Women's Health East
Investing in Equality and Wellbeing for Women

A STRATEGY FOR EQUALITY:

Women's Sexual and Reproductive Health in Melbourne's East 2020 – 2025

BACKGROUND PAPER

Acknowledgement of Country

Women's Health East acknowledges the Traditional Owners of the land on which we work, the Wurundjeri people of the Kulin Nations. We pay our respects to their Elders past and present.

Acknowledgements

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Women's Health East's *A Strategy for Equality: Women's Sexual and Reproductive Health in Melbourne's East 2020 – 2025* was developed in consultation with a range of stakeholders including the Eastern Metropolitan Region Sexual and Reproductive Health Strategic Reference Group, which comprises representatives from local government, community health organisations and other service providers committed to improving the health and wellbeing of women in the region. The Strategic Reference Group is responsible for overseeing the implementation of the Strategy.

Women's Health East would like to thank the Strategic Reference Group members and other stakeholders for their valuable contributions to the development of the Strategy:

- Access Health and Community
- Boroondara City Council
- 360 Boroondara Youth Resource Centre
- Boroondara Maternal and Child Health
- Deakin University
- EACH
- Eastern Health
- Eastern Melbourne Primary Health Network
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- Headspace Knox
- Hepatitis Victoria
- Jean Hailes for Women's Health
- Knox City Council
- Manningham City Council
- Marie Stopes Australia
- Maroondah City Council
- Monash City Council
- Multicultural Centre for Women's Health
- Primary Care Partnerships Inner East
- The Royal Women's Hospital
- Whitehorse City Council
- Yarra Ranges Shire Council

About Women's Health East:

Women's Health East is the women's health promotion agency for the Eastern Metropolitan Region of Melbourne. We aim to improve health outcomes for women across the seven local government areas of Boroondara, Knox, Maroondah, Manningham, Monash, Whitehorse and the Yarra Ranges. Women's Health East also influences women's health and wellbeing at a state and national level.

Our vision is equality, empowerment, health and wellbeing for all women.

Women's Health East works across three, interlinked strategic priorities: Advance Gender Equality, Prevent Violence against Women, and Improve Women's Sexual and Reproductive Health.

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An important note:

Our understanding of the relationship between sex and gender is constantly evolving, as is the impact of sex and gender on sexual and reproductive health outcomes. Women's Health East works within an intersectional feminist framework and acknowledges the diverse sexual and reproductive health needs of people who do not identify as cisgender, including transgender people, gender diverse, non-binary and gender non-conforming people, transfeminine and transmasculine people and intersex people. Unless otherwise stated, where this Background Paper and accompanying Strategy uses the terminology women, it aims to be inclusive of cisgender women, LGBTIQ women and people who identify as women. This Background Paper and Strategy also refer to people with a uterus in acknowledgement of the fact that some sexual and reproductive health issues may affect people who have female reproductive organs but do not identify as women. Although the Strategy may not explicitly focus on all these groups, we support the provision of more accessible, inclusive, community-centred and rights-based sexual and reproductive health services for all.

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About this Background Paper

Women's Health East (WHE) is an established leader in women's sexual and reproductive health promotion in the Eastern Metropolitan Region (EMR). In 2016, WHE undertook a needs analysis to identify sexual and reproductive priorities in the region and convened a Strategic Reference Group (SRG) to operationalise the Needs Analysis and promote coordinated sexual and reproductive health work in the EMR. To strengthen established partnerships and to influence and align with the current municipal planning cycle, Women's Health East commenced development of a background paper to inform the regional women's sexual and reproductive health strategy, with the support of the SRG.

The initial consultation process helped define the scope of the Background Paper and presented the opportunity to identify and engage with other key regional and state-wide stakeholders, and to invite them to join the SRG. This included local government, community health organisations, health promotion agencies and other service providers, both regional and state-wide.

The consultation process involved individual consultations, feedback through regular SRG meetings and a survey of SRG members and other stakeholders in the region using the online platform Survey Monkey to establish sexual and reproductive health gaps and opportunities. For the results of the survey, see Appendix 1. The development of the Background Paper also included utilisation of regional sexual and reproductive health data, mainly sourced from Women's Health Atlas and presented in Appendix 2, and an appraisal of existing peer-reviewed literature. Though there is limited regional, gender-disaggregated sexual and reproductive health data available, the information captured in the Background Paper to inform the strategy is robust.

Each iteration of the Background Paper and the final Strategy were circulated to stakeholders before inviting them to issue a statement of support for the Strategy's priorities and objectives. Additionally, organisations representing the LGBTIQ communities and Aboriginal and Torres Strait Islander women were consulted separately to ensure the Strategy was culturally appropriate and fit for purpose. We circulated the final draft to the Department of Health and Human Services, to ensure they were familiar with regional developments in sexual and reproductive health led by WHE.

The priorities and objectives identified in the Strategy and this Background Paper are designed to align with those articulated by the Victorian government in *Women's sexual and reproductive health: key priorities 2017–2020*. The Victorian government has identified a need to increase women's knowledge of all forms of contraception and access to long-acting contraception in primary care, increase general practitioners' awareness about contemporary contraception and ability to provide it to women, increase awareness of and access to medical termination in primary care, and improve access to surgical termination, especially for women in regional and rural Victoria.[1]

About the Eastern Metropolitan Region: Select characteristics

The Eastern Metropolitan Region of Melbourne (EMR) is an area covering seven local government areas (LGAs) consisting of Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and the Yarra Ranges. The region is predominantly urban but includes rural areas. In the Yarra Ranges, one of Victoria's largest municipalities, about 30% of residents live outside of urban areas.[2] There is also considerable variation in the socio-economic and cultural composition of the LGAs, all of which have implications for service access. The EMR is rich with cultural diversity and while it is considered to be a region of relative socioeconomic advantage, it also contains pockets of disadvantage.[3, 4]

The Eastern Metropolitan Region has below average population growth, compared to metropolitan Melbourne and the state of Victoria generally.[3, 4] While the proportion of the population above the age of 65 years in the region is higher than that in metropolitan Melbourne and the state of Victoria generally, the majority of people in the LGAs are aged between 15 and 64 years of age.[3]

As with most regions across Victoria, Australia is the most common place of birth for the majority of residents in the EMR, however.[12-13] some LGAs have a substantial proportion of people born overseas.[3] Monash, Manningham and Whitehorse have a higher proportion of people born in North East Asia and South East Asia, relative to metropolitan Melbourne and Victoria generally.[3] Knox, Maroondah and parts of the Yarra Ranges have a higher proportion of people born in North-West Europe, relative to metropolitan Melbourne and Victoria generally.[3] Notably, a significant number of Aboriginal and Torres Strait Islander people live in the Yarra Ranges compared to the other local government areas within the EMR.[3]

EMR sexual and reproductive healthprofile: A snapshot

The diversity of ages, cultural and ethnic backgrounds and socioeconomic status within the EMR has important implications for sexual and reproductive health (SRH) literacy, access to services and thus, SRH outcomes. The EMR has a relatively high prevalence of Hepatitis B, compared to the Victorian average. This data is presented in Appendix 2. Similarly, the proportion of older people in the region may contribute to relatively low rates of some sexually transmissible infections and relatively low birth rate. While prevalence of sexually transmitted infections (STIs) and some blood borne viruses (BBVs) in the region is lower than the state average, there are nonetheless opportunities to substantially improve SRH outcomes across the region, based on data from 2018 and published in Appendix 2.

For example, while chlamydia is higher among men than women in Victoria generally, it is higher among women in all LGAs in the Eastern Metropolitan Region except Boroondara. Chlamydia is highest in Boroondara (670 recorded cases) and lowest in Manningham (312 recorded cases). Similarly, gonorrhea is highest in Boroondara (207 recorded cases) and lowest in Manningham (77 recorded cases). HIV is highest in Whitehorse (12 recorded cases) and lowest in Knox and Manningham (5 recorded cases each). Hepatitis B is highest in Monash (108 recorded cases) and lowest in the Yarra Ranges (12 recorded cases).

In addition to addressing disease prevalence through access to testing and treatment, SRH efforts in the region should focus on ensuring access to reproductive healthcare. The teenage birth rate is highest in the Yarra Ranges (7.10 live births per 1,000 teenaged women), and lowest in Boroondara (0.31 live births per 1,000 teenaged women). Total births were highest in Monash (1936 live births in total) and lowest in Manningham (1130 live births in total). Cervical screening participation is highest in Boroondara (65% of women) and lowest in Monash (55.3%). Contraceptive implant use is highest in Yarra Ranges (661 implants) and lowest in Manningham (330 implants). Intrauterine device uptake is highest in Boroondara (490 devices) and lowest in Maroondah (226 devices). This data is available in Appendix 2 of the Strategy.

"...much of the inequity in sexual and reproductive health arises from the societal conditions in which people are born, grow, live, work and age, and the wider set of forces and systems shaping the conditions of daily life, such as political systems, economic policies and systems, development agendas, social norms, gender inequalities, and social and environmental policies. Additionally, the manner in which health education, information and services are delivered plays a pivotal role."[5]

World Health Organization Regional Office for Europe. Action Plan for Sexual and Reproductive Health: Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Denmark: World Health Organization; 2016.

Evidence for Action: Key Themes

Women's sexual and reproductive health (SRH) is influenced by a complex interplay of micro- and macro-level factors. What follows is an overview of how gender inequality impact on women's physical and mental health resulting in poor SRH outcomes. Available data and literature and extensive consultation with stakeholders reinforces the need for a social determinants approach to advancing **equity** that builds the health system's **capability** to understand and respond to women's SRH needs to improve women's **access** to safe, appropriate, affordable, timely and inclusive care. The consultation and research also identified priority populations, whose SRH outcomes and access to services are mediated by distinct experiences of discrimination and stigma that compounds experiences of gender inequality.

Gender is a determinant of sexual and reproductive health (SRH)

Gender **equity** is central to SRH, however persistent structural and social gender inequalities continue to impact outcomes. Structural gender inequality, such as income and wealth inequality, reinforces and reflects an unequal distribution of power and resources between women and men that limits women's capacity to exercise their SRH, rights and bodily autonomy. Gendered socialisation, or the process by which individuals are informed about the norms and behaviours associated with their assigned sex, is shaped by a binary understanding of sex and gender. It occurs from birth and is entrenched by the time children reach puberty, when adolescents are also developing knowledge and attitudes towards sex and sexuality. Socialisation based on gender extends to both public and private spheres, including expressions of sexuality which often conforms to a "sexual script" that performs traditional gendered scenarios, such as a man initiating sex.[6-11] This means that while adolescent boys and men are expected and encouraged to be sexually aggressive, domineering and hypersexual, adolescent girls and women are not viewed as sexual agents, but rather sexual objects.[6, 7] Additionally, women are expected to delay sexual activity until an emotional connection has been established, while for men sex can be purely physical gratification or pleasure. [6, 7] Rigid gender roles that position women as submissive in heterosexual romantic or sexual relationships result in women's lesser autonomy and power to negotiate aspects of the sexual exchange, including contraceptive use.[6, 9] Patriarchal gender norms and unequal power relations between women and men may function as barriers to contraceptive use by supporting pro-natal attitudes and control over women by men, limiting women's decision-making power and inhibiting their access to resources, information and services.[9] Furthermore, these gender norms and power relations between women and men negatively impact sexual satisfaction, intimacy and relationship satisfaction for both sexes.[10, 11]

One of the major structural factors underpinning gender inequality is socioeconomic status. In addition to gender, it is one of the major determinants of SRH outcomes.[12, 13] It influences an individual's access to healthcare, their environmental exposure to risk and protective factors and their health behaviours.[14, 15] According to the Australian government, the full-time gender pay gap is 13.9% or an average of $242.90 less per week for women than men.[16] While Australia has a public healthcare

system, some costs for contraception, abortion, sexual health screenings and treatment for SRH conditions are borne by the user. This puts an additional burden on women, who already experience financial disadvantage compared to men. Women from lower socioeconomic backgrounds are particularly disadvantaged. Studies have shown, for example, that low socioeconomic status is a risk factor for unintended pregnancy and STI diagnosis.[17-20] In addition to the immediate financial disadvantage created by user-pays healthcare and income inequality, the gender pay gap reinforces power imbalances in interpersonal relations, thus limiting women's sexual rights and autonomy.[21]

Gender inequality drives sexual violence against women and reproductive coercion

Violence against women is a pervasive and prevalent social issue with direct implications for women's physical, mental and sexual and reproductive health (SRH). *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*, the first national framework for the primary prevention of violence against women, describes how gender inequality sets the necessary social context for violence against women to occur and is therefore the primary driver of violence against women. One in three Australian women (34.2%) has experienced physical and/or sexual violence perpetrated by a man and one in four Australian women (23.0%) has experienced physical, sexual or emotional abuse from a current or former partner.[22, 23] The prevalence of reported violence against women in the EMR is lower on average than in Victoria, however in some local government areas it is on par or higher: Knox, Maroondah and the Yarra Ranges have average or greater than average rates of violence against women compared to Victoria.[24] Similarly, incidents of reported sexual violence in the EMR are generally on par or lower than the Victorian average with the exceptions of Yarra Ranges and Maroondah.[24] Despite the prevalence of sexual violence and the significant impact of violence against women on SRH, the majority of policies and frameworks to address violence against women do not acknowledge the complex and dialectical relationship between physical, emotional and sexual abuse and women's SRH.

Some women are more likely to experience violence, such as Aboriginal and Torres Strait Islander women, women from LGBTIQ communities and women with disabilities. Aboriginal and Torres Strait Islander women were three times as likely to experience sexual violence than non-Aboriginal women in Australia in 2017.[25] Sexual violence against women with disabilities is also widespread. An estimated 70% of women with disabilities experience sexual violence and 90% of women with cognitive disabilities experience sexual violence, many before adulthood. Though longitudinal data on prevalence of violence towards women from migrant and refugee backgrounds or within the LGBTIQ community is limited, existing research suggests that it is at least equal to that in the wider community.[23]

Violence against women can also occur in the form of reproductive coercion: behaviour that interferes with the autonomy of a person to make decisions about their reproductive health. (198) Reproductive coercion includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making and can take a variety of forms, including sabotaging contraception, controlling pregnancy outcomes, and sterilisation. Women with disabilities disproportionately experience forced, involuntary or coerced sterilisation. While the prevalence of sterilisation procedures on women and girls with disabilities in Australia is not known, bodies such as the Australian Human Rights Commission and United Nations Committee on the Rights of the Child are concerned that forced, involuntary or coerced sterilisation is ongoing, and may be increasing.[26]

Sexual violence against women is associated with poorer SRH outcomes, such as increased risk of unintended pregnancy, inconsistent contraceptive use, reduced sexual autonomy, pain during sex, genital and reproductive tract infections, difficulty achieving arousal and higher rates of sexually transmissible infections.[27-37] Survivors of violence also tend to experience poorer maternal and child health outcomes in pre- and post-partum periods, such as increased risk of low birth weight infants,

pre-term delivery and neonatal death and difficulty breastfeeding.[33] Violence against women also has implications for health-seeking behaviours and **access** to SRH care. Research indicates, for instance, that women experiencing violence find it more difficult to negotiate contraception use with their partners and have less autonomy to make decisions about their own contraception use.[30] Women experiencing violence may also have reduced financial independence, thus limiting their ability to utilise services and obtain contraception and abortion.[30] Women with experiences of sexual violence or reproductive coercion are also more likely to experience mental health issues, which in turn impacts SRH outcomes.[31, 38, 39] Women with chronic mental health disorders are less likely to consistently use contraception, more likely to experience an unplanned and unwanted pregnancy, increased risk of obstetric complications and adverse psychiatric events during pregnancy, low birth weight or preterm birth.[40] Additionally, women with mental illness are more likely than their peers to receive inadequate antenatal care.[40] SRH outcomes can have profound significance for mental health rehabilitation, relationships, and individual agency.[40]

Gender inequality is compounded by other forms of discrimination

SRH outcomes for some women are also structurally and socially determined by other forms of discrimination that compound experiences of gender inequality, such as racism, ableism, ageism, homophobia, biphobia and transphobia. Structural discrimination and discriminatory social attitudes and norms also limit access to healthcare. While gender inequality and other forms of discrimination are complex social determinants of health that impact women's SRH in a myriad of ways, they are also modifiable through determined political, economic and social intervention, including advocacy to promote gender **equality**, sector and workforce development to build **capability** and inclusive service or program design and delivery to enhance **access**.

Racism is a key social determinant of health and significantly compounds gender inequality. For example, the ongoing impacts of colonisation include institutional racism and discrimination, dispossession, the removal of Aboriginal children from their families and intergenerational trauma which compound economic and gender inequality to limit Aboriginal women's access to housing, education and employment opportunities.[41-44] These conditions combined with a lack of culturally safe health and social services profoundly shape low health literacy and health promoting behaviours, and low engagement with mainstream health services. One of the most critical factors for improving Aboriginal women's SRH is **access** to culturally appropriate, accessible and affordable healthcare services, by building the **capability** of healthcare systems, services and providers to deliver SRH care for Aboriginal women.

Institutional racism also restricts access to SRH care for women from culturally and linguistically diverse backgrounds. At an organisational level, this is the result of a lack of culturally safe and relevant services, including the limited use of interpreters and culturally relevant and multilingual health information.[45] At a public policy level, this manifests through the prevention of women from refugee backgrounds, international students and women on temporary visas, from accessing Medicare. While they may access subsidised healthcare through other mechanisms, there are still social and structural barriers to accessing affordable healthcare for women who are not legal citizens or permanent residents. Some women, such as international students, are required to take out private health insurance as a condition of their residency in Australia but are not able to make pregnancy-related claims within the first twelve months of their arrival.[46] Given the central importance of **access** to healthcare on SRH outcomes, this puts migrant women at a significant disadvantage.

Ableism, or discrimination towards people with disabilities also compounds gender inequality and impacts SRH. According to Family Planning NSW, the factors that limit the ability of women with disabilities to participate fully in society also limit their ability to exercise their SRH rights.[47] These include negative gendered attitudes and stereotypes about women with disabilities, specifically expectations of asexuality; limited or inaccessible services and inadequate funding for

specialised services; lack of consultation and involvement of people with disabilities in planning and implementation of services that will impact them; limited data and research on the needs of women with disabilities; entrenched poverty and inadequate policies to address these structural factors.[47] Women with disabilities can have fulfilling and pleasurable sex lives but may require tailored relationships and sexuality education or **access** to specialist healthcare to address any sexual issues that may be associated with or impacted by their disability, such as chronic pain.

Ageism, towards both young and older women, compounds gender inequality and shapes poorer SRH outcomes in distinct ways.[48-50] Rigid social norms regarding women's sexuality that endorse abstinence or sexual "purity" for young women while objectifying and sexualizing them and treat older women as asexual, stigmatise their sexuality and SRH, thus limiting their ability to **access** healthcare. Women's sexual and reproductive needs change in accordance with age. Evidence suggests that young women may have an unmet need for contraception, for example. Women aged 24 years and younger account for 43% of abortions, which may indicate that, among other factors, some young women do not have adequate **access** to contraception or are not using it effectively.[51, 52] Many young women are reliant on less effective contraceptive methods such as condoms and contraceptive pills rather than long acting reversible contraception, which could be due to limited SRH literacy, or limited relationships with healthcare services. The evidence shows that factors such as cost, inexperience navigating the public healthcare system or using contraception, and lack of trust that their confidentiality and privacy will be upheld all impact on young women's ability to explore contraceptive options with clinicians.[53, 54] These factors are related to expectations of young women's abstinence or sexual ambivalence.

Older women have a right to fulfilling, pleasurable and consensual sex lives, and sexual health is an important component of health ageing.[55] However, the compounding impact of gender inequality and ageism contributes to assumptions of asexuality in older women, in similar ways that women with disabilities' sexual feelings and desires are often dismissed or disregarded. Ageism also contributes to social isolation, exclusion and reduced access to services for older women, as outlined in WHE's report, *The Unheard Story: The impact of gender on social inclusion for older women*.[56] Older women's SRH is broadly linked to a range of factors including physiological, hormonal and emotional changes associated with menopause or ageing.[57-59] Despite this, women generally continue to regard their sexuality and its expression as important to their sense of self, health and wellbeing.[60-61] It is acknowledged that sexual activity provides physical and emotional benefits such as improved cardiovascular health and decreased pain sensitivity, increased psychosocial well-being, and improved self-esteem and overall quality of life.[55]

Homophobia, biphobia, transphobia and heterosexism compound gender inequality for women from LGBTIQ communities. These experiences of stigma, discrimination and prejudice limit **access** to healthcare and result in a disproportionate burden of disease and ill-health.[62, 63] LGBTIQ women and people with a uterus are also more likely than heterosexual women to be dissatisfied with their experience at a SRH service.[64] WHE's publication *Young and Queer in Melbourne's East: Exploring LGBTIQ young women's access to Sexual and Reproductive Health services* is an important contribution to understanding the barriers and enablers to accessing services for young LGBTIQ women.[64] This research identified that service providers' assumptions about sexual or gender identity and sexual behaviour, and incorrect use of pronouns discouraged further disclosure from patients and acted as a barrier to appropriate SRH care. This is consistent with other studies that show that some LGBTIQ women experience barriers to SRH care, resulting in poorer SRH outcomes and SRH literacy.[62, 65] For example, evidence demonstrates that prevalence of STIs among lesbian women is similar to that of heterosexual women, and possibly higher among bisexual women.[66] Additionally, women from LGBTIQ communities are more likely to experience an unplanned pregnancy or urinary tract infection, and less likely to have a cervical screening or use a condom during penetrative sex than their heterosexual peers.[67] Transgender and gender diverse people are also more likely to report

inconsistent condom use, experiences of sexual violence or coercion and negative experiences in accessing SRH care and services. Trans men and gender diverse people with an intact cervix also need **access** to cervical screenings, but emerging international evidence suggests that previous negative experiences in healthcare settings deters uptake.[68] Improving LGBTIQ women's SRH also requires enhanced **capability** in the delivery of inclusive relationships and sexuality education and SRH care.

Women experience disproportionate burden of poor SRH outcomes, and experience gendered SRH stigma and discrimination

In addition to discrimination that compounds gender inequality as expounded above, women often experience stigma and discrimination related to their SRH that is gendered in nature. Women have the right to make decisions about their bodies and their health free from judgement, but stigma resulting in shame, guilt and fear is often a major barrier for accessing services such as contraception and abortion. Abortion challenges two fundamental ideas of womanhood: nurturing motherhood and sexual purity.[69] Utilising contraception and terminating a pregnancy violates gender norms that reinforce the idea that women's 'natural' purpose is to procreate.[69] They continue to be regarded as contentious issues rather than essential services, which can result in its provision, consciously or unconsciously, not being prioritised. This becomes particularly evident during times of crisis such as the onset of the COVID-19 pandemic.

Access to a variety of affordable contraceptive options is critical for women's SRH. A large-scale study highlighted that many Australian women are frustrated by the lack of practitioner knowledge about contraception other than the pill, including long-acting reversible options.[70, 71] Long acting reversible contraceptive options, such as intrauterine devices, contraceptive implants and injections, are the most effective forms of birth control, however uptake in Australia and in Victoria is low.[72] Many women reported that prescribers do not discuss potential side-effects of contraceptives with them.[70, 71] This is concerning in light of the impact of adverse side-effects on contraceptive adherence and on women's physical and mental health. Some women perceived their doctor to be unsupportive or judgmental in discussing contraception.[70] The results of a survey of general practitioners conducted by Gippsland Women's Health identified that many doctors lack the necessary knowledge, training and therefore **capability** to provide medical abortions or discuss telehealth options for medical abortions.[73] This has a direct impact on the quality of care available to patients and has significant implications for women living in semi-rural and rural areas such as parts of the Yarra Ranges.

Abortion is a safe and essential medical procedure that requires timely access dependant on effective referral pathways and the availability of individual providers and services to meet demand. Although abortion is legal in Victoria, **access** to medical and surgical abortion continue to be negated by cost, proximity and availability of services, and conscientious objection.[74, 75] Doctors may refuse to provide abortion services if they have a moral or religious objection to doing so.
As Keogh et al argue, this puts women at a disadvantage:

> "In most fields of medicine a doctor may not refuse to help a patient access a service which is legally permitted, efficient, and beneficial to the care of a patient simply because it conflicts with their values. For example, a surgeon who has a religious objection to blood transfusion cannot use that as grounds for denying a patient access to a major surgical procedure that may require transfusion."[74]

In addition to making women feel stigmatised for accessing essential health services, societal norms and attitudes regarding abortion marginalise doctors, nurses and pharmacists who do provide SRH services, as many report feeling stigmatised by their colleagues and society.[76]

Stigma associated with sexually transmitted infections (STIs) and blood-borne viruses (BBVs), while universal, is highly gendered due to assumptions that STIs and BBVs are transmitted through risky or unprotected sex with multiple partners, which is less socially acceptable in women than in men. Gendered stigma regarding SRH issues is a major barrier to the prevention, diagnosis and treatment of related health issues in women. Although STIs and BBVs are key SRH issues that are generally well understood by primary providers, the gendered nature of STI and BBV transmission, and its relationship to sexual violence against women, is less widely understood. Though the prevalence of STIs and BBVs in the EMR and Victoria generally is relatively low, the impact on those affected is significant. Women are disproportionately impacted by STIs and BBVs and experience a disproportionate burden of disease, despite the fact that STIs and BBVs in the EMR overall and Victoria are generally more prevalent among men than women. Some STIs are asymptomatic in women. In both chlamydia and gonorrhoea, up to 80% of cases in women are asymptomatic, however only 50% of gonorrhoea cases are asymptomatic in men.[77] Though easily treated by antibiotics, untreated chlamydia and gonorrhoea can cause pelvic inflammation and infertility in women. Women also uniquely experience the burden of vertical transmission of STIs and BBVs (i.e. from mother to child), which is stigmatised.[77] People born in countries with a high prevalence of BBVs, such as viral hepatitis or HIV, and Aboriginal women are disproportionately impacted by BBVs and STIs.[78-80]

Research indicates that limited **access** to healthcare services combined with relatively limited SRH literacy and the stress and isolation associated with acculturation increases the risk of unplanned pregnancy, particularly for international students.[46] Use of contraception, and consultations with clinicians to discuss or obtain contraception are significantly lower among women born overseas, resulting in a higher birth rate.[45] Maternal and child health outcomes and access to maternal health services are also generally poorer among women born overseas. Stillbirths, preeclampsia, low birth rates, delayed antenatal care, postnatal depression and dissatisfaction with antenatal and postnatal care are all higher among women born overseas.[45] Viral hepatitis and Female Genital Mutilation/ Cutting (FGM/C) may also be significant SRH issues for women from culturally and linguistically diverse backgrounds.

Women's SRH issues are often dismissed, rendering them invisible

Gender inequality contributes to the invisibility of women's SRH issues, specifically menopause, endometriosis, polycystic ovary syndrome (PCOS), which can lead to infertility. Despite the significant individual- and population-level impact of these health issues, there are structural barriers to providing and accessing appropriate care at both an organisational and societal level. For example, the reasons for delays in diagnosis and treatment are complex, and include both reliance on inadequate diagnostic methods, and normalisation of patient symptoms that reflect broader societal attitudes, the invisibility of women's reproductive health issues and stigma around SRH issues. Evidence demonstrates that while women are more likely to experience chronic pain, they are less likely to receive a diagnosis or treatment due to societal normalisation of women's pain, particularly when associated with women's SRH issues such as menstruation and menopause. Seminal studies have found a significant gender bias in the identification and treatment of chronic pain, to the detriment of female patients.[81-83] The invisibility of these health issues, the dismissal of women's pain and discomfort, and the lack of treatment or guidelines contributes to the marginalisation of women in the workplace and social settings. The invisibility of other women's health issues also contributes to their SRH outcomes. For instance, women's mental health is a mutually reinforcing determinant of their SRH outcomes, however the relationship between these two areas of health is often overlooked. Evidence suggests a biopsychosocial relationship between mental health and SRH; specifically, women with mental health such as depression or significant stress are less likely to engage in safe sexual practice and contraceptive behaviours.[84-85]

Menopause, endometriosis and polycystic ovary syndrome (PCOS) are prevalent health issues that have significant implications for women's health and reproductive health, as well as broader physical and mental health. Despite the availability of effective and safe pharmaceutical and non-drug therapies for menopausal symptoms, many women and people with a uterus experiencing menopause are untreated.[86] Research suggests that many women do not have access to up-to-date, evidence-based information to optimise their health during menopause.[87] For example, many women have been discouraged from using menopausal hormone therapy (MHT) due to now-obsolete research that led researchers and doctors to believe that MHT use caused coronary heart disease, stroke breast cancer and other cancers.[88-90]

Endometriosis affects at least 200,000 Victorians (an estimated 830,000 Australians), or 10% of those who menstruate and can cause debilitating pain for those affected. Nationally, endometriosis is estimated to cost society $9.7 billion per annum with two-thirds of these costs attributed to a loss in productivity with the remainder, approximately $2.5 billion being direct healthcare costs.[91] Endometriosis is associated with infertility. Currently treatment is focused on managing symptoms as there is no cure for endometriosis. Many women and people with a uterus living with endometriosis report receiving diverse and sometimes contradictory information from health professionals, particularly about the impact of their diagnosis on fertility.[92] In one study of women with endometriosis in Victoria, the majority of women interviewed said their clinicians privileged treatment for fertility issues over other endometriosis-related concerns, such as their symptoms and quality of life.[92]

These health issues are associated with mild to severe symptoms and side effects that can interfere with participation in school, work and other activities. PCOS affects 8-13% of women and people with a uterus of reproductive age, and around 21% of Aboriginal women.[93] It is associated with infertility. Up to 70% of women with PCOS are undiagnosed.[93] In 2017, the Victorian government opened the first Australian PCOS clinic at the Monash Medical Centre.

Infertility affects an estimated one in six couples in Australia and is increasingly common due to a range of complex social, environmental and biological factors. Assisted reproductive technology (ART) is essential reproductive healthcare not only for heterosexual women experiencing difficulty conceiving, but also lesbian, bisexual and transgender women. There are ongoing barriers to accessing ART, including the potentially prohibitive cost. For LGBTI women, there are additional barriers. For example, in order to access Medicare rebates for the first round of treatment, people need to prove that they are "medically" rather than "socially" infertile, which excludes LGBTI women and people with a uterus.

Research has shown, for instance, that menopause symptoms can have a serious impact on a woman's attendance and performance at work.[90] The Australasian Menopause Society has advocated for the introduction of workplace policies and training to support menopausal women in the workforce.[90] This issue has been highlighted recently as the Health And Community Services Union has included a claim for five days of paid Reproductive Health and Wellbeing leave in their current Mental Health Enterprise Bargaining Agreement; if adopted the scheme would entitle all workers covered by the Agreement to paid leave for health issues such as severe menstrual pain to vasectomies to menopause to gender transitioning therapies.

One of the major barriers to optimal SRH is the absence of clinical guidelines to inform the provision of quality care.[94] – 96 While the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is currently developing clinical guidelines to inform the treatment of endometriosis, this has been lacking. Similarly, it is only in August 2020 that Australian guidelines for the diagnosis and treatment of PCOS have been launched, in an international first. The lack of clinical guidelines significantly limits the capacity of primary providers to effectively diagnose, refer and treat women presenting with fertility management issues, such as endometriosis and polycystic ovary syndrome. This contributes to substantial delays in diagnosis and treatment for many women.

The PCOS guidelines have been developed alongside renewed efforts to refine individual diagnostic criteria with a focus on improving accuracy of diagnosis, reduce unnecessary and invasive testing, increase focus on education, lifestyle modification, emotional wellbeing and quality of life, and an emphasis on evidence-based medical therapy and cheaper and safer fertility management. It is hoped that these measures will provide practitioners with the infrastructure, referral pathways and information to diagnose and treat women with PCOS.

Taking action in the region

This Background Paper provides evidence to inform priorities for improving women's sexual and reproductive health in the EMR, as outlined in the Strategy. The Strategy provides a framework for action from which to develop activities such as advocacy, policy and legislative reform to advance gender **equity**, sector and workforce development to improve health system **capability**, community capacity building, social marketing and research and evaluation, including data and information management, to increase **access** and inform inclusive service design and delivery.

Gender **equity** is a key issue for the Victorian government and city councils in 2020.[97] Approximately 68% of surveyed SRH stakeholders in the EMR identified gender equity as a priority for their organisation. Consultation with stakeholders, comprising local government, community health organisations and other service providers confirmed that SRH **capability**, literacy and education is a key priority for the majority of leading stakeholders in Melbourne's east. (Appendix 1) Of the stakeholders surveyed, over 80% cited SRH capability as a priority, indicating it is an important part of a multipronged approach to women's SRH. A further 25% of stakeholders surveyed indicated that increasing **access** to fertility management and family planning, abortion, contraception and prevention, screening and treatment of STIs was one of the top three identified priority for their organisation.

It is important for clinicians and healthcare services to be supported and enabled to identify, triage and refer women experiencing violence such as reproductive coercion, sexual violence, physical or emotional abuse and other forms of violence. In light of the relationship between violence against women and poorer SRH outcomes, such as unplanned pregnancy and sexually transmissible infections, it is important that healthcare providers have the capability to discuss these issues with patients to prevent and respond in instances of violence against women.

Improving SRH **capability** among service providers and within the healthcare system has the potential to improve women's SRH as it relates to scheduled and opportunistic screening and treatment for fertility management issues such as polycystic ovary syndrome and endometriosis, STIs and BBVs, abortion and contraception, violence against women and mental health. Higher literacy of sexually transmissible infections, including asymptotic presentations, among general practitioners is directly linked to increased rates of testing of patients.[98] Primary health services are often the first point of contact between community members and healthcare providers regarding SRH issues, such as unintended pregnancies.[99] Enhancing the capacity of service providers and health systems to provide care that is culturally appropriate, safe and inclusive is a fundamental component of improving **capability**. Improving health infrastructure, referral pathways and relationships between primary providers and specialist services is also crucial to enhancing health provider capability.

Improving health infrastructure is dependent on comprehensive data capturing women's lived experiences. While there is insufficient data available measuring regional access to SRH care, there is some data available on the availability of general primary healthcare, which comprises an important part of improving access to SRH care, and thus improving outcomes. The number of General Practitioners per 1,000 people in the EMR is the highest in the state, which suggests relatively good access to primary healthcare.[3] This has positive implications for some health outcomes: for example, the proportion of women who participate in cervical cancer screening in the region is 62.7%, slightly higher than the Victorian average of 60.2%.[3] More robust and comprehensive quantitative and qualitative data systems are required to identity gaps in women's SRH service provision, thus improving the **capability** and responsiveness of the healthcare system and enhancing **access**.

SRH **capability** among service providers improves and facilitates **access** to services which improves community health outcomes. **Access** to SRH services increases the ability of women and people with a uterus to make informed decisions about their own health: to decide if, when and how many children they wish to have; to avoid unintended pregnancies; and to protect themselves and their sexual partners against the transmission of communicable diseases such as sexually transmissible infections and blood borne viruses. Access to services also provides women and people with a uterus with the opportunity to have enhanced SRH outcomes: to experience pregnancy, childbirth and post-natal care safely; to receive treatment if they contract an infection or are unwell; and to experience safe, consensual and pleasurable sex.[1, 100, 101] Increasing access to services and reducing barriers has the potential to improve women's SRH by improving women's fertility management including endometriosis and polycystic ovary syndrome, increasing testing, diagnosis and treatment for STIs and BBVs, and increasing women's reproductive choices through access to contraception and abortion. Access to healthcare includes physical and financial accessibility, as well as social and cultural safety and acceptability.[1] Therefore, access to healthcare requires not only the provision of appropriate, affordable services, but an economic, social, cultural, and political environment that facilitates utilisation of the healthcare system. The healthcare system encompasses infrastructure, people, policies and relationships within the healthcare system, such as patient referral pathways, coordination of care, and hospital design.

The Sexual and Reproductive Health Hub offered through EACH in Ringwood is the only service of its kind funded in the outer east, which provides fully bulk-billed services for eligible patients. The main providers of abortion and long-acting reversible contraception in the Eastern Metropolitan region are Family Planning Victoria, EACH Ringwood and Marie Stopes Australia in Maroondah. There is an unmet need for publicly funded surgical abortion in the EMR, presenting an opportunity for advocacy, workforce and sector development to increase health system and provider capability and increase women's **access** to necessary services. It is also noted that the EMR is the only region not funded to address FGM/C among its constituents.

This Background Paper highlights a need for coordinated and sustained action to address women's SRH in the region. The accompanying Strategy provides a framework for regional action to advance gender equity, improve health system **capability** and increase **access** to SRH services. Women's Health East, by leveraging the expertise of the EMR SRH Strategic Reference Group and collaborating with other key local government, community health and other health promotion partners, aims to optimize women's SRH in the EMR through advocacy. This includes for example submissions on the renewal of the HIV, Sexually Transmissible Infections and Viral Hepatitis strategies and the Victorian government's *Women's Sexual and Reproductive Health: Key Priorities 2017 - 2020*; policy and legislative reform; sector and workforce development to improve health system **capability**, including increasing the capacity of doctors to provide medical abortions; and community capacity building, social marketing and research and evaluation to increase **access** and inform inclusive service design and delivery, particularly for priority populations.

Definitions:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Achieving optimal sexual health requires a positive and respectful approach to sexuality and sexual relationships, encompassing pleasurable and safe sexual experiences free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[102]

Reproductive health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Optimal reproductive health implies that people are able to have a satisfying and safe sex life and that they have as much autonomy as possible in deciding if, when and how many children to have.[103]

Reproductive rights rest on the recognition of the basic rights of all women and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of SRH. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, and the right to bodily autonomy for all women and people.[103]

Sex refers to a set of biological attributes. It is primarily associated with physical and physiological features including chromosomes, gene expression, hormone levels and function, and reproductive and sexual anatomy. A binary categorisation of sex distinguishes between female and male but there are known variations in the biological attributes that comprise sex and how those attributes are expressed, often described as intersex.[104]

Gender interacts with, but is different from, the commonly understood binary categories of biological sex. Gender refers to the socially constructed roles, behaviours, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men.[105] Expectations and understandings of gender have traditionally focused on rigid, binary interpretations of femininity and masculinity, but these have varied historically over time and in different cultural settings.[106] People whose gender identity corresponds with the sex assigned to them at birth are referred to as **cisgender**. Those whose gender identity diverges from the cultural expectations of the sex assigned to them at birth may refer to themselves as gender **fluid, non-binary or transgender**.

Intersectionality is a theory and approach which recognises and respects that our identities are made up of multiple interrelated attributes (such as race, gender, ability, religion, ethnicity, sexual orientation, sexual identity, and socio-economic status) and understands the intersections at which women, experience compounding cultural and structural oppression, discrimination, violence and disadvantage.[107-109] An intersectional approach to gender equality makes links between various forms

and diverse experiences of discrimination. Equality for all women can only be achieved with specific and intensive effort for those who experience the most disadvantage. This means balancing universal strategies with specialist, tailored approaches for women who experience intersectional disadvantage, including Aboriginal women, culturally and linguistically diverse women, women with disabilities, sexuality diverse women and gender diverse people, and women living in rural areas.[21, 110]

Health literacy encompasses the cognitive and social skills which affect the motivation and ability of individuals to gain access to, understand and use information to promote and maintain good health.[111] The health literacy of individuals is profoundly influenced by their socio-political, cultural and economic environment, including the complexity of health systems and macro-level policies that affect other social determinants of health, such as education and employment.

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Appendix 1: Summary of results of stakeholder survey

1. What type of organisation do you work for?

Type of organisation	Number	Percentage
Local government	8	40%
Community health service	8	40%
Primary health network	0	0%
Primary care partnership	1	5%
Health promotion organisation	0	0%
Women's health service	1	5%
Other health service	0	0%
Other (please specify): » University » Tertiary women's health hospital	2	10%
Total	**20**	**100%**

2. Are there sexual and reproductive health activities articulated in your current business plan for the 2019-20 financial year?

Response	Number	Percentage
Yes	9	45%
No	6	30%
Unsure	5	25%
Total	**20**	**100%**

3. To what extent do you agree with the following statement: The development of a Sexual and Reproductive Health Strategy will assist my organisation in developing their own priorities for addressing sexual and reproductive health.

Response	Number	Percentage
Strongly agree	7	35%
Agree	9	45%
Neither agree nor disagree	4	20%
Disagree	0	0%
Strongly disagree	0	0%
Total	**20**	**100%**

4. Are there any specific barriers for your organisation in adopting or maintaining sexual and reproductive health as a priority area?

Response	Number	Percentage
Yes	12	60%
No	5	25%
Unsure	3	15%
Total	**20**	**100%**

5. If yes, what are they? Please select all that apply:

Response	Number	Percentage
Resources, including funding and staff	10	42%
Competing priority areas	8	33%
Limited evidence that sexual and reproductive health is an issue for my organisation and/or community	3	13%
Other (please specify): » Research/evidence of sexual and reproductive health issues for our community » Partner organisations not working on this priority at the moment » Unable to provide free STI screening for high risk group at the Women's health clinic run by sexual health practitioners/ Nurses& midwives. The requested tests have to be signed off by a GP to be eligible for Medicare and Eastern Health has not funded the Women's health screenings for processing	3	13%
Total	**24**	**100%**

6. How have you used the current Sexual and Reproductive Health Needs Analysis in your organisation?

Response	Number	Percentage
I've used the information and data to increase my knowledge of sexual and reproductive health issues in the community	1	5%
I've used the information and data to inform the development of my organisation's strategic planning or framework	2	10%
I've used the identified key priorities to inform my work in sexual and reproductive health	1	5%
I've used the identified key priorities to inform the development of my organisation's strategic planning or framework	0	0%
I've never used this resource	8	40%
I wasn't aware this resource existed	7	35%
Other (please specify): » I have used this in a previous role to extract baseline data and rationale for project plans	1	5%
Total	**20**	**100%**

7. How could the Sexual and Reproductive Health Strategy 2020 be useful for your work or your organisation? Please select all that apply:

Response	Number	Percentage
Sexual and reproductive health is a core part of my work	4	9%
To inform strategic planning in my role or the organisation	7	16%
To determine organisational priorities	5	11%
Professional capacity building in my workplace	9	20%
To increase my knowledge of sexual and reproductive health in the Eastern Metropolitan Region	13	29%
To inform my engagement with partner organisations	5	11%
Other (please specify): » To raise the profile of SRH as an area of need » Health Promo for vulnerable clients	2	4%
Total	**45**	**100%**

8. In which of the following fields is your organisation most influential? Please select the three most important to your organisation:

Response	Number	Percentage
Gender equity	13	19%
Intersectionality	6	9%
Sexual and reproductive health capability	17	25%
Fertility management and family planning	2	25%
Access to abortion/termination	3	4%
Access to contraception	3	4%
Prevention of sexually transmissible infections	6	9%
Screening and treatment of sexually transmissible infections	3	4%
Capacity-building for service providers	6	9%
Challenging stigma and discrimination related to sexual and reproductive health issues	3	4%
Reproductive coercion	1	1%
Sexual and reproductive health data and research in the Eastern Metropolitan Region	4	6%
Total	**67**	**100%**

9. Are there priorities related to sexual and reproductive health for your organisation that were not listed above? If so, what are they?

» Sexual & Reproductive health care for women who use drugs

» Yes, Cervical screening program/CST, continence management, menopausal symptom management

» We aim to increase our capacity to include an outreach service to other outer eastern communities

» We are keen to get more Yarra Ranges specific data on SRH to inform the focus areas for us.

10. Which groups are priority populations in relation to sexual and reproductive health for your organisation? Please select all that apply:

Response	Number	Percentage
Young women	11	10%
Aboriginal and Torres Strait Islander women	9	8%
Older women	9	8%
Women experiencing physical, emotional or sexual abuse	9	8%
Women living with HIV or Hepatitis	6	6%
Same-sex attracted women (e.g. lesbian and bisexual women)	5	5%
Trans and gender-diverse women	5	5%
Non-binary people	5	5%
Trans and gender-diverse men	5	5%
Intersex people	5	5%
Women with physical disabilities	8	8%
Women with cognitive disabilities	6	6%
Women with psycho-social disabilities	9	8%
Women from culturally and linguistically diverse backgrounds	8	8%
International students	6	6%
Total	**106**	**100%**

Appendix 2: Summary of regional sexual and reproductive health and demographic data

Note: N/A denotes data not available.

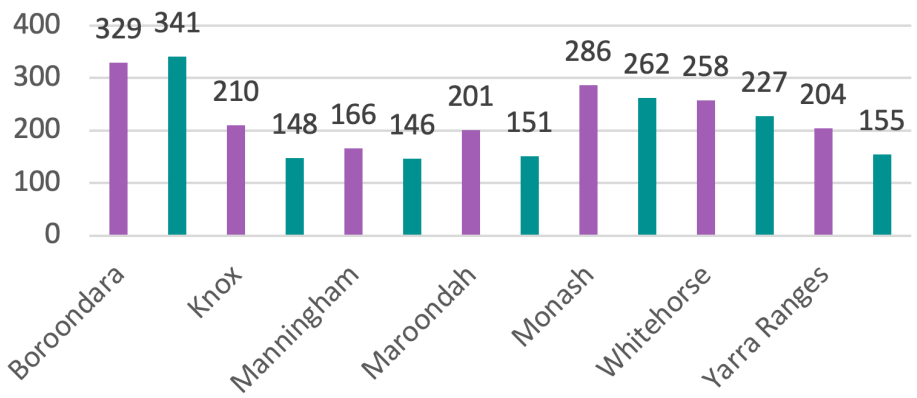
Sexual and reproductive health data

This data is sourced from *Women's Health Victoria's Women's Health Atlas*: Sexual and Reproductive Health. Available from: https://victorianwomenshealthatlas.net.au/

Chlamydia notifications (actual numbers) by location and gender, 2018

Boroondara	Female	329
	Male	341
Knox	Female	210
	Male	148
Manningham	Female	166
	Male	146
Maroondah	Female	201
	Male	151
Monash	Female	286
	Male	262
Whitehorse	Female	258
	Male	227
Yarra Ranges	Female	204
	Male	155
Eastern Metropolitan Region	Female	1654
	Male	1,430
Victoria	Female	12,761
	Male	13,351

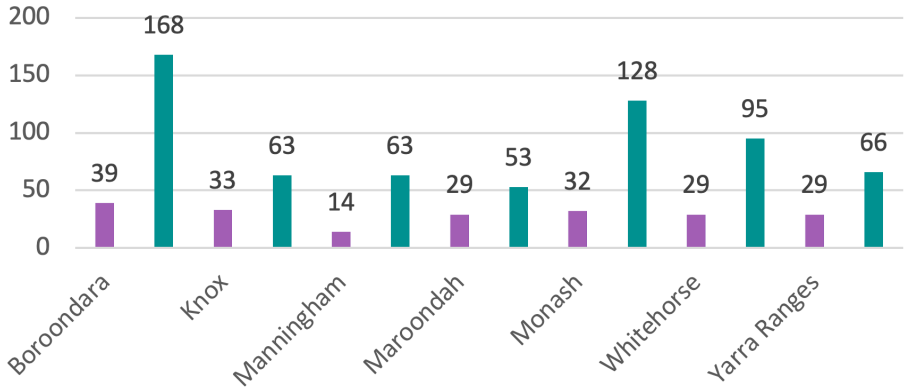
Chlamydia notifications (actual numbers) by location and gender, 2018



Gonorrhoea notifications (actual numbers) by location and gender, 2018

Boroondara	Female	39
	Male	168
Knox	Female	33
	Male	63
Manningham	Female	14
	Male	63
Maroondah	Female	29
	Male	53
Monash	Female	32
	Male	128
Whitehorse	Female	29
	Male	95
Yarra Ranges	Female	29
	Male	66
Eastern Metropolitan Region	Female	176
	Male	636
Victoria	Female	1,638
	Male	6,527

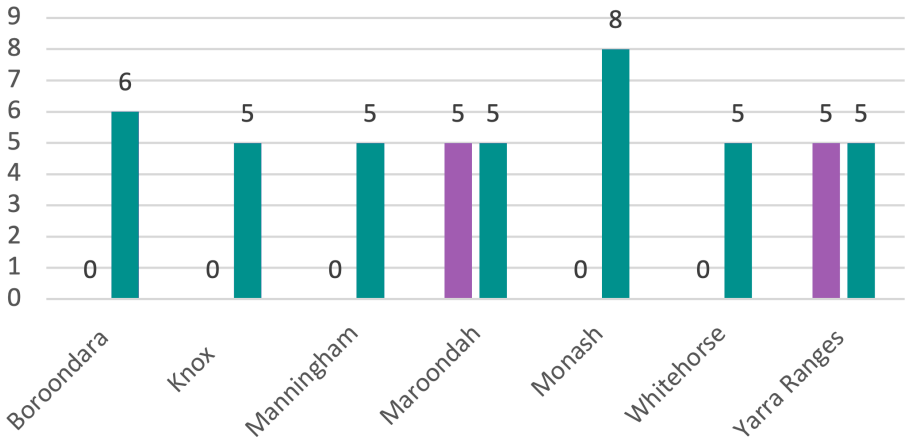
Gonorrhoea notifications (actual numbers) by location and gender, 2018



HIV notifications (actual numbers) by location and gender, 2018

Boroondara	Female	0
	Male	6
Knox	Female	0
	Male	<5
Manningham	Female	0
	Male	<5
Maroondah	Female	<5
	Male	5
Monash	Female	0
	Male	8
Whitehorse	Female	0
	Male	5
Yarra Ranges	Female	<5
	Male	<5
Eastern Metropolitan Region	Female	<10
	Male	<39
Victoria	Female	28
	Male	241

HIV notifications (actual numbers) by location and gender, 2018



Hepatitis B notifications (actual numbers) by location and gender, 2018

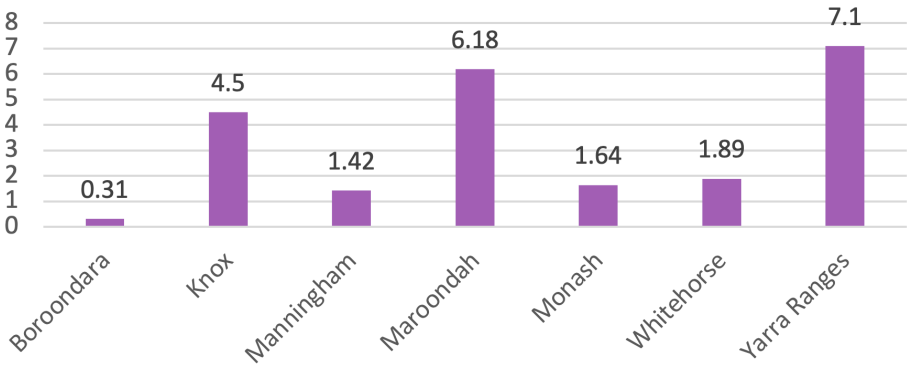
Boroondara	Female	36
	Male	34
Knox	Female	16
	Male	22
Manningham	Female	30
	Male	25
Maroondah	Female	11
	Male	16
Monash	Female	58
	Male	50
Whitehorse	Female	45
	Male	36
Yarra Ranges	Female	5
	Male	7
Eastern Metropolitan Region	Female	201
	Male	190
Victoria	Female	800
	Male	923

Hepatitis B notifications (actual numbers) by location and gender, 2018

Teenage birth rate (number of live births to mothers aged 13-19 years per 1,000 women aged 13-19 years by location), 2016-2017

Boroondara	0.31
Knox	4.50
Manningham	1.42
Maroondah	6.18
Monash	1.64
Whitehorse	1.89
Yarra Ranges	7.10
Eastern Metropolitan Region	N/A
Victoria	10.63

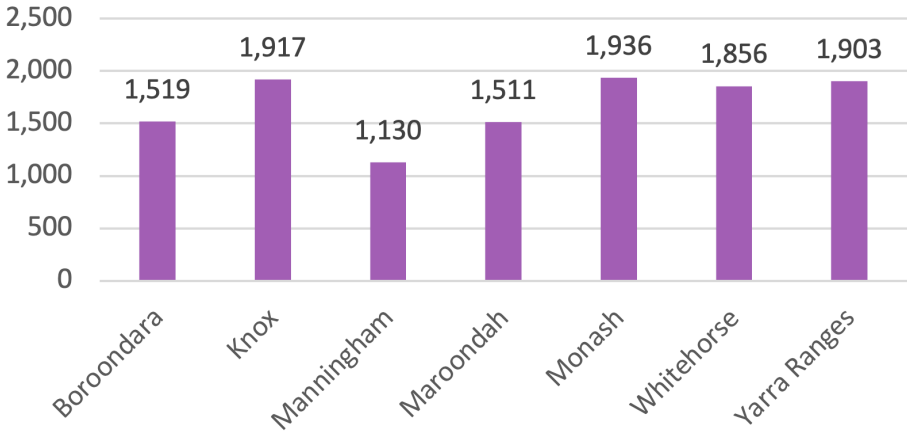
Teenage birth rate (number of live births to mothers aged 13-19 years per 1,000 women aged 13-19 years by location), 2016-2017



Total births registered by location, 2017

Boroondara	1,519
Knox	1,917
Manningham	1,130
Maroondah	1,511
Monash	1,936
Whitehorse	1,856
Yarra Ranges	1,903
Eastern Metropolitan Region	11,772
Victoria	82,094

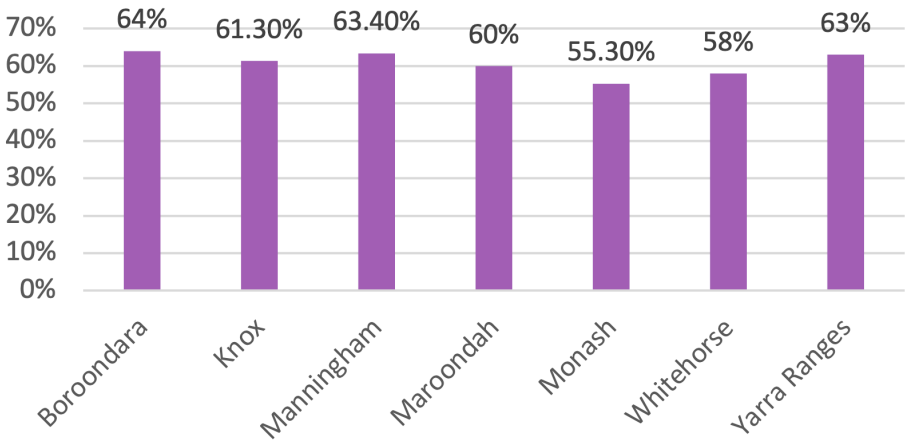
Total births registered by location, 2017



Cervical screening participation (%), 2015

Boroondara	64%
Knox	61.3%
Manningham	63.4%
Maroondah	60%
Monash	55.3%
Whitehorse	58%
Yarra Ranges	63%
Eastern Metropolitan Region	N/A
Victoria	60.5%

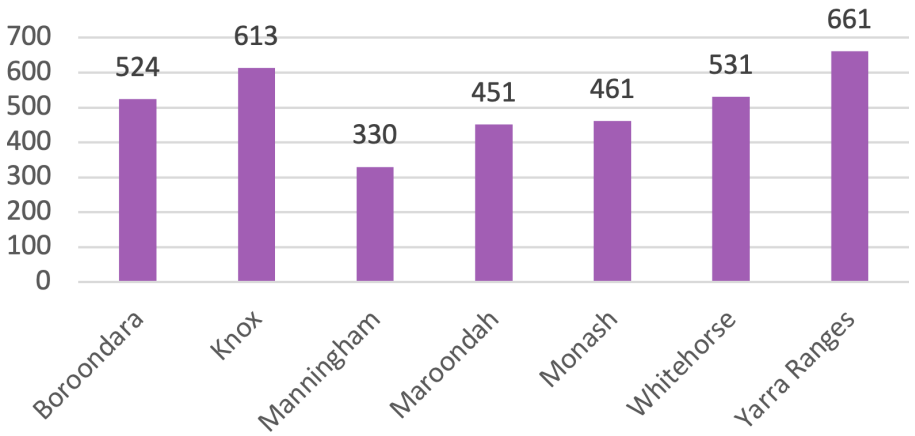
Cervical screening participation (%), 2015



Contraceptive implant use by location, 2018

Boroondara	524
Knox	613
Manningham	330
Maroondah	451
Monash	461
Whitehorse	531
Yarra Ranges	661
Eastern Metropolitan Region	3,156
Victoria	25,647

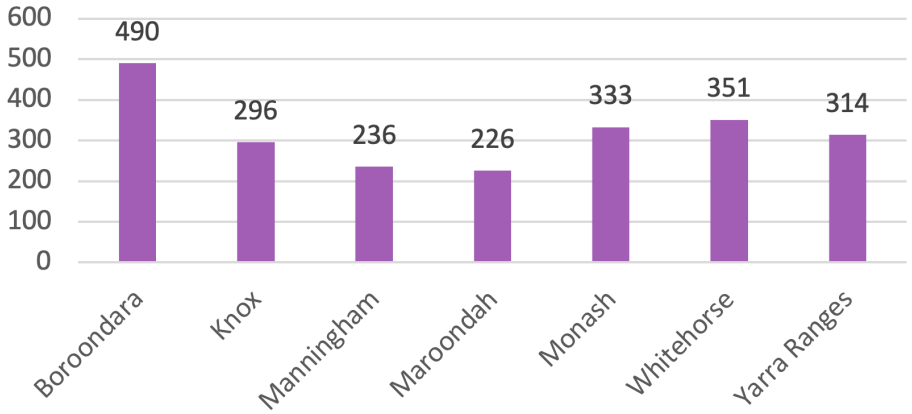
Contraceptive implant use by location, 2018



Contraceptive intrauterine device use by location, 2018

Boroondara	490
Knox	296
Manningham	236
Maroondah	226
Monash	333
Whitehorse	351
Yarra Ranges	314
Eastern Metropolitan Region	2,246
Victoria	15,234

Contraceptive intrauterine device use by location, 2018



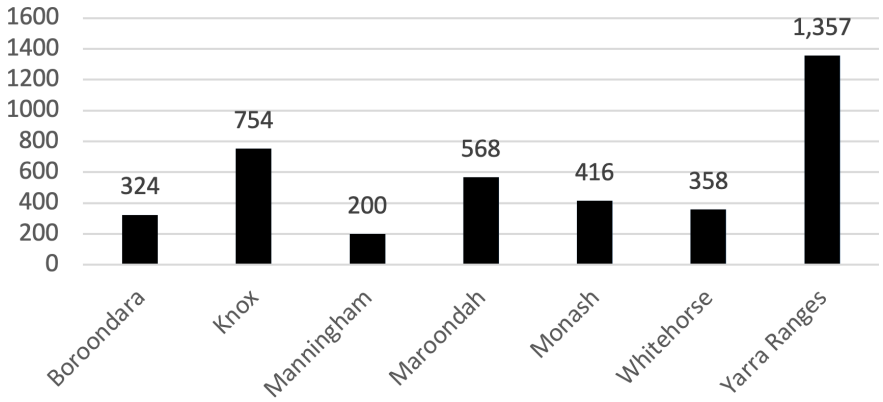
General population data

This data is sourced from the Australian Bureau of Statistics's 2016 *Census Community Profiles*. Available from: https://www.abs.gov.au/websitedbs/D3310114.nsf/Home/2016%20Census%20Community%20Profiles

Aboriginal and Torres Strait Islander status by location and gender, 2016

Boroondara	Female%	47.8%
	Male%	52.2%
	Total persons (n)	324
Knox	Female	49.5%
	Male	50.5%
	Total persons (n)	754
Manningham	Female	51.4%
	Male	48.6%
	Total persons (n)	200
Maroondah	Female	51.2%
	Male	48.8%
	Total persons (n)	568
Monash	Female	50.7%
	Male	49.3%
	Total persons (n)	416
Whitehorse	Female	49.6%
	Male	50.4%
	Total persons (n)	358
Yarra Ranges	Female	53.1%
	Male	46.9%
	Total persons (n)	1,357
Eastern Metropolitan Region	Female	N/A
	Male	N/A
	Total persons (n)	2,814
Victoria	Female	50.6%
	Male	49.4%
	Total persons (n)	47,787

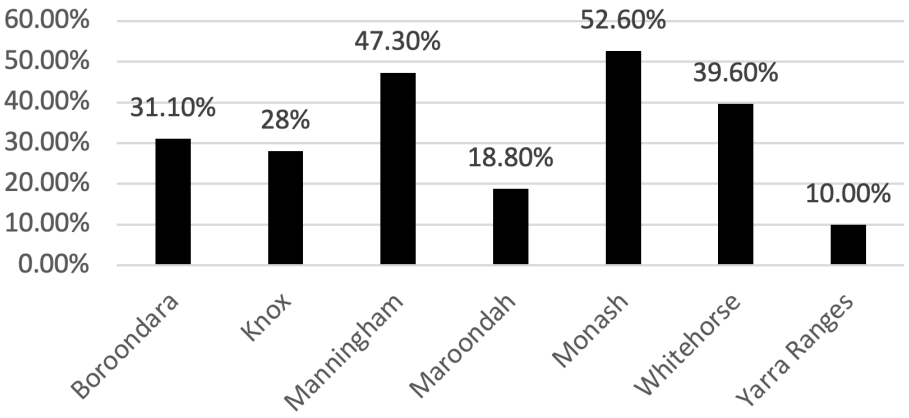
Aboriginal and Torres Strait Islander status by location and gender, 2016



Proportion of households in which a language other than English is spoken by location, 2016

Boroondara	31.1%
Knox	28%
Manningham	47.3%
Maroondah	18.8%
Monash	52.6%
Whitehorse	39.6%
Yarra Ranges	10.0%
Eastern Metropolitan Region	N/A
Victoria	27.8%

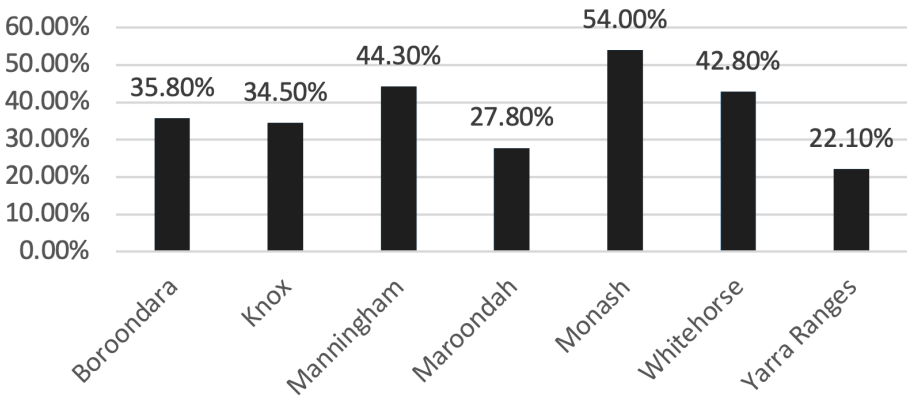
Proportion of households in which a language other than English is spoken by location, 2016



Proportion of residents born overseas by location, 2016

Boroondara	35.8%
Knox	34.5%
Manningham	44.3%
Maroondah	27.8%
Monash	54.0%
Whitehorse	42.8%
Yarra Ranges	22.1%
Eastern Metropolitan Region	N/A
Victoria	35.1%

Proportion of residents born overseas by location, 2016



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