1].

In accordance with other organisations SIECUS now incorporates a rights based approach in five position statements on: human sexuality; sexual rights; sexual health; sexuality education; and culture and society. Their position statement on sexual health begins:

> All people have a right to healthcare services that promote, maintain, and if needed, restore sexual and reproductive health. Healthcare providers should assess sexual and reproductive health needs and concerns as integral parts of each individual's health and wellness care and make appropriate resources available[2].

A rights based approach to sexual health is also part of the World Health Organisation's (WHO) definitions of sexual health and reproductive health:

> Sexual health is a state of physical, emotional, mental and social well-being 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[3].

> Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, 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[4].

> Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate

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> health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant[4].

This Issues Paper looks at women's sexual and reproductive health (SRH) by incorporating the clinical, relational and rights based aspects of sexual and reproductive health as per the definitions given.

The paper contains information about: contraception; unplanned pregnancy; the incidence and prevalence of sexually transmitted infections (STIs) amongst women; sexual violence and abuse; and population groups who are at increased risk.

The review also highlights the gendered nature of sexual and reproductive experience and behaviour, which has implications for policy, practice, education, health promotion, and prevention strategies linked to women's sexual and reproductive health.

3. Safe sex and contraception

Safe sex refers to protecting oneself and sexual partner against sexually transmitted infections (STIs) and unplanned pregnancy[5]. Contraception refers to methods taken to avoid becoming pregnant. Not all contraceptive methods limit STI transmission.

In Australia, a number of contraceptive methods are available to women and men. They include physical methods, hormonal methods and permanent procedures[6]. Contraception methods used by men usually falls into two categories: the male condom (a latex or polyurethane sheath), which is worn over the penis and when used correctly is 95-98 percent effective; and the vasectomy, which involves surgically cutting the sperm ducts in the testes to prevent sperm entering the semen[6]. This is considered a permanent method (although may at times be reversed) and is also highly effective.

The male condom reduces the risk of human immunodeficiency virus (HIV), chlamydia and gonorrhoea transmission, but it is less effective against human papillomavirus (HPV) or herpes simplex virus (HSV)[7].

The World Health Organisation (WHO) has stated that factors that influence women and girls' vulnerability to unsafe sex practices include the reliance on male sexual partners to use condoms[8]. Gender power imbalances and lack of autonomy are major factors in women's vulnerability to STIs. Women may have limited control over resources and be socially and economically dependent on their husbands or partners, which has the potential to affect their sexual and reproductive choices and decisions[8].

There are many more contraceptive tools targeted at women's use; some of these are described below, but few protect against STIs[6].

3.1 Diaphragm

Diaphragms are similar to cervical caps. They are a soft, shallow rubber dome that fits in the vagina, covers the cervix and stops sperm from entering the uterus. The diaphragm is fitted

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by a doctor or health professional. It can be 85–95 percent effective but does not provide protection against STIs[6].

3.2 Female condom

This is a loose polyurethane sheath with a flexible ring at each end that is inserted into the vagina and collects semen. It is stronger than the male latex condom[9]. It decreases the risk of STIs for women and their partners[9].

3.3 Hormonal contraceptives

Implanon is a hormone implant inserted under the skin by a doctor under local anaesthetic. The etonogestrel, a progesterone-like hormone, prevents ovulation and changes cervical mucus, preventing sperm from entering the cervix. It is close to 100 percent effective and lasts 3 years[6].

Depo Provera is a highly effective progesterone based hormone contraceptive that is injected. It prevents ovulation, changes cervical mucus and the lining of the uterus to make it unsuitable for a fertilised egg to implant[6].

Other hormonal contraceptives include pills or the vaginal ring. The combined pill is made up of oestrogen and progesterone, while the mini-pill is a form of progesterone only. Both pills are taken orally, with the mini-pill taken at the same time every day. It makes the cervical mucus thicker, preventing sperm from entering the uterus. The combined pill also does this and prevents ovulation. They provide 94-99 percent effectiveness. Neither pill protects against STIs[6]. The vaginal ring is inserted in the vagina where it remains for three weeks. It slowly releases hormones by way of the vagina into the bloodstream[6].

None of these hormonal contraceptive methods provides protection against STIs.

3.4 Intrauterine device

An intrauterine device (IUD) is a small device inserted into the uterus that is toxic to sperm. It also restricts egg movement, making it difficult for an embryo to be implanted in the uterus. IUDs are long-lasting, easily reversible and are a highly effective contraceptive (98-99 percent). They do not provide protection against STIs[6].

3.5 Tubal ligation

Tubal ligation is a permanent form of contraception that involves blocking the fallopian tubes, ensuring that eggs cannot pass down and be fertilised. A less invasive 'sterilisation' procedure involves *Essure* micro-inserts into the fallopian tubes, which has a greater than 99 percent effective rate[10]. Neither offers protection against STIs.

4. Unplanned pregnancy

In 2006 Marie Stopes International surveyed 2003 women in Australia who had experienced at least one unplanned pregnancy [11]. The report highlights the awareness of women about contraception and that contraception was in use much of time when unplanned pregnancy occurred[11]. Sixty percent of women at the time of pregnancy were using contraception and forty-three percent of those were on the hormonal pill[11].

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Women who were using more than one method of contraception at the time of pregnancy were more likely than those who were using no contraception or one form, to choose to have a termination of pregnancy. This finding suggests that for many women who do not want a child, the efforts taken to avoid pregnancy are significant, though not always successful[11].

Termination of pregnancy (TOP) is a medical procedure to remove a foetus or foetal tissue from a pregnant woman, and is more commonly known as abortion[12]. The World Health Organisation (WHO) states that globally, 40-50 million abortions occur annually, and that nearly half of those take place in unsafe conditions[13]. Accurate data for the numbers of women who have an abortion, or termination of pregnancy (TOP), each year in Australia is unavailable. What is known is that even in areas where family planning is widely accessible, pregnancies occur as a result of contraceptive failure, difficulties in using contraceptives, non-use of contraception or because of incest and rape[13].

The negative life impact of an unplanned and unwanted pregnancy has the potential to threaten a woman's mental and physical health, and her life[13]. Approximately 13 percent of all maternal deaths worldwide, are due to complications of unsafe abortion, with some 70 000 women dying and tens of thousands more suffering long-term health issues that include infertility[13].

There are also strong associations between partner violence and a range of reproductive health outcomes. One Australian study found that partner violence was the strongest predictor of having a TOP among young Australian women[14].

Access to safe, legal and affordable TOP services is good public health practice. After several years of campaigning in Victoria, the medical procedure for the termination of a pregnancy was removed from the Victorian Crimes Act. On 19 August 2008 the Abortion Law Reform Bill 2008 was tabled in the Legislative Assembly in Victoria. After being passed without amendments in both Houses over September and October, it received its Royal Assent on 22 October 2008 and is now legislation.

Removing TOP from the Crimes Act aligns the procedure with other health services. It gives doctors the confidence and security to deliver appropriate services. Most importantly, this legislation safeguards women's rights over control of their reproductive capacity. It helps to alleviate potential negative health impacts of unplanned pregnancy and is a step toward ensuring safe and accessible service conditions.

5. Sexually transmitted infections

5.1 Chlamydia

Chlamydia is the most commonly reported notifiable disease in Victoria[15]. Population groups at risk are young people, sex workers, Aboriginal and Torres Strait Islander (ATSI) people, men who have sex with men, and people living with HIV/AIDS. In 2005, over half of the chlamydia notifications were from women (58 percent), with 65 percent of that group aged 16-24 years. This compares with 43 percent of notifications from young men in the same age group[15].

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Men with chlamydia rarely experience complications[15]. However, chlamydia in women, if left untreated, can increase risk of additional health complications[15]. Pregnant women with chlamydia are at greater risk of pre-term labour, and in vaginal delivery, untreated chlamydia infection may be transmitted from pregnant women to their babies[15]. Women with chlamydia who have a pregnancy termination or insertion of an intra uterine device risk the infection spreading to the upper genital tract[15].

Other risks for women with chlamydia include pelvic inflammatory disease (PID), tubal infertility and chronic pelvic pain[15].

5.2 Pelvic inflammatory disease

It is estimated that over 10 000 Australian women are treated in hospital each year in Australia for pelvic inflammatory disease (PID)[16]. Women aged 20-29 have the highest incidence of PID[16].

PID is usually sexually transmitted and is caused by chlamydia about 50 percent of the time and gonorrhoea about 25 percent of the time[16]. The most common complication is scarring to the fallopian tubes, which can block an egg moving from the ovary to the uterus, causing infertility. One episode of PID doubles the risk of tubal infertility; three episodes of PID increase the risk of a blocked fallopian tube to 75 percent. Women with PID who are trying to get pregnant are also 7 times more likely to have an ectopic pregnancy[16].

5.3 Genital herpes

Women are at higher risk than men for contracting genital herpes and one in six Australian women are estimated to be carriers of the virus[17].

Genital herpes is a sexually transmitted infection caused by the herpes simplex virus (HSV). There are many types of herpes viruses and both herpes simplex type 1 (HSV1) and herpes simplex type 2 (HSV2) can infect the genital area, although HSV1 more commonly causes 'cold sores' and occurs in the upper body[18].

Genital herpes has many symptoms including blisters or sores on and around the genital area, but not all symptoms are present all the time and the first outbreak is generally the worst[19].

The risk of babies contracting genital herpes during birth is small especially in women who have had the virus for some time[20]. Babies are more at risk if a woman acquires genital herpes for the first time, late in pregnancy. Neonatal herpes in babies born in Australia is very rare, but serious illness and death can occur for babies who do acquire the virus[20].

Condoms and dental dams help to reduce the risk of infection, but transmission is by skin-to-skin contact and can occur when symptoms are present and also when there are no visible signs[21].

5.4 Human immunodeficiency virus

Human immunodeficiency virus (HIV) is transmitted by body fluids from people who are infected with the virus. These fluids include blood, semen, vaginal fluid and breast milk[22]. While HIV may also pass from woman to baby during pregnancy, birth or breastfeeding, with medical intervention the HIV transmission rate may be below 2 percent[22].

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According to the latest WHO report, women comprise 50 percent of people across the globe living with HIV and only 38 percent of young women are estimated to have accurate information about HIV/AIDS [23].

Medical opinion varies about the effects of HIV treatments on women[24]. Limited research in the field makes informed opinion more difficult. Some doctors argue that the usual medication doses, which are calculated by body weight, are too high for women and lead to greater side effects[24]. Two out of three women will experience side effects from HIV medication[24]. These can include tiredness, nausea, vomiting, diarrhoea, muscle pain, headaches, changes in menstrual patterns, skin rashes and changes in body shape[24]. Some of these disappear in a few months but others persist[24].

In 2005, the Australian Research Centre in Sex, Health and Society (ARCSHS), surveyed 982 HIV positive people for its *HIV Futures Five* study, representing 6.4 percent of the estimated HIV population in Australia[25]. Eighty-four HIV positive women participated, representing approximately 5.8 percent of HIV positive women in Australia[25]. Twenty-two of the women (27 percent) were Victorian, the second highest representation of HIV positive women in the sample, next to New South Wales (45 percent). Almost 92 percent of the HIV positive women in this study identified as heterosexual[25].

The self-rated health of HIV positive women in the *Futures* study was found to fall below the population comparison, highlighting the negative impact living with the virus has on women's lives. This is despite HIV often being considered a chronic manageable illness[25]. More than one third of the women surveyed were living below the poverty line, with the same number of women working part or full-time as there were relying on Government benefits[25].

Women (55.6 percent) in this study were more likely than men (35.6 percent) to see different medical practitioners for their general medical issues and HIV management. Over the six months prior to survey, women (33.7 percent) were less likely than men (59.3 percent) to have seen an HIV doctor, but were almost twice as likely than men to have visited a peer support officer or to use a peer support group[25].

The single greatest difference reported between women and men in this study related to parenting[25]. HIV positive women were more inclined to consider parenting an important issue that related to their decisions about having children, disclosure of HIV status, and the effects on parenting in light of treatment and possible illness[25]. Researchers in this study concluded that improvements still need to be made in service provision and in care and support for women living with HIV to alleviate social and economic disadvantage[25].

In the 2006-2007 annual report for the organisation Positive Women, Victoria is recorded as having 20-22 new HIV diagnoses each year among women[26]. The number of women living with HIV in all regions of Victoria has increased, but particularly more so in the North-Western metropolitan area[26]. A concern expressed by Positive Women is the increase in new cases of older women with HIV. In the years 1997-2001 the highest number of HIV diagnoses among Victorian women was for those aged 20-29 years[26]. During 2002-2006 this changed, with a dramatic increase in the numbers of women aged 30-39 years diagnosed with HIV[26]. This has implications for parenting and family situations[16]. Another significant increase in HIV incidence has been in women aged over 50 years[26]. Advocacy and support

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organisation Positive Women, states that most women are infected via heterosexual sexual activity and that this needs to be considered in safe sex campaigns as well as targeting women across all age groups[26].

5.5 Human papillomavirus

Human papillomavirus (HPV) is a common sexually transmitted infection and is spread through genital skin contact. It is estimated that four out of five women will be infected with HPV at some point in their life. Infection rates are highest among young women, peaking just after most young women become sexually active. The number of sexual partners a woman has is a predictor of infection[27]. Women who have sex with women can also acquire the infection[27].

HPV is present most of the time in cases where cervical cancer is detected in women[27]. Low grade changes in the cells on the surface of the cervix, which are due to HPV infections, are found in about 90,000 women each year in Australia[27]. While almost all of these changes return to normal, some progress to high grade changes and are found in approximately 15,000 women each year[27]. These may also return to normal, but in some instances, if the virus continues and remains undetected, they can lead to cervical cancer[27]. Each year in Australia, about 750 new cervical cancer incidences are reported, 1800 women need treatment and 250 women die from cervical cancer[27].

Safe-sex practices such as using condoms offer limited protection as they do not cover all of the genital skin[27].

In 2007, the Australian Government launched its HPV vaccination program where women under the age of 26 could access the *Gardasil* vaccine, offering protection against HPV strains 16 and 18, which cause around 70 percent of all cervical cancers, and protection against HPV types 6 and 11, which cause 90 percent of genital warts[27]. People over 26 years can have the vaccine for the full cost, which is around $500[27]. *Gardasil* is given as a series of three vaccinations over a period of seven months[27].

The Australian Department of Health and Ageing Therapeutic Goods Administration (TGA) has been monitoring research on *Gardasil* and states that expert advisory groups review adverse events reported following *Gardasil* vaccination[28]. The TGA notes that most reports of adverse effects have been for mild and common problems[28]. In October of 2007, the Australian Technical Advisory Group on Immunisation (ATAGI) reviewed the safety of *Gardasil* and agreed that no changes were required to the recommended use of the product, but that the situation would continue to be monitored[28].

5.6 Bacterial vaginosis

Women have aerobic bacteria called lactobacilli that produce lactic acid and small amounts of hydrogen peroxide to ensure the vaginal environment is acidic[29]. Bacterial vaginosis (BV) occurs when a change in the ecosystem of the vagina occurs and the lactobacilli are compromised by the proliferation of harmful bacteria[29].

BV is the most prevalent form of vaginal disturbance in women of reproductive age[29]. Rates of infection vary from about 10 percent generally to 35 percent of gynaecology inpatients, and up to 60 percent in women attending a sexual health service[29]. The exact cause of BV is

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unknown. It is more often irritating and embarrassing than harmful, but it can be harmful in pregnancy and is associated with increased risk of miscarriage[29].

6. Sexual violence and abuse

Differences in gender relations mean that women do not always feel they have power to refuse sex and to insist that their partners use protection. This applies to women of all ages, across sexual behaviours and sexualities, even within relationships, but when age and gender interact, young women are even more vulnerable[8].

One Australian telephone survey found that 21.1 percent of women had experienced sexual coercion, which mainly occurred prior to the age of 18 years[30]. This compared with 4.8 percent of men. Of these, 10.3 percent of women and 2.8 percent of men reported sexual coercion at the age of 16 years of younger[30]. A more recent Australian study found that 32 percent of the 40 young women they surveyed, aged 16-25, had been subjected to sexual assault[5].

Sexual assault is not limited to young people, with adult women also at risk, particularly in violent or coercive relationships[31]. Research reveals a relatively high prevalence of rape and coerced sex in marriage and intimate partner relationships[31]. Furthermore, unlike rape outside of intimate relationships, rape in marriage and intimate partner relationships generally occurs more frequently[31].

Women with disabilities are also at risk of experiencing high levels of violence that is not reflected in service use or access to services data[32]. Unlike women without disabilities, women with disabilities are vulnerable to violence and sexual assault from paid and non-paid carers[32]. This can include unsolicited sexual talk, being forced to kiss someone or touch their genitals, being touched themselves or being forced to have sex[33]. It could also mean being forced to look at sexual pictures or videos, have sexual favours demanded in return for access to services or care, or sexual abuse that is framed as teaching about sexuality[33]. Those in care-providing roles can continue the sexual violence by maintaining access to potential victims. They can also select women who are least able to resist or make a formal complaint[34].

One Australian study cites recent Victoria Police[35] data that revealed that just over a quarter of sexual assault victims had a disability[34]. The authors of this study discuss the gendered nature of sexual violence perpetrated against adults with a disability, stating that Australian and international research show that women with disabilities continue to be the victims[34]. This remains the case across diverse abilities and across the lifespan[34].

7. At risk and diverse population groups

7.1 Aboriginal and Torres Strait Islander women

Aboriginal and Torres Strait Islander communities have the highest rate of sexually transmissible infections (STIs) in any Australian population, with the most common STIs being chlamydia, gonorrhoea and syphilis[36,37]. Approximately 1207 per 100,000 Aboriginal and Torres Strait Islander people become infected with chlamydia; ten times as many as non-Aboriginal Australians who are infected at a rate of about 95 per 100,000[35]. Social

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disadvantage greatly impacts access to health services and sexual health information and resources[38].

The author of a 2006 review of Aboriginal and Torres Strait Islander people's sexual and reproductive health issues advocated for a human rights approach in taking positive action and making change[37]. The report called for effective policy and legislative environments that removed obstacles to contraceptive access and prioritised addressing sexual violence. It also advocated for the development of an urban and rural setting workforce trained in sexual and reproductive health; youth-friendly sexual and reproductive healthcare services, and education and prevention programs[37].

7.2 Workers in the sex industry

In the context of the sex industry, sexual health becomes an occupational health and safety issue, as well as a public health issue. The social stigma attached to working in the industry can mean that workers are discriminated against in all aspects of society if they are open about what they do[39].

The stigma attached to sex work means that sex workers' experiences of sexual assault, both in work and in their private lives, are questioned, minimised or silenced[38]. They are often disbelieved and perceived as undeserving of support or legal justice because of their work[38].

Underage sex workers in particularly are vulnerable to sexual assault and other disadvantage, and are reluctant to go to the police[38]. A Victorian report about people in commercial sexual activity in Melbourne provided results from interviews with 30 young sex workers aged between 16 and 29 years[40]. Sixteen of the young people reported being introduced to sex work while in state care. At least one had been sex-working at St Kilda since the age of 12, after escaping an abusive family life. Five girls were introduced to sex-work by their boyfriends, who in some cases took the money the girls earned[39]. The study found that nearly all of the young people had experienced rape or other violent situations since they started sex-working[39]. This was also the case for a sample of sex-workers in Sydney with a 2006 report finding that 81 percent had been raped while working or in their personal lives[41].

There is also research that links childhood sexual abuse with sex work. While not all children who are subjected to sexual abuse go on to work in the sex industry, research suggests that sex workers have much higher rates of histories of sexual abuse than in the general population[39]. The 2004 Child Wise report mentioned above also cites a range of research that links childhood sexual abuse with sex work[39]. In a Sydney based study, 75 percent of sex workers reported having experienced sexual abuse before the age of 16 years[40].

Almost half of the Sydney sample of sex-workers met the criteria for life-time diagnosis of post-traumatic stress disorder, while 87 percent reported some depressive symptoms[40].

7.3 Refugee and other culturally and linguistically diverse (CALD) women

There are a range of sexual health issues for newly arrived refugees and for some culturally and linguistically diverse (CALD) women in Australia.

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In 2004-2005 seventy percent of all refugee entrants to Australia came from African nations, with the majority from South Sudan. Women and girls from these countries have often been subjected to rape, sexual torture and mutilation and sexual slavery. This is common not only in places of conflict but also in camps and places where women seek refuge[42].

The Victorian Foundation for Survivors of Torture reports that health concerns specific to women and girls who have been subjected to sexual violence include:

- Gynaecological problems including:
  - Damage to cervix, upper vagina, vulva, anus and rectum, urethra, uterus and oral cavities, fistula and other internal injuries
  - Dysfunctional uterine bleeding
- Broken bones: untreated because of inability to access health services
- Sexual problems
- Increased risk of sexually transmitted infections
- Nutritional deficiencies
- Pregnancy and birth complications
- Mental health issues[41]

Female Genital Mutilation (FGM), sometimes referred to as female circumcision, is also practiced in many countries from which Victoria takes refugees. Complications arising from FGM vary depending on the nature and severity of the mutilation, but can include vulval scarring and pain, chronic pelvic pain, urinary tract infections, incontinence, obstructed menstrual and urinary flow, obstructed miscarriage and childbirth, vaginal and perineal damage during delivery, difficulties and pain with sexual intercourse[41].

A compounding issue is that many women may not have had access to health care and may not have the cultural concepts around help-seeking for psychological problems[41].

7.4 Lesbian, bisexual and samesex attracted women

Research indicates that many women who identify as lesbian or samesex attracted (SSA) have had sexual experiences with men, and that both lesbian and bisexual identifying women have varied sexual histories with women and men[43]. In one UK study that surveyed 1,218 SSA women within the community and who used either of London's two lesbian health clinics, 82 percent of lesbians and 97 percent of bisexual women gave a history of sex with men[42]. Ninety-eight percent of SSA identifying women reported having had sex with women, and 83 percent within the last year[42].

Eighty-six percent of participants who reported having oral sex with a woman, had never used a dental dam. Of the women who'd ever had sex with men, only 23 percent reported always using a condom[42]. Researchers in this study conclude that SSA women are at risk of STI transmission from men and women, but they acknowledge that other safe-sex strategies may be being used: latex gloves, washing hands and avoiding certain sex acts where infection is known[42].

Researchers in this study also refer to a demand for SSA women's specific sexual health services as an indication that mainstream sexual health or primary health care services do not meet SSA women's needs[42]. This is linked to research found in Australia as well, where practitioner attitudes have been found to render SSA women invisible by assuming

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heterosexuality[42,44]. A lack of practitioner knowledge about SSA women's sexual health is also blamed, along with other indirect or direct forms of homophobia and discrimination[43,45].

PapScreen Victoria recognise that lesbian and SSA women require specific health information; they target SSA women as a distinct population and provide relevant health advice that includes the *Lesbians need Pap tests too* pamphlet[46].

The reproductive health needs of SSA women are also specific, with the majority electing self-insemination or clinic-based insemination to become pregnant[43]. In these instances, a health professional with relevant knowledge about insemination practices, costs, referrals, screenings, safety and so on, is required[43]. There are also social and legal structures that will impact on SSA women and parents differently to heterosexual persons, so knowledge about relevant support services would be advantageous as well. This is in light of many Australian lesbian and gay parents reporting negative experiences with their children's healthcare that relate back to their own sexuality[43].

In 2002, The Australian Medical Association (AMA) issued a position statement on *Sexual Diversity and Gender Identity*, outlining the shared and specific health needs of lesbian and gay people. It promotes equity of access to health care, is supportive of 'interventions that prevent the development of homophobia', states that acknowledgement of samesex partners is important in medical decision making, and identifies that a 'doctor's non-judgmental acknowledgment of a patient's sexual orientation, gender identity and behaviour enhances clinical care'[47].

7.5 Women with disabilities

As previously discussed, women with disabilities are at high risk of experiencing sexual violence. Women with disabilities are also subject to myths about their sexuality. Myths about the sexual and reproductive lives of women with disabilities perpetuate the notion that they are non-sexual and therefore do not require formal sex-education[48]. Family Planning Victoria states that individuals with disabilities are more vulnerable to sexual assault and other forms of exploitation than the general population[47].

While women with disabilities may have difficulties with aspects of their sexuality including finding satisfying ways to express it, managing loss of sensation or reduced sexual function, the attitudes of others is also an important factor[47].

Women who want to become pregnant may experience prejudice from people who consider individuals with disabilities to be non-sexual or unable to care for children[47]. Pregnancy needs will be specific to individual women and close medical support and greater attention to antenatal care may often be an issue[47]. For women with disabilities who don't want to get pregnant, contraceptive options are sometimes limited[47].

Women with disabilities do live sexual lives and are susceptible to sexually transmitted infections. For this reason, it is important for health professionals to include sexual histories and have awareness around sexual practices, so as to provide relevant health advice.

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7.6 Young women

Young women across the board are generally at greater risk of unwanted sex and contracting STIs than older women[49]. This is in a climate where the socioeconomic and health disparity of adolescent mothers is far greater than in previous generations[48].

One 2007 Australian study that surveyed 939 young people aged between 16 and 29 at a music concert, found that nearly 47 percent had had two or more sexual partners, and a third reported recent unprotected sex with multiple partners[50]. Forty-four percent reported not using a condom, when they ordinarily would have used one, because they were intoxicated. Fifty-one percent reported having had sex or being in a situation they ordinarily wouldn't find themselves in because were affected by alcohol or drug intoxication[49].

Knowledge about STIs was generally low, with participants more likely to answer questions about HIV correctly than STIs and hepatitis. Women were among those who had overall better knowledge[49]. Those who had lower levels of education and who were younger had less knowledge[49]. The study found that knowledge associated with STIs did not reduce risk-taking behaviour.

Between 1996 and 2007 chlamydia notifications in Victoria increased six-fold from 1611 to 11, 231, with women aged 15 to 24 years representing the greatest number of cases[51]. The social, economic and health consequences of chlamydia can be severe, with ascending infection being the main cause of pelvic inflammatory disease (PID)[15]. PID can lead to infertility, chronic pelvic pain and ectopic pregnancy[15].

Researchers state that the way to adequately cater to the sexual and reproductive health needs of adolescents and young people is to have accurate STI and pregnancy surveillance; standardised practices for STI screening; comprehensive evidence-based sexual and reproductive health education for children and younger adolescents; clinical services that have reduced barriers to access; and evidence-based interventions that target teenagers at risk of STI and pregnancy[52].

7.7 Older women

Older women are often stereotyped in society to be devoid of sexual needs, problems or expression. Just as with any other age group, older women have sexual and reproductive health concerns. These are diverse and can range from a lack of sexual desire related to post-menopause hormone levels, desire but without or with little physical arousal, a loss of desire in a partner or anxiety about not having a partner, and not feeling attractive due to society's emphasis on youth[53]. While many older women enjoy satisfying sexual lives, one option for those who do not may be to seek counselling with their partner or to obtain additional information that they might use for themselves[52].

8. Conclusion

This paper has discussed a range of sexual and reproductive health issues for women. Sexual and reproductive health issues overlap with many other areas of health including education, health promotion, violence prevention, socialisation of gender roles and sexuality and mental health issues.

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Young women hold the burden of contraception and are at high risk of contracting sexually transmitted infections, particularly chlamydia. Unsafe sex practices are exacerbated by gendered power relations, which render women of any age less able to insist on male contraceptive use and more vulnerable to sexual coercion and unwanted sex. The immediate sexual health repercussions can mean embarrassing and painful health conditions, infertility or unplanned pregnancy. Sexual coercion and sexual assault can have long term and often severe psychological impact.

Women with unplanned or unwanted pregnancies are at greater risk of compounding negative health effects. Research shows that circumstances of pregnancy are often traumatic for women. The Victorian Government has assisted in minimising this by removing the medical procedure for termination of pregnancy from the Victorian Crimes Act. Focus can now shift to safe, affordable and accessible termination of pregnancy services.

Exploring women's sexual and reproductive health underscores specific issues attached to gendered health experience and needs. It demonstrates the requirement for targeted sexual and reproductive health education, health promotion and prevention strategies, particularly for 'at risk' or marginalised population groups, such as young women, Aboriginal and Torres Strait Islander women, women with disabilities and samesex attracted women.

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