

Women's Health Victoria



Women's Sexual and Reproductive Health: A Literature Review

May 2008

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First Published May 2008

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Introduction

The Sexuality Information and Education Council of the United States (SIECUS) use the following definitions for sexual and reproductive health:

'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.'

'Reproductive health is a state of complete physical, mental and social well-being 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 therefore implies that people are able to 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. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law.'

This review looks at women's sexual health and sexuality as dynamic and changing throughout life. It identifies some of the social aspects of sexual health and sexuality that impact on and influence women and men's behaviours. Addressing these social determinants can decrease risk behaviour and increase health benefits for all women. The review contains information about the incidence and prevalence of sexually transmitted infections (STIs) amongst women, contraception, information about safer sex practices and respectful relationships, termination of pregnancy, and outlines population groups who are at increased risk. The review highlights the gendered nature of sexual and reproductive experience and behaviour, which has implications for policy, practice, health education, promotion, and prevention strategies linked to women's sexual and reproductive health.

Sexually transmitted infections

Chlamydia

Chlamydia is the most commonly reported disease in Victoria. 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/AIDS¹. In 2005, over half (58%) the chlamydia notifications were from women, with 65% of that group aged 16-24 years. This compares with 43% of notifications from young men in the same age group.

Men with chlamydia rarely experience complications. However, chlamydia in women, if left untreated, can increase risk of additional health complications. 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. Women with chlamydia who have a pregnancy termination or insertion of an intra uterine device risk the infection spreading to the upper genital tract.

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

Pelvic inflammatory disease

It is estimated that over 100 000 Australian women experience pelvic inflammatory disease (PID), with 4000 needing hospital treatment each year². A young woman with a chlamydia infection in her lower reproductive tract has about a 1 in 12 chance of contracting PID.

PID is caused by chlamydia about 50% of the time and Gonorrhoea about 25% of the time. Symptoms may include vaginal discharge that is white/yellow to brown or greenish and have an offensive odour; longer or heavier periods and spotting between; pain and tenderness in the lower abdomen; deep pain during penetration, pain when urinating, fever and nausea or vomiting.

The most common complication is scarring to the fallopian tubes, which can block an egg moving from the ovary to the uterus, causing infertility. With one episode of PID a woman is twice as likely to experience infertility; 40% of women who have had three episodes of PID will be infertile because of a blocked fallopian tube. Women with PID who are trying to get pregnant are also 7 times more likely to have an ectopic pregnancy.

Approximately 60% of women do not know they have PID.

Genital herpes

Women are at higher risk than men for contracting genital herpes and one in six Australian women are carriers of the virus³.

Genital herpes is a sexually transmitted disease 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 body⁴.

Genital herpes has many symptoms including: redness or irritation of the skin; itchiness, tingling or soreness, stinging and burning when urinating, blisters or sores on genitals. Some of these may appear on the buttocks, thighs or other areas⁵. However, not all symptoms are present all the time and the first outbreak is generally the worst.

The risk of babies contracting genital herpes during birth is small especially in women who have had the virus for some time. 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 virus⁶.

Condoms and dental dams help to reduce the risk of infection. However, because the affected area may not be protected by these devices, genital herpes may still be transmitted. The virus can be spread even if there are no visible signs⁷.

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. The virus enters another person either directly across the mucosa, (the lining of the vagina or bowel) or into the bloodstream⁸. HIV may also pass from woman to baby during birth or breastfeeding.

There are an estimated 17.5 million women living with HIV/AIDS world-wide⁹. Globally, women who are young and living in poverty are at greater risk, due to social, economic, political,

religious and cultural factors, which limits their access to information, and renders them disempowered and less able to negotiate safer sex.

Medical opinion varies about the effects of HIV treatments on women. 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 effects¹⁰. One out of three women will experience side effects from HIV medication. These can include tiredness, nausea, vomiting, diarrhea, muscle pain, headaches, changes in menstrual patterns, skin rashes and changes in body shape. Some of these disappear in a few months but others persevere.

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% of the estimated HIV population in Australia¹¹. Eighty-four HIV positive women participated, representing approximately 5.8% of HIV positive women in Australia. Twenty-two of the women (27%) were Victorian, the second highest representation of HIV positive women in the sample, next to New South Wales (45%). Almost 92% of the HIV positive women in this study identified as heterosexual. This is consistent with international research that shows heterosexual HIV transmission is on the increase¹².

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. 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 they were relying on Government benefits.

Women (55.6%) were also significantly less likely than men (35.6%) to see the same medical practitioner for their general medical issues and HIV management, preferring to see a doctor for HIV specific treatment and another for generalist medical treatments. Furthermore, over the six months prior to survey, women (33.7%) were less inclined than men (59.3%) to have seen an HIV doctor, but were almost twice as likely than men to have visited a peer support officer or use a peer support group.

The single greatest difference reported between women and men in this study related to parenting. 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. 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.

In Victoria, new HIV diagnoses among women number 20-22 each year¹³. The number of women living with HIV in all regions of Victoria has increased, but particularly more so in the North-western metropolitan area. While young people are generally at greater risk of HIV infection, the age for Victorian women being diagnosed with HIV is increasing. In the years 1997-2001 the highest HIV incidence rates amongst Victorian women was for those aged 20-29 years. During 2002-2006 this changed, with a dramatic increase in HIV diagnoses amongst women aged 30-39 years. This has implications for parenting and family situations. Another significant increase in HIV incidence has been in women aged over 50. Advocacy and support 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.

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. Women who have sex with women can also acquire the infection¹⁴.

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

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

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 two strains of HPV infection, 16 and 18, which cause around 70% of all cervical cancers, and HPV types 6 and 11, which cause 90% of genital warts. Women must be vaccinated against these strains prior to being infected by them in order for protection to work. *Gardasil* is given as a series of three vaccinations over a period of seven months. A school-based program is targeting girls aged 12-13 years, and 13-18 years with the *Gardasil* vaccination.

Reports about negative side-effects from the immunisation have not been fully substantiated. The Australian Therapeutic Goods Administration has been monitoring research on *Gardasil* and states that every 6 weeks the Adverse Drug Reactions Advisory Committee (ADRAC) reviews adverse events reported following *Gardasil* vaccination¹⁵. Severe allergic reaction or anaphylaxis is an important aspect of the vaccination, but is rare in Australia, with an estimated occurrence rate of 5.1 per million. 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.

Bacterial vaginosis

Bacterial vaginosis (BV) is the most prevalent form of vaginal disturbance in women of reproductive age¹⁶. Rates of infection vary from about 10% generally to 35% of gynaecology inpatients, and up to 60% in women attending a sexual health service. There are known risk factors associated with BV but the exact cause is unknown. It is more often irritating and embarrassing than harmful, but BV infection can put some women at increased risk of giving premature birth, having miscarriage and contracting sexually transmitted diseases including HIV¹⁷.

Contraception

A number of contraceptive methods are available to women and men in Australia. They include physical methods, hormonal methods and permanent procedures¹⁸. Contraception in 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% effective; and the vasectomy, which involves surgically cutting the sperm ducts in the testes to prevent sperm entering the semen. This is considered a permanent method (although may at times be reversed) and is also highly effective.

Contraceptive methods and practices have and continue to be largely the responsibility of women. As such, there are many more contraceptive tools targeted at women's use. These include the cervical cap, diaphragm, female condom, intrauterine devices (IUDs), oral hormone contraceptives and hormonal implants and devices.

Cervical cap

Cervical caps are a soft, rubber dome-shaped cap with a flexible rim that fits over the cervix, preventing sperm coming into contact with an egg. Their effectiveness ranges from 75-91% and they do not provide protection against STIs.

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

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 provides a high level of protection against sexually transmitted infections (STIs) and when used properly, has an effectiveness rate of between 80–95 per cent.

Hormonal implants, devices and injectables

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% effective and lasts 3 years.

Depo Provera is a progesterone based hormone injected into a woman. It prevents ovulation, changes cervical mucus and the lining of the uterus to make it unsuitable for a fertilised egg to implant. It is also highly effective, with a failure rate of 0.01%.

Mirena intrauterine device (IUD) is T-shaped and releases small amounts of a progesterone-like hormone into the uterus. It increases the cervical mucus and thins the lining of the uterus, preventing fertilised eggs from implanting. It is near 100% effective and can be left in for up to 5 years.

None of these hormonal contraceptive methods provides protection against STIs.

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%). They do not provide protection against STIs.

Oral hormone contraceptives

The mini-pill and the combined pill are made up of synthetic forms of hormones. 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% effectiveness. Neither pill protects against STIs.

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. Another common 'sterilisation' method is *Essure* micro-inserts. Both have low failure rates (0.2%). Neither offers protection against STIs¹⁹.

At risk and diverse populations

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^{20,21}. 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. Social disadvantage greatly impacts access to health services and sexual health information and resources²².

Adolescent pregnancies in Aboriginal and Torres Strait Islander women are common, and undiagnosed STIs occur with limited or no access to emergency contraception, other forms of contraception or abortion. Young women may not even be able to access kits to determine pregnancy. This remains despite high incidences of sexual assault, incest and rape.

Sexually active young Aboriginal and Torres Strait Islander people sometimes refuse to participate in STI screening programs because they fear being reported for having underage sex.

Additional barriers around sexual health include the way safe-sex information is aimed at the general populace and often not targeted at Indigenous groups. English is not the first language for many Indigenous Australians and the definitions of 'sex' are differently interpreted amongst groups. Furthermore, access to health information is often limited, particularly in rural and remote locations and access to Indigenous health workers is even more difficult.

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. This can make accessing health services including STI checks difficult for those living outside major metropolitan areas where specialised sexual health services may be available. Despite this, sex workers in Australia have lower rates of STIs than the general population²³.

In particular, the stigma attached to sex work makes it difficult to be taken seriously when wanting to report sexual assault, and many workers do not report for fear of judgmental attitudes and not being taken seriously²⁴.

A summary of research findings from Australian eastern seaboard cities found that between 33% and 61% of street based sex workers report having been sexually assaulted by a client while working²⁵. Rates were lower for those workers based in brothels or other environments (13%-20%). These figures do not include sexual assault that occurs outside of the work environment (e.g. with partners or sexual abuse in childhood). The nature of street based work means that workers have less control over their environment, including the ability to insist on safer sex practices.

There has also been some research suggesting a link between sexual abuse in childhood and sex work. While not all children who are subject to sexual abuse go on to work in the sex industry, surveys of sex workers have found much higher rates of histories of sexual abuse than in the general population. One study in Kings Cross in Sydney found that 75% of sex workers had a history of child abuse²⁶ while another study based in Adelaide found that among young (aged 12 to 23 years) sex workers based on the streets, 80% of young women and 27% of young men had a history of child abuse²⁷.

Sex workers are also over-represented among female murder victims²⁸.

Refugee and other culturally and linguistically diverse (CALD) women

There are some significant sexual health issues for newly arrived refugees, and a range of issues for CALD women who have been living in Australia for some time.

There is a high level of sexual abuse including rape of women and girls in many countries from which Victoria takes refugees, including in refugee camps which may be in a country of transit. Religious and cultural factors including risk of social ostracism can make some refugee women reluctant to report this sexual violence²⁹.

Female Genital Mutilation (FGM) is practiced in many countries from which Victoria takes refugees, although it is not possible to know exactly how many women in Victoria have undergone the procedure. Complications arising from FGM vary depending on the nature and severity of the mutilation, but can include; painful sex, complications in pregnancy, childbirth, miscarriage and abortion, high risk of infections, difficulty with Pap smears, chronic pain, and urinary and faecal fistulae³⁰.

Lesbian, bisexual, 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 men³¹. 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% of lesbians (n=1085) and 97% of bisexual women (n=101) gave a history of sex with men. Ninety-eight percent of SSA identifying women reported having had sex with women, and 83% within the last year.

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% reported always using a condom. 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.

Researchers in this study 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. This is linked with practitioner attitudes found globally, that often render SSA women invisible by assuming heterosexuality^{31,32}. 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^{31,32,33}.

Australian research reports that SSA women are less likely to have regular Pap smears than heterosexual women; they access other forms of screening less frequently, delay treatment and are less likely to have a regular general practitioner (GP). This is despite SSA women having similar rates of cervical abnormalities as heterosexual women, and reports that HPV occurs in 21% of lesbian women with no prior sexual contact with men. 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* pamphlet³⁴.

The reproductive health needs of SSA women are also specific, with the majority electing self-insemination or clinic-based insemination to become pregnant. In these instances, a health professional with relevant knowledge about insemination practices, costs, referrals, screenings, safety and so on, is required. 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 27% of Australian lesbian and gay parents reporting negative experiences with their children's healthcare that relate back to their own sexuality.

It is important that health professionals take careful and considered sexual histories in a non-judgmental manner, and without making assumptions. 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 same-sex 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'³⁵.

Women with disabilities

Long-term disability may have an impact on a woman's sexual function and sense of sexuality, and women with disabilities often have to face myths about their sexual and reproductive lives³⁶. These may include beliefs that 'disabled women are asexual'; that they 'must be single', 'cannot be mothers' or 'should be grateful for sexual relationships'.

An informed and non-discriminating health practitioner may be difficult to find, and this has been reported by women with disabilities who want to get pregnant. Infertility among women with disabilities has similar rates to women without disabilities³⁷ and research shows that physicians are often unable or unwilling to assist women with disabilities with pregnancy information. Pregnancy needs will be specific to the individual and close support and greater attention to antenatal care may often be an issue. Birthing may also need to be considered, with caesarean sections sometimes a necessary procedure.

Contraceptive options for women with a disability who don't want to get pregnant are sometimes limited. Women with quadriplegia for example, are unable to insert diaphragms. The contraceptive pill may contribute to blood clots or conversely, medications may interfere with the pill or contraceptive implants.

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.

Young women

Young women across the board are generally at greater risk of unwanted sex and contracting STIs than older women, and this in a climate where the socioeconomic and health disparity of adolescent mothers is far greater than in previous generations³⁸. Half of adolescent pregnancies occur during the first six months of sexual activity, but young women have been found to delay seeking prescription contraception for an average of one year after first having sex³⁹. There is a lack of research into why this is the case, and is an area that needs more attention. Adolescents are also the most frequent users of emergency contraception at Australian family planning clinics.

One 2007 Australian study that surveyed 939 young people aged between 16 and 29 at a music concert, found that 48% had multiple partners in the previous year and 66% had a new partner in the past three months⁴⁰. Forty-three percent did not use a condom all or most of the time because they reported being 'drunk' or 'high' during sex. Knowledge about STIs was generally low with participants more likely to answer questions about HIV correctly than STI and hepatitis. Females were among those who had overall better knowledge. Those who had lower levels of education and who were younger had even less knowledge.

Young women are at increasing risk of contracting sexually transmitted infections (STIs)^{39,40}. The rate of chlamydia in Australian females aged 15 to 19 years is second only to the rates seen in women aged 20 to 24 years⁴¹. The social, economic and health consequences of chlamydia can be severe, with ascending infection being the main cause of pelvic inflammatory disease (PID). PID can lead to infertility, chronic pelvic pain and ectopic pregnancy.

A variety of explanations exist for young women contracting sexually transmitted infections, including sexual experimentation, short-term and numerous relationships, the need for peer approval, and a lack of knowledge or understanding about the likelihood and consequences of pregnancy, which affects protective contraception use. It is also known that over 10% of women report being sexually coerced prior to the age of 16 years³¹.

Researchers state that increased screening strategies and cost-effective interventions need to be ongoing in order to target adolescent STI rates, unplanned pregnancy and pregnancy terminations^{38,39}. General practitioners need to take on preventative sexual health counselling and care³¹ and coordinated sexual and reproductive health education packages must be aimed at children and adolescents in school³².

Older women

Further in this paper, the sexualisation of young women and girls in the media and popular culture is explored. At the other end of the spectrum, 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 with physical arousal problems, a loss of desire in a partner or lack of a partner, and a sense of lack of sexual attractiveness due to society's emphasis on youth⁴².

Safer sex and respectful relationships

Safe sex (or safer sex) refers to protecting oneself and sexual partner against sexually transmitted infections (STIs) and unplanned pregnancy. Male condoms are the more common device promoted in safe sex practices. They assist in protecting against some STIs and pregnancy. Women who are taking the contraceptive pill are still advised to have their sexual partner use a condom (whether male or female, over penis or sex toy). Dams, placed over the anus or vagina, are another method of protection against STIs.

The male condom reduces the risk of HIV, chlamydia and gonorrhoea transmission, but it is less effective against HPV or HSV. Research findings are mixed around the degree to which Australian men use condoms. One study found that men used condoms 41% of the time when having casual sex and less with excessive alcohol consumption³⁴. A later study found that condom use was an accepted part of casual sexual encounters, for protection against disease, and in mixed sex couples, for preventing pregnancy⁴³.

Factors that influence women and girls' vulnerability to unsafe sex practices include the reliance on male sexual partners to use condoms. In this and other ways, women are at increased risk of contracting STIs and becoming pregnant.

Sexual violence and abuse

Differences in gender relations means that women having sex with men 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 vulnerable⁴⁴.

Nationally, 10% of women report being sexually coerced prior to the age of 16 years³¹. One Australian telephone survey found that 21% of women reported a history of sexual coercion, which mainly occurred prior to the age of 18 years³⁴. Within high schools, almost 26% of sexually active year 10 and 12 students have reported at least one incidence of unwanted sex, and 6.4% of young women reported that their last sexual encounter was unwanted³⁴. Another recent Australian study found that 32% of young women aged 16-25 had been subjected to sexual assault, either as a child or within the twelve months leading up to survey³⁵.

In addition to the acts of violence, there have also been several disturbing cases where groups of young males sexually assault a female and record it using mobile phone technology then distribute it by phone, email or internet.

Sexual assault is not limited to young people, of course, with adult women also at risk, especially in violent relationships. Women with physical or intellectual disabilities or mental illness are also at high risk, particularly if they are in institutional care.

Childhood sexual abuse is also a significant factor in sexual and reproductive ill-health, as well as psychological and emotional health. A 2002 review of seven Australian studies into the prevalence of child abuse found that a history of sexual abuse in childhood was reported among 5.1% of males and 27.5% of females⁴⁵. The abuser was known to the victim in 75% of cases,

40% of the time being a family member. They also found sexual abuse of children to be more common in families 'beset by other adversity', indicating that social determinants are a significant factor.

As well as sexual abuse having obvious impacts on a person's sense of safety, trust and future sexual relationships, more severe psychological disorders and rates of suicide have been found to be up to twice as high in people who have been sexually abused as children⁴⁶. One Victorian based study linking records from the Victorian Institute of Forensic Medicine with later contacts with the mental health system via the Victorian Psychiatric Case Register found a near fourfold increase in contacts with mental health services compared with the general population⁴⁷.

Sexualisation of women and girls in the media and popular culture

The way that women and girls are portrayed in the media and in popular culture impacts on their self-image, on society's view of the role of women and girls, and on what is deemed to be socially acceptable treatment of women and girls.

While there is little published research from Australia, the American Psychological Association (APA) convened a task force in 2007 which included international research. It evaluated the evidence suggesting that sexualisation in the media has negative consequences for girls and for the whole of society. Their report found that the cumulative exposure of children and young people to sexualised images and themes has negative effects in many areas. In particular, it links sexualisation with three of the most common mental health problems of girls and women: eating disorders, low self-esteem, and depression or depressed mood⁴⁸.

The Australian Psychological Society (APS) states that adolescent girls affected by 'self-objectification', partly as a result of sexualized images in media, have diminished sexual health, including reduced assertiveness and a decrease in protective behaviours⁴⁹.

Educators commonly take the view that children who receive quality, age-appropriate, sequential sexuality and relationships education from early childhood are better equipped to deal with the stereotypes and negative messages coming from media and marketing sources⁵⁰.

Termination of pregnancy

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'⁵¹. The World Health Organization (WHO) states that worldwide, 40-50 million abortions occur annually, and that nearly half of those take place in unsafe conditions⁵². Accurate data for the numbers of women who have an abortion, or termination of pregnancy (TOP), each year in Australia is unavailable. However, in Australia, as it is reported by the WHO worldwide, access to TOP services is a primary concern.

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. The negative life impact of an unplanned and unwanted pregnancy can affect a woman's education, employment and financial security⁵³, and has the potential to threaten a woman's mental and physical health, and her life³⁹. Approximately 13% 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 consequences that include infertility³⁹.

Access to safe, legal and affordable terminations is good public health practice. In Victoria, this is complicated by the ambiguous legal context of TOP procedures with its inclusion in the Victorian Crimes Act⁵⁴.

Victorian laws that regulate the practice of medicine apply to the provision of termination of pregnancy. However, it is the only medical procedure listed in the Victorian Crimes Act, and under three categories of criminal law relating to termination of pregnancy: unlawful termination of pregnancy, child destruction and homicide³⁸. This means that courts have decided under which circumstances a TOP is lawful. This is, however, currently under review.

At the time of writing, in Victoria the penalty for unlawful termination is five years imprisonment for both the woman and the doctor carrying out the procedure, and one year's imprisonment for supplying or procuring anything to assist.

This current legal status inhibits the provision of reliable, well-planned delivery of services across the state. This results in patchy and inequitable service provision with a serious under-supply of public sector services. Health professionals are unclear about their legal status when providing terminations and have a well founded fear of criminal prosecution³⁸. In addition, it is not uncommon for health professionals who provide termination of pregnancy to be subjected to harassment and violence, making it difficult to attract people to work in the service provision. If termination of pregnancy were not under the Crimes Act, incidents against TOP service providers could be countered more readily, or would not occur at all. It would be far less acceptable to harass women, their accompanying family and friends, health service staff and doctors involved³⁸.

Access to termination of pregnancy is broadly supported by Australians³⁸. According to the 2003 'Australian Survey of Social Attitudes', 81.2% of Australians agree that women should have the right to decide whether to have a termination⁵⁵. This was independent of their gender or religious affiliation. Only 9% of the 5000 adult participants disagreed with a woman's right to decide, and the remaining 10% were undecided⁴². A more recent study reported that 96% of Australians did not consider termination to be wrong⁵⁶. Similarly, a study commissioned by Marie Stopes International surveyed 2500 general practitioners (GPs) nationally and found that 85% of Australian GPs believe women should have access to termination services⁵⁷.

Removing TOP from the Victorian Crimes Act would align the procedure with other health services. It would give doctors the confidence and security to deliver appropriate and value-free services. The community would have reliable and visible avenues for seeking information about reproductive health. It would also act as a deterrent for anti-choice activists who regularly intimidate and harass TOP doctors and their clients⁴¹. Most importantly, it would safeguard a woman's right to control her reproductive capacity; it would help to ensure safe practice conditions and help alleviate potential negative health impacts of unplanned pregnancy.

Social implications of unplanned pregnancy include disruptions to domestic or economic activities, abuse, partner abandonment and sometimes divorce³⁷. There are also strong associations between partner violence and a range of reproductive health outcomes. Particularly among young women, those in abusive relationships are more likely to become pregnant, have a higher rate of miscarriages and terminations, preterm and full term births compared with young women who do not experience violence⁵⁸.

Education as a preventive strategy

Education is a key component to acquiring information about safer sex practices, risk and respectful sexual and relationship behaviour. Formal and informal sex education at schools and within families is generally the way heterosexual young people learn about safe sex practices and relationships^{35,59}.

A study comparing sexual health outcomes in young people in the context of sex educational policies in the Netherlands, the United States, France and Australia found that in France and the Netherlands, where there is mandatory secondary school sex education, there are fewer STIs than in Australia and far fewer than in the US, where sex education is patchy. The study also found that school-based education is likely to be more effective if it portrays sex as a positive thing, and does not focus solely on delaying or abstaining from sex⁶⁰.

Northern European countries have some of the best sexual and reproductive health outcomes in the world, and this is achieved partly through a comprehensive sexuality and relationships education program throughout the school system as well as easy access to contraception, particularly for young people⁶¹.

Formal education is not only relevant to acquiring information about safer sex practices but also for learning about healthy sexual relationships. In the 2006 study referred to above, young men regarded their first sexual experience as an achievement of masculinity; they 'scored' or felt 'on top of the world'³⁵. Those young women, who reported positively about their first sexual experience, framed it within a romantic relationship or friendship context. Sixty-four percent of young women and men had experienced casual sex, but more women than men reported having negative feelings after the event, which generally involved little verbal negotiation prior to, during or after sex. Young people who were in ongoing relationships reported that the level of verbal communication increased, with talking about the sexual component of the relationship highest among women and young gay men. Women were also more likely than men to use directive communication to set boundaries with their sexual partners and to tell them what they liked or wanted. When asked what they might like to see added to education programs, young people expressed strong support for single gender classes to address issues around the risks of sexual activity and alcohol, sexual assault, setting boundaries, gaining an awareness of what is expected of sex and in relationships, increasing self-respect and for learning how to be treated with respect by their sexual partners³⁵.

Samesex attracted (SSA) young people, however are not able to rely on these sources and turn more to the internet for information. In 2005, Hillier et al surveyed 1,749 young people aged 14-21 years about their sexuality, sexual health and wellbeing. When asked where they gained information about safe sex practices, 93% of heterosexual young people reported that they received this information from school, while 63% said they learnt it from their family. However, only 21% of young lesbian identifying women reported learning about safe sex at school and even less from family (10%)³⁶. Another smaller study of 16-25 year olds (n=56) found that 34% of the sample identified as being attracted to the opposite sex. This group of young people also reported that school was inadequate for samesex education. Formal education, which was aimed more at heterosexual people failed to cover issues faced by SSA youth. This more subtle form of homophobia, asserts and perpetuates heterosexuality as the 'only' sexuality, and increases health risks for SSA people who do not identify with education and promotion models. In this instance SSA youth reported increased isolation, depression and pressure to conform³⁵. Hillier et al, suggest that SSA young people 'tune out' when they are not represented in classroom education and therefore miss relevant health and safety information that would apply to them when they are having sex with someone of the opposite sex³⁶. They state that school based sex education programs, that do not cater to the health and relationship needs of SSA

people, need to be considered in light of the higher rates of STIs and pregnancy found amongst SSA young people.

Conclusion

Young women having sex with men hold the burden of contraception and are at high risk of contracting sexually transmitted infections, particularly chlamydia. Unsafe sex practices are exacerbated by not using contraception, not having partner sexual history, and by social environments of alcohol and drug use. This, combined with gendered power relations, 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 assault, including childhood sexual abuse, can have long term, often severe, psychological impacts.

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 psychological and emotional health issues.

In a climate where the general Australian populace supports the decriminalisation of termination of pregnancy (TOP), but where within Victorian law the procedure remains a crime, women with unplanned or unwanted pregnancies are at greater risk of compounding negative health effects. Research shows that pregnancy circumstances are often traumatic for women. Denied or difficult access to TOP services can further impact on a woman's psychological, emotional, and physical health, and has the potential to negatively affect all aspects of her life.

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, 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 same-sex attracted women. Women's sexual and reproductive health research also highlights the importance of pregnancy options for women. It raises awareness of the need to decriminalise termination of pregnancy and increase safe and supported access to TOP services.

Glossary of terms

AHMF	Australian Herpes Management Forum
AMA	Australian Medical Association
ARCSHS	Australian Research Centre in Sex, Health and Society
ATSI	Aboriginal and Torres Strait Island
BHC	Better Health Channel
BV	bacterial vaginosis
CYH	Children, Youth and Women's Health Service
DHS	Department of Health Services
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	same-sex 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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