Sexual and Reproductive Health

2014

1. Introduction

Sexual and reproductive health is an essential element of good health and human development.

The AMA endorses the World Health Organisation's[1] working definitions of sexual and reproductive health:

Reproductive health refers to a state of 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, and across all stages of life.[2] 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. Implicit in this is the right to be informed of, and to have access to, safe, effective, affordable and acceptable methods of fertility regulation, and the right to access health care services to support a safe and healthy pregnancy and childbirth, and to provide parents with the best chance of having a healthy infant.

Sexual health refers to a state of physical, emotional, mental and social wellbeing related 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. While sexual health is vital for (and therefore a part of) reproductive health, it is important to also consider sexual health in its own right.

The impacts of sexual and reproductive health are human and economic, and direct and indirect. Unwanted pregnancy, sexual violence, sexually transmissible infections (STIs) and infertility are major contributors to morbidity and associated costs in Australia.[3,4,5] 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. There is evidence that investing in sexual and reproductive health is cost effective, with the potential to minimise future health system costs and to realise significant benefits at the personal, family and societal levels.[6,7,8]

2. Guiding principles

To support better sexual and reproductive health outcomes, the AMA believes that polices, programs and service delivery should be informed by the following principles:

- **National policy leadership** to drive strategic coordination and a commitment to improving and sustaining better sexual and reproductive health outcomes.
- A **population health** approach that addresses the **social determinants of sexual and reproductive health**.
- Recognition of the **right to sexual and reproductive health** that implies that people are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or unwanted pregnancy, and with the ability to regulate their fertility without adverse or dangerous consequences.

- A comprehensive approach that includes **disease prevention, sexual and reproductive health promotion, and early intervention**.
- A focus on **healthy relationships** as a central part of sexual and reproductive health, and recognition that this requires a positive and respectful approach to sexuality and sexual relationships, and confidence in negotiating boundaries and making informed choices.
- Acknowledging **diversity** and recognising the needs of all persons regardless of age, ethnicity, sexual orientation, gender identity, disability, geographic location, financial means, and any other status.
- A focus on **reducing inequities in sexual and reproductive health** outcomes, and improving access to relevant information and services for at risk or vulnerable population groups.
- Development of **evidence based and accountable** policies and programs that are underpinned by research, systematic data collection, and ongoing evaluation and monitoring.
- **Support for the central role of medical practitioners** in supporting sexual and reproductive health through the provision of non-judgmental, confidential and quality care.

3. A coordinated national strategy for sexual and reproductive health

Federal, state and territory governments have a range of policies on individual aspects of sexual and reproductive health, but a coordinated approach is lacking. No policy or strategy has been developed that addresses sexual and reproductive health as a whole, or that attends to interconnections with other relevant areas, such as mental health, education, or drug and alcohol strategies. National policy leadership is imperative in overcoming policy fragmentation, maximising the linkages between interdependent strategies, and to support cooperation across federal, state and territory levels.

The AMA recommends that a national strategy for sexual and reproductive health be developed as a priority. A coordinated national approach is required to overcome gaps in policy provision, reduce the isolation of existing sexual and reproductive health strategies from each other, improve the delivery of services, increase the efficacy of existing strategies, and improve public health outcomes.

4. Priority populations

There are significant disparities in sexual and reproductive health in Australia. Groups at increased risk of poor sexual and reproductive health include young people, Aboriginal people and Torres Strait Islanders, immigrants and refugees, people with disabilities, gay, lesbian, bisexual, transgender and intersex people, sex workers, and people in prisons. Older adults also face particular issues that are often overlooked in existing sexual and reproductive health strategies, and which require a renewed focus in the context of an ageing population.

The incidence and impact of STIs is uneven across the Australian population, and interventions that are targeted and tailored to identified priority populations are essential. Priority populations should be determined on the basis of the epidemiology of specific STIs and associated risk factors, and social or structural factors that may act as barriers to STI prevention. Engaging priority populations in turn requires an understanding of the social and cultural contexts that shape sexual behaviours and the specific risk and protective factors in different population groups.

Aboriginal people and Torres Strait Islanders

Aboriginal people and Torres Strait Islanders experience poorer sexual and reproductive health outcomes than other Australians, including substantially higher rates of STIs, particularly for chlamydia, gonorrhoea, syphilis and hepatitis B.[9] Among teenage Aboriginal and Torres Strait Islander women, the birthrate is more than five times that of all teenage

women[10], and more than half of all hospitalisations are related to pregnancy complications; the proportion of low birth weights and rates of infant mortality are double the non-Indigenous rate.[11,12] Cervical cancer mortality is five times that of non-Indigenous women, in part reflecting lower cervical cancer screening rates[13], while the ovarian cancer mortality rate is nearly 40 percent higher than the rate for non-Indigenous women.[14] There are also major disparities between the sexual and reproductive health of Aboriginal and Torres Strait Islander men and non-Indigenous men, with low levels of screening and help-seeking behaviour for sexual and reproductive health disorders.[15]

Improving the sexual and reproductive health of Aboriginal and Torres Strait Islanders should be prioritised in national sexual and reproductive health strategies, and supported by an action plan and sustained investment at both federal and state levels.

Services to support the sexual and reproductive health of Aboriginal peoples and Torres Strait Islanders should be accessible and culturally safe. Cultural respect strategies should be a part of all sexual and reproductive health services. The AMA supports the proactive recruitment and retention of Aboriginal and Torres Strait Islander staff within the sexual and reproductive health sector.

Targeted health promotion programs should be developed in partnership with communities and tailored to the needs of people from Aboriginal and Torres Strait Islander backgrounds.

Young people

Adolescence is a critical time for the development of sexual identity and interpersonal relationships, and the onset of sexual attraction and related behaviours. An essential element in the sexual health and wellbeing of young people is developing a positive body image and the skills and confidence to negotiate interpersonal relationships and make informed choices about sex. The sexual and reproductive health outcomes of young people do not emerge in isolation, but are shaped by a range of social determinants and behavioural risk factors, including homelessness, substance use, and mental disorder.[16] Evidence suggests that same-gender attracted, intersex and gender diverse young people may face challenges due to heterosexism, homophobia, transphobia or intersex exclusion, and this contributes to higher rates of suicide, mental health problems and risk-taking behaviours, including risk-taking in sexual activities[17,18]; the lack of relevant and accessible resources that address same-sex sexual health information, sexuality, and gender identity can be a barrier to improving sexual and mental health. The relationship between pornography, social media, and the sexualisation of children are additional emerging issues, and further efforts are required to better understand these relationships and appropriate interventions.

The early onset of sexual activity during adolescence is associated with a greater risk of unplanned pregnancy and STIs.[19] Acquiring STIs at an early age can also have important effects on future sexual and reproductive health, including increased risk of cervical and anal cancer (human papilloma virus), infertility (chlamydia infection) and recurrent pain (herpes simplex virus). While some young mothers and their babies do well, on a population basis, teenage pregnancy is associated with a wide range of indicators of poor health. Teenage mothers are more likely to experience economic disadvantage, compromised educational outcomes, and higher levels of psychological distress.[20] These adverse outcomes, however, can be mitigated if young parents are provided with appropriate support.[16,19,21]

Policies and programs to improve the sexual and reproductive health of young people need to be integrated and linked with wider health and welfare initiatives relating to mental health, alcohol and drug use, and youth poverty and homelessness.

Comprehensive, clinically accurate and culturally appropriate sexual and reproductive health education programs should be implemented in schools.

Young people should have access to affordable, confidential, and comprehensive clinical services to address their sexual and reproductive health needs. Barriers to accessing such services should be identified and minimised, particularly in relation to young people who are at risk.

Comprehensive data on the sexual health of young Australians should be regularly collected and reported. Monitoring should include STI notification rates, birth and abortion rates, and frequency of contraception use. Cross-referencing this data with wider social indicators of health and wellbeing (e.g. mental health indicators, drug and alcohol use, school attendance and homelessness) would provide a foundation for informed policy development and planning.

People with a disability

Individuals with physical, cognitive, or psychiatric disabilities have a right to education about sexuality, sexual health care, and opportunities for sexual expression and affirmation of their gender. People with disabilities are a diverse group, and this diversity translates into a diversity of particular issues and needs relating to sexual and reproductive health. However, the sexual and reproductive needs of persons with disabilities are often overlooked or neglected, and variations in sexuality or gender identity may be pathologised for people with developmental or cognitive disabilities.[22] People with disabilities are also more likely to be victims of physical and sexual abuse and rape.[23]

The AMA advocates that people with disabilities should have access to information, education and resources to make informed choices about their sexuality and sexual and reproductive health.

The policies and procedures of sexual and reproductive health services should ensure that healthcare is provided to all persons without discrimination because of disability.

Medical practitioners, healthcare workers and other caregivers should have access to comprehensive sexuality education, as well as training in understanding and supporting sexual development, behaviour, and related healthcare for individuals with disabilities. Medical workforce training with respect to sexual and reproductive health should include content on supporting sexual relationships and sexual and reproductive health needs for people with a disability, as well as the associated ethical and legal aspects of informed consent, substitute and supported decision making and fertility control.

Competent patients, regardless of disability, have the right to make their own informed decisions regarding sterilisation. For patients with impaired decision-making capacity, surrogate consent must be in the best interests of the patient, not the interests of others, including carers, other family members, or the wider community.

Gay, lesbian and bisexual people

Sexual and reproductive ill health disproportionately affects gay, lesbian and bisexual (GLB) people.[24,25,26] Experiences of discrimination can impact negatively on sexual health and wellbeing, contributing to the underutilisation of health services. For example, lesbian women access breast and cervical screenings less regularly than recommended, and often have limited access to information about safe sex practices.[25] Discrimination against GLB people may also impact on their ability to form and sustain relationships, and has been linked to increased drug and alcohol use, sexual risk-taking, and poorer mental health outcomes.[27,28,29] The absence of GLB identities and issues in sexual health promotion campaigns and resources can further undermine efforts to improve sexual and reproductive health.[17] There is limited research focusing on the health needs of bisexual people, however overseas studies have indicated they experience poorer mental and sexual health outcomes than lesbian and gay people, and are at a greater risk of STIs due to a lack of targeted health promotion.[30,31]

GLB people should access to healthcare that is free from discrimination and responsive to their sexual and reproductive health needs. Sexual health education, campaigns and information should

be developed that is relevant and targeted to gay, lesbian and bisexual people, including resources that promote safe sex practices.

Data collection and health surveillance methods should be improved, and research gaps addressed, to better capture and understand the sexual and reproductive health needs of GLB people.

Intersex, trans/transgender and gender diverse people*

While trans and intersex people may experience barriers to healthcare that mirror many of the obstacles faced by GLB people, they also face unique challenges and particular needs relating to their sexual and reproductive health. Many experience structural barriers to accessing subsidised medications and health screening, or to health services that presuppose binary gender categories that are assigned at birth. Within healthcare settings, gender-normative language and assumptions can play a powerful role in delegitimising people's own designations of their gender and bodies.[18,32] Intersex people have reported being pressured into "normalising" procedures to remove gonads and other tissue, based on limited data and inflated risk assessments.[22] Trans and intersex people remain at risk for cancers of the reproductive tract, including ovarian, cervical, uterine and prostate cancers.[33] However, they often underutilise screening services, and may avoid or delay seeking medical care due to fears of discrimination, judgment or stigmatisation. Although hormone therapies are medically necessary and beneficial for people who have undergone sterilisation or for people who are affirming their own gender, access to such therapies is restricted when coverage is defined by gender. Further research needs to be undertaken to establish the safest and most effective ways of providing long-term hormonal therapy, and clinical guidelines and practice updated accordingly.

Intersex, trans and gender diverse people should have equitable access to quality sexual and reproductive healthcare, and to health services that are inclusive, free of discrimination and stigma, and responsive to their individual healthcare needs. This includes access to health screening for STIs and cancers of the reproductive tract, and access to information about contraceptive and reproductive options.

For intersex, trans and gender diverse people, structural barriers to accessing to preventive health screenings, gender affirming procedures and necessary medications should be removed. This includes ensuring access to, and subsidies for, healthcare and pharmaceuticals is determined by the health needs and actual body parts of individuals, rather than their recorded gender. Medicare and private health insurers should provide equitable coverage of gender affirmation interventions for which intersex, trans and gender diverse people have given fully informed consent.

Data collection and health surveillance methods should be improved, and research gaps addressed, to better understand the sexual and reproductive health needs of transgender and intersex people.

Sex workers

Epidemiological studies have consistently shown that sex workers in Australia have lower rates of STIs than the general population, and very high rates of condom use.[34,35,36,37,38,39] This is largely due to the establishment of safe sex as a norm, the availability of safe sex equipment, community-driven health promotion and peer education, and improved access to clinical sexual health services.[35,36,40] Better sexual health outcomes are reported in jurisdictions where sex work is decriminalised, and regulatory models such as decriminalisation, which increase control over workplaces and the implementation of occupational health and safety laws, have been shown to increase the capacity to implement

* Intersex is an umbrella term for people whose biological sex cannot be classified in categorical terms of male or female. Trans is an umbrella term for people whose gender identity does not confirm to the gender assigned to them at birth, and includes people who identify as transgender, transsexual, and sister-girls/brother-boys in Aboriginal and Torres Strait Islander cultures. Some people who do not conform to gender stereotypes may identify as genderqueer, agender (having no gender), bigender (both a woman and a man) or as non-binary (neither woman nor man).[32]

safe sex practices.[36,41,42] Maintaining low rates of STI transmission and high rates of safe sex among sex workers in Australia requires ongoing legislative, policy, and programmatic responses. Studies investigating the rates of STIs among migrant sex workers have generally found low rates of STIs and high rates of condom use[43,44], however ongoing health promotion and outreach is required to sustain sexual health outcomes among a constantly changing and increasingly diverse workforce.

To maintain good sexual health and low rates of STI transmission among sex workers, all Australia governments should develop a legislative and policy framework that protects and supports the health and safety of sex industry workers.

Continued funding and support should be provided for programs and services that promote sexual health among sex workers, including peer education and support services that work in collaboration with mainstream health providers.

People from refugee and culturally and linguistically diverse backgrounds

There is significant variation in the sexual and reproductive health outcomes among people from culturally and linguistically diverse (CALD) backgrounds. However, many experience poor sexual and reproductive health outcomes due to the underutilisation of sexual health services, lack of knowledge, and social stigma associated with discussions of sexuality.[45,46,47] This can be complicated by cross-cultural variations in the way sexuality or gender is defined and expressed. People from countries with a high HIV prevalence are over-represented in the numbers of new HIV notifications and, within this population group, there is a much higher proportion of heterosexual transmission and late diagnosis.[39,48] Research has suggested that HIV-related stigma and discrimination is common among many CALD communities, and can contribute to late presentation.[49,50] Immigrant and refugee women are also at a greater risk of suffering poorer maternal and child health outcomes; are less likely to have adequate information and familiarly with modern contraceptive methods; are at greater risk of contracting STIs; and are less likely to use primary health services.[51,52] Young women from refugee backgrounds experience elevated rates of teenage pregnancy relative to other young women.[53,54]

Sexual and reproductive health services, information and resources should be available in a range of languages and formats, and sensitive to cross-cultural variations in understandings of sexuality and gender roles and relations. Health promotion interventions should engage CALD communities to promote community-level dialogue and to address stigma surrounding sexuality and STIs.

Sexual and reproductive health promotion should be a component of early resettlement services for people from refugee backgrounds. Strategies need to take account of pre-migration and resettlement contexts, and cultural understandings of sexuality and gender relations, including the needs of LGB and trans and intersex people from CALD and refugee backgrounds.

Policy and programmatic responses need to be implemented to increase understanding and capacity for reproductive choice among young women with refugee backgrounds, and to provide support for teenage parents in order to facilitate successful settlement.

Older people

Although sexual and reproductive health remain intrinsic elements of health and wellbeing in older age, older Australians are often overlooked in sexual and reproductive health policies and research.[55] Many older adults remain sexually active, yet most educational campaigns designed to prevent sexually transmitted diseases target younger generations. Women may experience gynaecological problems throughout their reproductive years and beyond, and are at risk from symptoms associated with hormonal changes, heart disease and stroke, gynaecological malignancies, osteoporosis, and various genitourinary conditions.[56] Post-menopausal changes to the lining of the vagina may also increase susceptibility to STIs. There is evidence that STI prevalence is increasing among older Australian women, partly due to re-partnering after divorce or death of a spouse.[57] Most reproductive and sexual health

disorders are more common as men age, and many of these conditions are linked with chronic health conditions. Twenty-one percent of Australian men over 40 are affected by erectile dysfunction and, despite a proliferation of products and services in the media, important links to associated conditions such as chronic disease and diabetes are rarely made.

The AMA recommends that the sexual and reproductive health needs of midlife and older adults be recognised and supported in policy and programs, including targeted sexual and reproductive health education, health promotion and prevention strategies. These policies and programs should be underpinned by ongoing research and the provision of information and education to health and aged care service providers on strategies to promote the sexual health of older people, and to ensure services are inclusive of the full diversity of sexual orientations, gender identities, and sexual health needs.

Prisoners

Prisoners are a high-risk group in terms of their sexual health, exposure to STIs, and engagement in risky sexual behaviours.[58,59] Intersex, trans and gender diverse prisoners are frequent and visible targets for discrimination, violence, and sexual assault, and may be subject to daily refusals by correctional officers and other prisoners to recognise their gender identity.[60,61]

All prisoners and juvenile justice detainees should have access to comprehensive and confidential sexual and reproductive health services. This includes access to screening and treatment for STIs; vaccination for hepatitis B; prevention information, education and counselling for STIs and sexual assault; screening for cancers of the reproductive tract; access to hormone therapies and gender affirmation interventions for intersex and trans prisoners; and access to condoms and dental dams. Systems should be in place that support continuity of treatment when prisoners are transferred between prisons and released into the community, and comprehensive prison programs should be developed to respond to the social determinants of sexual and reproductive health.

Conjugal visitation programs should be supported by access to safe sex equipment and make provision for same-gender partners.

Policies and procedures should be in place to support the sexual and reproductive health of intersex and trans prisoners, including placement in the gender housing of their choice.

Women prisoners and adolescent juvenile detainees should have access to appropriate antenatal, obstetric and postnatal care.

5. Priority issues and areas for action

Primary prevention

Primary prevention aims to support and promote good health and eliminate or reduce the factors contributing to poor health. Opportunities to prevent many sexual and reproductive health problems before they occur are more likely to be effective when a range of coordinated and mutually reinforcing strategies are targeted across individual, community and societal levels. This involves redressing the wider social determinants underlying sexual and reproductive health, as well as implementing strategies that focus on behavioural risk and protective factors.

Supportive social environments and minimising risk factors

Identifying and minimising risk factors is fundamental to improving sexual and reproductive health. An exclusive focus on sexual behaviours, without consideration of the context in which these behaviours occur, is less likely to be successful.[4,62,63] Problematic alcohol and substance use, depression, domestic violence, and childhood and adult sexual violence and abuse are consistently associated with poorer sexual and reproductive health outcomes.[62] Insecure housing, unsupportive social relationships, limited literacy and low levels of

education are also common determinants. Cultural and social attitudes and expectations can also contribute to unhealthy or risky sexual behaviours, including sexualised media representations of girls and women, stigma associated with STIs, stereotypes about masculinity, and stigma surrounding the sexual needs or preferences of older people and people living with disabilities.[64,65]

Ongoing research and data collection should be undertaken to improve understanding of the behavioural and environmental risk factors contributing to poor sexual and reproductive health, and to develop interventions to minimise these risk factors.

To reduce the behavioural and environmental risk factors of sexual and reproductive ill health, there should be strengthened linkages between interdependent policies and strategies at local, state and national levels, including improved coordination between sexual and reproductive health strategies and policies targeting mental health, homelessness, drug and alcohol use, and domestic violence.

Health education and promotion

Health education and promotion are critical to securing better sexual and reproductive health outcomes. The AMA recommends that, in developing and implementing sexual and reproductive health promotion strategies and policies, attention be given to developing resources and approaches that are appropriate to people with limited literacy, culturally relevant to people from culturally diverse and Indigenous backgrounds, inclusive of GLB relationships and trans and intersex status, and accessible to other hard-to-reach populations. Information and resources should also be developed that are relevant to people across the lifespan. Publicly funded sexual health services should be supported in providing education and outreach to at-risk populations.

Sexual health promotion and education policies should support the promotion of sexual and reproductive wellbeing in all stages of life, from young people through to rapidly growing older age cohorts.

Sexual and reproductive health information and education should be evidence based and culturally appropriate. Health promotion programs should involve relevant stakeholders, settings and communication mediums. Core teaching competencies and minimum standards should be developed for sexual health education in schools; and key intermediaries should be engaged to support the provision of sexual and reproductive health information, including medical practitioners, community and population-specific organisations, and peer educators.

To be effective, information and promotion strategies should include tailored approaches for specific population groups, including Aboriginal, Torres Strait Islander and culturally and linguistically diverse populations, prisoners, people in rural and remote localities, sex workers, and LGB, trans and intersex people.

Parents should be supported in obtaining the skills and knowledge necessary to provide their children with clear, accurate and developmentally appropriate information on sexual health.

Vaccination

Vaccination is an important method of preventing certain STIs and associated comorbidities, including cervical and oral cancer, infertility, and anal cytological abnormalities.

Appropriate support and resources should be made available to promote the uptake of immunisation known to prevent STIs. This includes promoting HPV vaccination to all genders, and facilitating access to the hepatitis B vaccine for neonates and groups at elevated risk, including people in prisons, immigrants from endemic regions, men who have sex with men, injecting drug users, and Aboriginal people and Torres Strait Islanders.

Contraception

A range of safe and affordable methods of contraception should be accessible to people of all genders, and accompanied by appropriate information strategies. In addition to reliable, reversible long-term contraception, emergency hormonal contraception should be affordable and accessible through registered medical practitioners.

Restrictions on the access and availability of condoms, dental dams and water-based lubricants should be removed, including in correctional facilities and other detention settings.

Secondary prevention and treatment

Secondary prevention interrupts, prevents or minimises the progress of a disease at an early stage. Treatment and care services are important to support the health of those with sexual and reproductive health conditions and disorders, and to identify, treat or manage associated comorbidities. Such services should be accessible, affordable and inclusive to people of diverse social and cultural backgrounds and identities.

Early detection and intervention

Once diagnosed, most STIs can be treated and many can be cured. However, STIs such as chlamydia, gonorrhoea and trichomonas can be asymptomatic for long periods, increasing the potential for undiagnosed infection and complications. Complications may include infertility, pelvic inflammatory disease, cancers of the reproductive tract, and ectopic pregnancy.

It is imperative individuals living with an STI or a reproductive health condition are identified to institute treatment and reduce onward transmission. The majority of testing and treatment for STIs in Australia occurs in general practice, and STI control strategies should support general practitioners and other primary care providers in this role. Publicly funded sexual health clinics also play an essential role in improving access to high priority groups. Screening programs should be targeted at populations most at risk, and supported by systematic follow-up mechanisms and treatment. Medical practitioners should be aware of local epidemiology and at-risk groups to facilitate opportunistic screening.

Despite the importance of early detection, a significant proportion of at risk groups do not access sexual health screening. While clinically supervised contexts should be the primary and preferred setting for testing STIs, there have been rapid improvements in the quality of point-of-care tests and some self-administered testing kits, and the range and demand for such tests is expanding.[66,67,68,69] Evidence-based regulation of these new testing technologies is required, based on careful consideration of risks and benefits, and supported by quality assurance processes, ongoing monitoring of outcomes, and linkages to clinical care and support services.

The AMA affirms the value of both targeted and population-based screening programs for the early detection of STIs, and where there is a strong evidence base showing long-term reduction in the morbidity from the conditions concerned. The allocation of funding to screening programs should be informed by considerations around epidemiology, affordability, equity and access, the likely reach and size of impact, and the quality of the evidence base. The central role of general practice should be also recognised and prioritised in STI screening policies and programs.

Particular consideration should be given to improving the uptake of sexual health screening among populations that are underscreened or at heightened risk, or who face systemic barriers to accessing sexual health services. This may include opportunistic testing, targeted outreach and health promotion strategies, reducing financial barriers, incorporating sexual screening into existing health checks, and measures to support medical practitioners deliver screening in areas of identified need. Initiatives to introduce point-of-care testing and self-testing should be tightly regulated and include monitoring for quality control, clinical confirmation of test results and appropriate links to counselling, care, treatment and prevention services.

Treatment and management, including for chronic sexual/reproductive health conditions

Standard clinical pathways and referral options should be in place to assist clinicians and patients in treating and managing sexual and reproductive health conditions. Treatments for those diagnosed with chronic conditions, such as HIV, should be accessible and affordable. Specialist sexual health clinics should be supported in managing more complex clinical problems, supporting referrals between primary, secondary and tertiary services, and ensuring priority or hard-to-reach populations can access treatments.

Cervical cancer prevention and screening

The AMA supports effective interventions for the prevention, screening and treatment of cervical cancer, include routine vaccinations against the human papilloma virus (HPV) and a national program for cervical cancer screening. Additional measures should be adopted to improve screening rates among groups of trans men and gender diverse people with cervixes, and among women who experience heightened mortality rates associated with cervical cancer, including women from Aboriginal and Torres Strait Islander backgrounds. An evidence-based approach should be taken in reviewing the appropriate screening intervals, age at first screen, impact of HPV vaccination, and the role of new technologies in the national cervical screening program.

Family planning and maternal health

The health of mothers before conception, during pregnancy and in the postnatal period can have profound and long-term effects on their own health and that of their children. Access to antenatal and postnatal care is important but varies among different population groups. For example, compared with other women, access for Aboriginal and Torres Strait Island women or women living in remote and regional areas generally occurs later in pregnancy, and less frequently.

Unwanted pregnancies

Unwanted pregnancies can have significant health, social and financial costs. It has been estimated that almost a half of all unplanned pregnancies in Australia end in termination of the pregnancy.

The AMA supports measures to reduce unwanted pregnancies, including enhancing access to affordable and effective contraception; promotion of respectful, equitable, non-violent relationships; and reducing binge-drinking among young people.

Access to antenatal and postnatal care

Communities should have access to family planning and maternity services which meet the needs of the local population. These services should be appropriate, acceptable and accessible to pregnant people and their families, including those from disadvantaged or minority groups.

Pregnant people of all genders should be offered information on the full range of options available to them throughout pregnancy, birth and the postnatal period. This should include information about the risks and benefits of different options, the models of care available locally, screening tests, and recommendations for birth and postnatal care.

To reduce disparities in child and maternal outcomes, health information and promotion should be targeted towards women in groups and communities who under-use maternity services, or who are at greater risk of poor outcomes. Services should be proactive in engaging all women early in their pregnancy and maintaining contact before and after birth. Identified maternal risk factors for stillbirth, such as obesity, advanced age, social deprivation, smoking, primiparity, pre-existing diabetes, and hypertension, should also provide a foundation for targeted intervention strategies.

Fertility, sub-fertility, and infertility

Infertility is defined as the inability to conceive a pregnancy after twelve months of unprotected sexual intercourse. Infertility can affect people of any gender, and may arise from genetic abnormalities, infectious or environmental agents, delayed childbearing, lifestyle-related behaviours, and certain health problems, including endometriosis and STIs such as chlamydia.

The AMA acknowledges the value and place of established ethical techniques in reproductive technology in the management of infertility.

Ongoing education should be undertaken to heighten awareness regarding preventable risk factors for infertility, including the implications of delayed childbearing, and to support screening and treatment for STIs that can contribute to infertility.

Information and educational approaches should be developed and implemented in conjunction with the identification of gaps in diagnosis and treatment guidelines, and ongoing surveillance and research to support prevention and management strategies.

Domestic and sexual violence and sexual abuse

Exposure to domestic violence and/or sexual violence or abuse are strong predictors of poor sexual and reproductive health, along with a range of other adverse physical and mental health outcomes. Domestic violence is associated with poor functional health, somatic disorders, chronic disorders and chronic pain, gynaecological problems, and increased risk of STIs.[70,71]

The medical profession has a key role to play in the early detection, intervention and provision of specialised treatment of those who suffer the consequences of domestic and sexual violence and sexual abuse.

The role and extent of domestic and sexual violence, as determinants of medical and psychiatric morbidity, should be included in undergraduate curricula and postgraduate training programs. Continuing education of the profession is essential to emphasise the extent of such violence; the mental and physical consequences for the victims; and the important role of primary health care providers - especially general practitioners, emergency department personnel, midwives, and obstetricians and gynaecologists - in the early detection of victims of domestic and sexual violence.

Strengthening primary, secondary and tertiary prevention of domestic and sexual violence and sexual abuse is an essential component in improving sexual and reproductive health, and improving overall health outcomes. Interventions should be undertaken at a number of levels, including school-based education around respectful relationships, the development of appropriate referral pathways between primary care settings and support services, interventions targeting perpetrators of violence and abuse, and strategies that engage people of all genders.

Improving access to support services for those who have experienced domestic violence or sexual violence and abuse is critical, particularly in rural and regional areas. Primary health care providers should be supported in providing appropriate assessment, interventions, and referrals.

Body image, cosmetic modifications and sexuality

Body image can have a profound impact on people's ability to enjoy a satisfying and positive sexual life.[72,73,74,75] Body dissatisfaction has been associated with poorer levels of sexual functioning, including impaired sexual desire, enjoyment and performance. Behaviours arising from body dissatisfaction can also impact on other aspects of reproductive health. For example, fertility problems among men can result from the use of anabolic steroids, which may be taken for the purposes of achieving an idealised muscular male physique.[76,77] There is also evidence that women with poor body image are less confident in negotiating safe or pleasurable sex, and are more likely to engage in risky sexual behaviours.[72] For young people, poor body image has been associated with depression, impaired sexual development

in adolescence, and poor self-protective behaviours in adolescent relationships.[78,79] Perceptions of body image and ageing can also have significant implications for sexuality and sexual activity and satisfaction for older people of all genders.[80,81,82]

Genital cosmetic surgery

Over the past decade, there has been a dramatic increase in the number of men and women undertaking genital cosmetic surgery, both in Australia and worldwide.[83,84] These surgical procedures are marketed as ways to enhance sexual attractiveness and/or gratification. The growth in demand for such procedures has also been linked to idealised and highly selective images of male and, in particular, female genital anatomy that have proliferated through online pornography.

The AMA recognises that there are a range of health conditions that may merit surgery. These include genital prolapse, reconstructive surgery for female genital mutilation, labiaplasties with clinical indications, and trauma and excision of tumours. Gender affirmation surgery is a medical, not a cosmetic procedure, that is necessary and beneficial for intersex, trans and gender diverse people who seek such intervention.

There is a lack of data supporting the benefits of genital surgery undertaken for cosmetic reasons, and a range of potential complications and adverse outcomes have been associated with these procedures. The demand for genital cosmetic surgery is driven in part by a narrow understanding of normality that fails to recognise the diverse and healthy range of natural genitals.

Genital surgery for cosmetic purposes should not be undertaken on children or adolescents under 18 years of age.

The AMA opposes the advertising or promotion of genital cosmetic surgery services, including the promotion of surgical products and techniques that make unproven claims of enhancing female or male sexual satisfaction and/or attractiveness.

Clinicians who receive requests from patients for genital surgery procedures should discuss with the patient the reason for his or her request, and perform an evaluation for any physical signs or symptoms that may indicate the need for surgical intervention. Patients should be informed about the lack of data supporting the efficacy of these procedures and their potential complications, including infection, altered sensation, dyspareunia, adhesions, and scarring.

Normalising cosmetic genital surgery on intersex infants should be avoided until a child can fully participate in decision making.

The AMA supports education regarding the wide diversity of the appearance of human genitalia. The AMA opposes media and marketing representations that depict the appearance of normal adult genitalia as abnormal, or that promote the sexual desirability of a prepubescent appearance of female genitalia.

Sexualisation of children in contemporary media

The sexualisation of children refers to the imposition of adult models of sexual behaviour and sexuality onto children and adolescents at developmentally inappropriate stages. It encompasses the sexualisation of children themselves in the media, as well as the exposure of children to sexualised images, irrespective of whether these include children or not.

There is a growing body of evidence that premature exposure to sexualised images and adult sexual content has a negative impact on the psychological development of children, particularly on self esteem, body image and understandings of sexuality and relationships.[64] Exposure to sexualised imagery has been fuelled by the proliferation of online pornography and sexualised representations of children in advertising, in addition to the circulation of sexualised content through social media.[85]

The AMA supports interventions to prevent the further proliferation of sexualised images of children. This includes media and advertising regulations, and schools-based media literacy programs to provide children and adolescents with skills in media analysis and understanding of the impact of sexualised images, advertising and social media content.

Workforce and infrastructure development

A health system that supports sexual and reproductive health comprises a mix of general, specialised and community-based health services. General practice is central within this mix, and effective referral pathways and linkages should be in place between GPs, other primary care providers, sexual health services, and secondary health services. Publicly funded sexual health clinics have an essential role in improving access to high priority groups, managing more complex clinical problems, and providing expertise on STI prevention, detection, treatment and care. In addition to clinical care, many specialist services provide continuing professional development, clinical advice and support to GPs and other primary care providers, population health advice, and contact tracing.

Education and training

Medical practitioners and other primary care providers should be provided with opportunities to improve their skills in the prevention, management, and treatment of sexual and reproductive health conditions.

Expanding workforce capacity

Maintaining and expanding the current workforce capacity requires investment in comprehensive sexual and reproductive health services, and ensuring primary care providers have appropriate infrastructural support, time and adequate remuneration to provide quality care and support to their patients

Underserviced populations and regions should be identified, and strategies developed to address workforce shortages and reduce inequities in access. This includes increasing the sexual and reproductive health workforce in rural and remote regions, and addressing accessibility gaps for Aboriginal peoples and Torres Strait Islander peoples and for people from culturally and linguistically diverse backgrounds. Consideration of sexual and reproductive health needs and services should be incorporated into local health networks and population health plans.

Research and surveillance

Dedicated funding for sexual and reproductive health research is vital to provide a sound evidence base for practice, policy and service delivery. Surveillance is a critical aspect of disease prevention. Without knowledge of trends in rates of infection among different groups, policymakers have no way of knowing what are the important risk and protective factors, what issues are particularly relevant for specific groups, where services are required, and which prevention or intervention measures are most effective.

The AMA supports a funded collaborative mechanism to link current research activity, identify research priorities, optimise research outcomes, and assist in the translation of research and evidence into policy and practice.

Australia requires a comprehensive and coordinated national data collection system for sexual and reproductive health. Data collection, monitoring and reporting should be timely and reliable, and effectively and efficiently disseminated. Data collected in different jurisdictions should feed into national reporting against agreed benchmarks, with the outcomes used as a basis for evaluating policies and programs, identifying gaps in service delivery, prioritising areas of need, and allocating resources. In addition to tracking trends in health status and morbidity, information should be available on behavioural risk factors, health service usage, the social determinants of sexual and reproductive health, and outcomes for different population groups. Where possible, data and

monitoring systems should be enhanced by identifying gaps, improving linkage of existing data sets, and expanding sentinel surveillance programs.

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