



**Sexual Health &
Family Planning
Australia**

Leading the way in sexual and reproductive health

**SUBMISSION TO THE NATIONAL MEN'S
HEALTH POLICY**

JULY 2009

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About Us

Sexual Health and Family Planning Australia (SH&FPA) is the national peak body representing the eight independent state and territory sexual health and family planning organisations.

SH&FPA advocates for access to knowledge and knowledge of family planning and sexual and reproductive health to enable people to achieve reproductive and sexual health and well-being in the context of a sustainable environment.

SH&FPA and its Member Organisations (MOs) endorse the International Planned Parenthood Federation Charter on Sexual and Reproductive Rights. This rights-based approach is consistent with the International Conference on Population and Development (ICPD) Program of Action, developed in Cairo in 1994. At the heart of the Program of Action is the recognition that population policies that promote personal choice and human rights, and which are integrated with broader development goals such as poverty alleviation and gender equity, are effective both in improving quality of life and stabilising population levels.

Working both nationally and internationally, SH&FPA supports the delivery of a range of educative, clinical and training programs by MOs and partner organisations in a number of South East Asia and Pacific countries including; Timor Leste, Fiji, Papua New Guinea, Cook Islands, Solomon Islands and Laos.

SH&FPA facilitates professional working groups of State and Territory:

- Health promotion and education managers;
- Sexual and reproductive health nurses;
- Senior medical practitioners; and
- CEOs

These networks assist SH&FPA in identifying emerging sexual and reproductive health issues; trends and gaps in service delivery; promotes consistent levels of service delivery (clinical, education and training) across all jurisdictions; and facilitates professional development of staff through peer engagement.

As the national peak body, SH&FPA develops and strengthens relationships with other national organisations in order to promote the sexual and reproductive health agenda across policy, sectoral and single issue divides. These relationships also assist MO in developing and strengthening relationships with similar State and Territory organisations.

SH&FPA receives funding from the Commonwealth Department of Health and Ageing and AusAID.

SH&FPA's MOs are:

- Family Planning Tasmania (FPT)
- Family Planning Victoria (FPV)

- Family Planning New South Wales (FPNSW)
- Family Planning Queensland (FPQ)
- Family Planning Welfare Northern Territory (FPWNT)
- Family Planning Western Australia and sexual health services (FPWA)
- Sexual Health information, networking, education (SHine) South Australia
- Sexual Health and Family Planning Australian Capital Territory (SH&FPACT)

Commitment to Men and Boys

Boys and men who are: Aboriginal or Torres Strait Islanders; from culturally and linguistically diverse communities; living with a disability; gay, bisexual, transgendered or a man who has sex with men; or otherwise isolated and disadvantaged are the key population groups for SH&FPA MOs.

Endorsement of this Submission

SH&FPA's submission to the National Men's Health Policy is endorsed by all eight State and Territory member organisations.

Acknowledgement and thanks

SH&FPA wishes to thank all member organisations for contributing to the development of this submission and in particular Ms Bridget Haire for her work in collating and writing the submission.

Executive summary

SH&FPA considers the development of a National Men's Health Strategy from the perspective of sexual and reproductive health, informed by a view of health that recognises social determinants.

These social factors include poverty, power inequalities, social/cultural attitudes, sexuality and gender identity, social isolation, discrimination and lack of access to information and education. Aboriginal men in particular face multiple disadvantage that translates into poor health outcomes, due to Australia's history of dispossession and disenfranchisement of Aboriginal people.

SH&FPA advocates for a Men's Health Strategy that addresses the diversity of Australian men, and the provision of health services that are tailored for and responsive to the needs of Australia's marginalised and disadvantaged men. This needs to be accompanied by a whole of government approach to addressing structural barriers to health equity.

The "Call to Action" released in 2008 by SH&FPA, the Public Health Association of Australia and the Australian Reproductive Health Alliance and endorsed by a number of national organisations called for a National Sexual and Reproductive Health strategy¹. Relationships are at the core of sexual and reproductive health heterosexual or not, and such a national strategy would encompass equally men, women, transgendered and intersex people.

Good sexual and reproductive health for men and for women goes beyond the absence of disease to include social, intellectual and emotional dimensions. This includes respecting the sexual health rights of others, the ability to make and participate in decisions that affect sexual and reproductive health and the ability to negotiate sexual practice with intimate others.

This submission looks in detail at the male priority populations serviced by SH&FPA MOs and makes recommendations about how a National Policy could better address the needs of these men with particular regard to their sexual and reproductive health. It identifies:

- Populations who lack access to health and other services;
- The need for comprehensive sexual health education in schools, including information on healthy relationships, contraception and prevention of STIs;
- The role of confidential, non-judgmental health services for sexual and reproductive health advice, STI screening and treatment for men and boys; and
- The need for a supportive environment where sexuality issues can be explored without stigma, discrimination or victimisation.

The many examples of best practice work currently undertaken by SH&FPA MOs in their individual jurisdictions provide potential pilot programs to be trialled nationally. Thereby increasing the number of men and boys reached and strengthening

¹ SH&FPA et al (2008)

collaborative relationships between SH&FPA MOs, other non government organisations, government agencies and commercial enterprises.

Sexual and reproductive health are particularly important to health equity as control over fertility and the exercise of sexual health rights are critical for enabling men and women to realise their human potential. In addition, good sexual and reproductive health implies healthy relationships and the removal of harmful gender norms – sound aspirational goals for a Men's Health Policy.

1. Gender Equity

Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female (or transgendered) in a particular point in time. It is the measurable equal representation of women and men, and equal opportunity for transgendered people. Gender equity does not imply that women and men are the same, but that they have equal value and should be accorded equal treatment.²

Striving for gender equity necessarily involves men and women but it also needs to address structural determinants of inequity.

Sexual and reproductive health are particularly important in terms of gender equity as control over fertility and the exercise of sexual health rights are critical for enabling men and women to realise their human potential.

Adverse sexual health experiences and outcomes for men include:

- not feeling comfortable using sexual health services when needed
- being victimised and subjected to discrimination if they do not conform to accepted modes of masculinity
- prevalence of adverse sexual and other health outcomes is higher for people of diverse sexuality (gay men, bisexuals, transgender and so on)
- few (if any) services for men of diverse sexuality
- denial of disabled people's sexuality (regardless of gender)

Recommendation

SH&FPA advocates that the National Men's Health Policy adopts a transformative agenda with respect to harmful gender norms and inequality.

The five key principles of gender transformative programming are to:

Build equitable social norms and structures:

Advance individual gender equitable behaviour

Transform gender roles

Create more gender equitable relationships

Advocate for policy and legislative change to support equitable social systems³.

1.1. Why Men's sexual and reproductive health matters?

Good sexual and reproductive health for men and for women goes beyond the absence of disease to include social, intellectual and emotional dimensions⁴.

The enjoyment of sexual health rights has been identified by the World Health Organisation, the United Nations and the International Federation for Planned

² International Planned Parenthood Federation (IPPF) <http://www.ippf.org.au/What-we-do>

³ Based on the International Planned Parenthood report, The truth about...Men, Boys and Sex: Gender transformative policies and programming IPPF <http://www.ippf.org.au/NR/rdonlyre/C1579050-CA7D-43C6-911F-D69DC5B1B795/0/TruthAboutMenBoysSex.pdf> accessed 1 July 2009

⁴ Un Definition cited by IPPF Sexual health: 'the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love... and that the notion of sexual health implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases.'

Parenthood as a critical factor in sexual and reproductive health. This includes respecting the sexual health rights of others, the ability to make and participate in decisions that affect sexual and reproductive health and the ability to negotiate sexual practice with intimate others⁵. While the relational aspects of sexual and reproductive health are harder to measure than embodied ones such as rates of infection or unwanted pregnancy, SH&FPA considers that they are particularly important in terms of reducing violence and increasing gender equity.

Poor sexual and reproductive health contributes directly to poor social and economic outcomes for individuals and communities, such as unwanted pregnancies and fertility problems caused by untreated sexually transmissible diseases (STIs).

For men's health, progression of treatable cancers, such as bowel and testicular resulting in increased morbidity and mortality could be ameliorated by improved uptake of screening and early intervention programs. SH&FPA recognises the need to make sexual and reproductive health services attractive to men, and the necessity of promoting sexual health screening as responsible health practice.

For example in 2009 FP NSW partnered with Andrology Australia and the Panthers Rugby League Club to promote testing for testicular cancer.

SH&FPA also acknowledges that it is important that all sexual and reproductive health clinicians, educators and services need to be responsive and accessible to men. To support men and boys access and feel comfortable with sexual and reproductive health services, FPWA developed a comprehensive protocol for working with men and boys, a client group which now counts for 10 percent of their total clients.

The attitudes of men to sexual health rights, including acknowledgment of and respect for women's agency with regard to the negotiation of sexual practice and fertility control, is critical for the sexual and reproductive health of women, especially those in heterosexual relationships.

Mental health issues such as suicide and self-harm in same-sex attracted youth can be caused by experiences of homophobic abuse and violence, which in itself is a lack of recognition by the homophobe of the sexual rights of same-sex attracted people.

⁵ IPPF endorsed the definition of reproductive rights agreed at the International Conference on Population and Development, which stated: 'Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples 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 sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community supported policies and programs in the areas of reproductive health, including family planning.'

Recommendation

SH&FPA is funded to work with FPWA to nationalize their protocol for working with men and boys.

1.2 Australian Men and diversity

A Men's Health Strategy needs to address the diversity of Australian men – sexuality and sexual orientation, life course stage, relationship status, disability status, gender identity, cultural and linguistic backgrounds, Aboriginal or Torres Strait Islander identity, reproductive status and reproductive ambitions are all critical factors that impact on the way men experience health and health services.

Sexual orientation and gender identity need to be recognised as social determinants of health. Certain sub-populations of gay, lesbian, bisexual and transgendered or intersex people are particularly vulnerable to sexual and reproductive health problems. To promote health equity in this respect it is important to design strategies that include people with diverse sexuality or gender orientation, that do not presume heterosexuality and that recognise that people in same-sex relationships may also be or plan to become parents.

One of several difficulties of operating under the policy framework of 'Men's Health' and 'Women's Health' is that sexual and reproductive health is about relationships, and relationships occur between men and women (whether heterosexual or not), and impact upon sexual and reproductive health. Working with men and boys in a sexual rights framework is a critical component of improving the sexual and reproductive health of women, because changing the attitudes of men is necessary for reducing and preventing violence against women.

The other difficulty in the separation of men's and women's health policy is that transgendered and intersex people – already marginalised and stigmatised – are displaced by the assumption of a population that divides neatly into two halves. Although transgendered and intersex people are a minority, they are a vulnerable population with a right to health equity.

Recommendation

Articulate a national framework that addresses sexual and reproductive health issues and priorities, which the Men's Health Strategy becomes the implementing arm in relation to specific men's issues

2. Social Determinants of Health

More than in other chronic disease states, it is possible to see the role of the social determinants of health at play in sexual and reproductive health. The incidences of some Sexually Transmissible Infections (STIs) and teenage pregnancy rates, for example, have been linked to low socio-economic status and income inequality.⁶

The underlying social causes of poor sexual and reproductive health for men are interconnected and some men face multiple layers of disadvantage. These social factors include:

- poverty
- power inequalities (for example, between men and women, adults and children)
- social/cultural attitudes, beliefs and expectations about relationships, sexuality, pregnancy
- social isolation
- discrimination
- lack of access to information and education to prevent ill health and increase self care
- lack of access to health and other services and support well being

Health and wellbeing is affected by the start people have in life and their everyday life experiences from pre-birth on⁷. Our capacity to make positive health choices and to manage our own health and wellbeing is linked to social factors, including our position on the 'social ladder'⁸.

The higher the level of an individual's or a group's power or status in society, the more resources and opportunities they will have to control their sexual and reproductive lives, and enjoy their sexuality.

Sexual and reproductive health outcomes are distributed unequally between and within different population groups of men (and women), as are other indicators of health⁹.

The best sexual health outcomes are achieved when the sexual rights of all persons are respected and protected¹⁰

Protection of sexual rights and access to safe, accessible, low-cost or free sexual health services develop positive social and cultural attitudes to relationships, sexuality and sexual behaviour, including:

- an emphasis on respect for self and others, mutually respectful relationships, trust and love
- a commitment to promote the rights of all people to be free from discrimination, abuse, violence or coercion

⁶ Obaid, UNFPA; Williams, H. and Davidson, S. (2004)

⁷ Bartlett, M. (2003)

⁸ World Health Organisation, Social Determinants of Health (2005)

⁹ http://who.int/social_determinants/links/publications/en and Smith and Aguis (2003)

⁹ Glover J (2006)

¹⁰ IPPF; DoHA (2005-2008); VACCHO (2008-2013)

- an affirmation that every individual is equally valued and has a right to pursue a satisfying, safe and pleasurable sex life
- an acceptance of the diversity of beliefs, values and moralities to be found across the community
- a belief that stable, committed relationships based on these values are fundamental for raising children
- an adult acceptance of sexual activity among teenagers combined with the expectation that teenagers will protect themselves and their partners from pregnancy, sexually transmitted infections, sexual coercion, and so on

The stigma and discrimination in Australia associated with sexuality and many sexual and reproductive health issues prevent some people, particularly men from using sexual health services and support, and result in poorer outcomes for some groups.

These poorer outcomes are the case particularly for men who are:

- Indigenous
- Culturally and linguistically diverse
- Disabled
- Teenagers
- Same-sex attracted, bisexual, transgendered and intersex
- Survivors of child abuse.

Recommendations

The National Men's Health Policy must ensure that adequate research is undertaken in relation to the social determinants of health and population groups impacted, and that such populations remain a priority for service delivery.

Provide sustainable resource SH&FPA to raise the profile of sexual and reproductive health and sexuality in the Australia, through advocacy and collaborative partnerships with non government, community (including sporting and cultural groups) and businesses, to reduce the stigma and discrimination associated with these issues.

The Commonwealth to work with SH&FPA and MOs to distribute free or low cost condoms to men particularly those in priority populations

3. The need for comprehensive education

Health promotion programs and specialised service delivery focused on key population groups must be underpinned by universal comprehensive sexuality and relationship education campaign targeted to children growing into adolescents.

Universal, comprehensive and age appropriate sexual health, sexuality and relationship education promotes positive sexual and reproductive health and is an essential element in reducing domestic violence, sexual assault and negative mental and psychological outcomes. As children grow into adolescents, a positive relationship and healthy understanding of their own bodies, sexuality, sexual and reproductive health, will support and assist them in accessing further information and services as well as developing positive relationships with others, heterosexual or otherwise.

Currently the value placed on providing comprehensive sexuality education largely depends on individual schools (private schools are exempt), as there is wide variation between schools (teacher confidence, school priorities) in their approach to sex education¹¹.

Health promotion and education managers from all States and Territories regularly meet and consistently report positive outcomes from their work in schools and in the community. However the lack of minimum standards or certified course for teachers in sexual health and sexuality¹², and the absence of universal, comprehensive and age appropriate courses limits their ability.

FPV reports that despite the availability of comprehensive sexuality education programs in Victoria,¹³ most school-based sex education remains focused on fact-based knowledge within a health and physical education framework. Effective sexuality education should be sex positive and reflect on healthy relationships and situations (social pressures, alcohol and other drugs, physical and emotional safety) that influence decision making¹⁴.

Recommendations

Sexual health education, including information on contraception, STIs and health relationships should be provided in all Australian schools, including rural and remote schools, at primary and secondary level.

¹¹ Jordan, L. et al pg 2

¹² Ibid pg 25

¹³ <http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality/teachingprog.htm>

¹⁴ Ibid pg 23

4. Focus on key population groups to achieve better SRH - reduce disease and violence

4.1 Priority population: Youth

Youth is a critical time for establishing and reinforcing good health behaviours and avoiding significant health problems later in life. Specific health interventions and approaches that target youth are imperative to deal with the emergence of risk behaviours during this stage. Helping youth make decisions and develop habits that will positively influence their future health and prospects is a challenge for communities, governments and public health organisations.

In addition to the social determinants discussed above, structural factors affecting sexual and reproductive health for young men and boys are:

- Provision of comprehensive sexual health education, including information on healthy relationships, contraception and prevention of STIs
- Access to confidential, non-judgmental health services for sexual and reproductive health advice, STI screening and treatment
- A supportive environment where sexuality issues can be explored without stigma, discrimination or victimisation.

In most Australian jurisdictions, family planning and sexual health services welcome young people, including those under the legal age of consent, and provide the appropriate services. In instances where the young person is deemed to be at risk, this is reported to the relevant government authority. If the young person is competent and not at risk, and does not wish to involve parents or guardians in the sexual and reproductive health consultation, this is respected.

In the Northern Territory, however, the *Care & Protection of Children Act 2007* defines young men under 16yrs engaging in sexual activity as committing a criminal offence, and requires mandatory reporting to the police by health services or indeed supermarket clerks selling condoms. The SH&FPA MO in Darwin reports that the Police will charge the older of the two young people, even if the age gap is as small as one day. This effectively blocks young men from buying condoms and seeking other sexual and reproductive health advice.

The corollary of this legislation is that young people are dissuaded from seeking health services, and the trust between young people and health services providers is strained. Increases in teenage pregnancy rates and STIs in young people may be expected to follow.

Examples of work

Tasmania

FPT promotes the offer of testing to men who accompany their partners to the clinic for Chlamydia through notices in our waiting rooms; this is achieving a measurable response (evidenced in the State statistics). FPT is about to embark on a Chlamydia awareness campaign for males aged 24-39.

FPT (Tasmania) is consulting with groups of young men in preparation for producing two booklets. One will be on sexuality and relationships and the second will be a guide for young, expectant and parenting fathers.

South Australia

Shine SA has developed - Youth Action Teams – 3 Teams of young people aged 16 to 24 involved in policy, planning and programs focusing on the development of life skills.

Shine SA and FPNSW offer - Young Dads Program – parenting, healthy relationships and understanding of sexual health program with young dads.

Recommendation

The sections of the Northern Territory *Care & Protection of Children Act 2007* that mandate reporting of underage sex must be repealed or redefined to support positive sexual health and reproductive health outcomes.

4.2 Priority population: Aboriginal and Torres Strait Islander Men and Boys

The burden of sexual ill-health and blood-borne virus is several times greater for Aboriginal people, compared with the burden for non-Aboriginal people. Aboriginal and Torres Strait Islanders have an eight-fold rate of diagnosis of Chlamydia (per 100,000 populations) than non-Aboriginal people¹⁵. Since the spread of STIs and blood-borne viruses are driven by the ways in which people interact with each other, this burden is in part reversible¹⁶.

Aboriginal young people under 25 years of age remain a high risk group. *Blood-borne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007* reports that people as young as 13 years old are being diagnosed with STIs, especially Chlamydia and syphilis¹⁷.

SH&FPA MOs are aware that cultural norms inhibit the capacity of some Aboriginal and Torres Strait Islander health and community workers to conduct STI screening and testing procedures. Currently communities are regularly visited by Aboriginal Medical Officers and other practitioners for the purpose of screening for chronic illness, recognising the prevalence of STIs in communities it is recommended that screening and testing is incorporated into the broader chronic illness testing.

Aboriginal and Torres Strait Islander men have higher rates of incarceration than non-Indigenous men. While 0.6% of the total male population is in jail at any one time, 6% of Aboriginal men – more than one in 20 – is incarcerated¹⁸. For this reason, what happens in prisons has greater impact on Aboriginal men as a population group than

¹⁵ DoHA (2005-2008)

¹⁶ VACCHO (2008-2013)

¹⁷ Ibid

¹⁸ HREOC

on non-Indigenous men, and access to high quality healthcare services and preventative tools like condoms and clean injecting equipment is very significant for this population.

SH&FPA and its member organisations are committed to working with Aboriginal and Torres Strait Islander men and communities to improve sexual and reproductive health outcomes. As the best practice and case studies practices highlight, SHINE SA and Family Planning WA have long-standing commitments to extending education, training, counselling and information services to rural, remote and Indigenous communities.

These programs are developed in consultation with communities to meet their specific cultural needs and are run in rural and remote areas with Aboriginal workers and those working with Aboriginal people. Evaluations of these programs provide the evidence that non government community led health promotion and education activities together with clinic services do result in improved sexual and reproductive health outcomes.

Examples of work undertaken

Western Australia

Mooditj program

‘Mooditj’ (the Noongar word for ‘solid’), is a sexual health and life skills program for Aboriginal young people aged 11 - 14 years. Developed in consultation with over 200 people, the program consists of ten community education sessions interactive activities are used to cover issues including self identity, puberty, hygiene, understanding emotions, relationships, sexual issues, sexual rights, parenting and identifying goals and dreams. ‘

Mooditj’ is supported by a manual and leader training program, enabling sexual health training for those working with Aboriginal youth. Resources and small grants, along with support from FPWA educators, are provided to assist newly-trained leaders, who then deliver the program to young people in their own community. Demand for leader training remains consistently high, indicating a strong need.

In 2008 a six month research project evaluated the sexual health impact and positive lifestyles effects of participation in ‘Mooditj’ groups on young people.

The main findings pertaining to sexual health outcomes included:

- Increased discussion of sexual health issues
- Increased knowledge of pregnancy issues
- Reported increased contraception use, mainly condoms and Implanon (contraceptive implant) in women
- Increased knowledge of STIs
- Increased attendance at clinics for STI testing and sexual health needs

Findings demonstrate the effectiveness of a relevant, culturally-appropriate program developed with close community participation.

Pilbara Sexual Health Community Capacity Building Project

In 2008 the Pilbara Sexual Health Community Capacity Building Project was developed. This three-year project will enable FPWA to build community capacity and work with existing stakeholders to promote sexual health among Aboriginal communities in the Pilbara region.

Sexual Health Network and Forum

The Sexual Health Network supports people working in sexual health, particularly Indigenous people and those working with Aboriginal communities, to regular distribution of sexual health information, activities and discussion of issues through email and teleconferencing. A forum is held once a year to further strengthen regional people's ability to access information.

Aboriginal Educator Program

FPWA's Aboriginal Educator Program aims to increase workforce capacity in sexual health within the Aboriginal community through the provision of a two-year traineeship. Currently in its ninth year, this program has contributed significantly to workforce development in WA.

South Australia

Investing in Aboriginal Youth

Youth participation and peer education program focussing on healthy and respectful relationships with Aboriginal youth, training of Aboriginal workers in health promotion, sexual health and youth participation and support with the implementation of local health promotion programs.

Wiltja Program

An out of school health education for male and female Aboriginal students attending secondary school in Adelaide from remote SA and NT. Programs are gender specific. Focus is on sexual health safety, rights, responsibilities, where to go for support and services.

Recommendations

Focussed resources for SH&FPA and MOs to strengthen relationships with Aboriginal and Torres Strait Islander national, state and territory non government organisations, to continue to develop culturally appropriate programs.

STI screening to become a feature of the regular chronic illness screening and testing undertaken in remote and regional Aboriginal and Torres Strait Islander communities.

4.3 Priority population: Cultural and Linguistically Diverse (CALD) Men and Boys

People from CALD backgrounds are priority populations for. SH&FPA MOs are genuinely committed to increasing capacity to deliver enhanced service delivery to CALD populations.

All SH&FPA MOs work with CALD communities within their State and Territories. In acknowledging different cultural sensitivities to sexual and reproductive health, the work SH&FPA MOs undertake with CALD men and boys has a two fold significance, in terms of their own health outcomes and the ability of the women in their lives to access information and services.

Discussions about choice with regard to sexual practices and fertility control need to start with the men in some CALD communities if they are to affect positive change. Similarly, men and boys need to be engaged in discussions about women's sexual rights and their right to live without threat of domestic and family violence.

Due to these cultural issues, SH&FPA MOs run information sessions specifically focused at CALD men promoting sexual and reproductive health education and services both for themselves and the women in their lives.

All member organisations have best practice work standards including:

- Given the sensitive nature of clinical consultations for sexual and reproductive health services, member organisations aim to provide men with male or female interpreters according to their preference.
- Longer appointment times are allocated (1 hour) for consultations that involve an interpreter, as opposed to 30 – 45 minutes for general appointments. This reflects commitment to ensuring that CALD men are provided a quality service.
- Most Member Organisations endeavour to provide block appointments at certain times or sites for men and women from particular language backgrounds.
- In recent years, there has been a strategic shift to increased professional education to health professionals, service providers and teachers, so as to maximise the impact of Member Organisations' knowledge, practices and funding.

Examples of work

Victoria

FPV educators work with newly arrived young refugee men 16-25 years of age at Victoria University, Footscray to deliver sexual and reproductive health education

Tasmania

FPT partners with Women's Health South and Centacare to work with groups of newly arrived immigrants and refugees. A process has been developed where the men from the group first met and find out about the organisation, staff, and services and then the women meet separately the next day to do the same thing. Experience has shown that if the men are onsite then they will encourage their partners to attend as well as seeking information and services for themselves.

Communities worked with include: Karen people from Burma; Congolese; and the Bhutanese communities.

New South Wales

Family Planning NSW has developed the following successful models of service delivery.

- A co-location partnership model has been developed where local CALD health organisations deliver services through local FPNSW clinics. For example, the monthly NSW Refugee Health clinic where NSW Refugee Health clinicians run a clinic for men and women from refugee backgrounds who live in the Fairfield area. Similarly, in Penrith, the Warehouse has a clinical partnership with Blacktown Migrant Resource Centre to provide clinical services to young people from CALD backgrounds.
- Recognising the importance of engaging CALD men in the development of health promotion projects, and generally, the set up phase of projects has involved consultation with key community members. This approach was seen as important as it helped to ensure that project processes and products were relevant and useful for community members. For example, the success of the “A User’s Guide – What Every Man Needs to Know” resource developed as part of the Andrology Men’s project was largely attributed to the input of men from each of the 12 CALD communities during the development phase.
- A number of the training programs currently offered by FPNSW contain components designed to improve participants’ ability to work effectively with CALD populations, (e.g. the ‘Sexuality and Health’ training focuses on working with culturally diverse groups along with other priority populations). Similarly, for the FPNSW Certificate in Sexual and Reproductive Health, working with interpreters is recognised as a competency of the clinical practice component.
- Partnered with education institutions such as the University of NSW to work with university students. Medical students from the UNSW in phase two (years 3-4 of the six year course) can undertake placements at FPNSW for their Society and Health term, which is a unique time for them to be exposed to issues around health service delivery and access in the community (as opposed to hospitals) and population/public health perspectives (as distinct from clinical training). This contributes to the training of medical undergraduates in terms of sensitising them to issues faced by CALD populations and raising their awareness of the special field of reproductive and sexual health.

Recommendations

Adequately resource SH&FPA, MOs, women’s and community health centres to work with men on a range of sexual and reproductive health issues, recognising that this work needs to be educative, inclusive and culturally appropriate in order to encourage men and subsequently women to access services.

4.4 Priority population: Same-sex attracted Men and Boys

Gay men and men who have sex with men but do not identify as gay (MSM), are significantly more likely to be living with HIV or at risk of acquiring HIV than other Australians¹⁹. In addition, there is a higher prevalence of other STIs in these populations²⁰, which impact on sexual health and also facilitate HIV transmission. Targeted HIV prevention strategies and access to the best proven and most tolerable anti-HIV therapies (antiretroviral or ARV) remain critical, along with access to efficient and non-judgmental testing for HIV and other STIs.²¹

While condom promotion has a key role in STI prevention, strategies beyond condom promotion are also required – testing, treatment and preventive vaccines also have important roles.

Vaccines for human papilloma virus (HPV) currently target young women only, for the prevention of HPV-related cervical cancers. In addition to causing cervical cancer, a subtype of HPV causes cancers that affect men - anal, penile and oropharyngeal cancers²². It may also be linked to laryngeal cancer and non-melanoma skin cancer. Although there is some debate about the cost effectiveness of vaccinating boys, there are compelling population health arguments and social justice arguments.

Men who have sex with men are at significant risk of anal cancer related to HPV infection²³, and rates are particularly high in men (and women) who are co-infected with HIV²⁴. HPV infection is endemic in men who have sex with men and vaccination is only effective prior to exposure, so vaccination needs to be taken prior to onset of sexual activity. In addition to protecting boys and men, vaccinating boys would significantly reduce the pool of HPV infection in the community, increasing the benefits of ‘herd immunity’ and protecting young women for whom vaccination is unavailable for whatever reason, or who do not become immune through vaccination.

“Sexual health” must not however be reduced to a simplistic absence-of-disease model for gay men, MSM and men living with HIV/AIDS. Same-sex attracted men and men with HIV/AIDS have the same rights to positive and enriching experiences of sexuality.

Health promotion activities and clinical services promoting positive sexual and reproductive health outcomes for same sex attracted men and boys must take into account the following:

- 80% of same attracted young people say general acceptance by the community, including equal rights and within this, acceptance by their parents, friends and the church would make a positive difference to their lives.²⁵

¹⁹ National Centre of HIV epidemiology and Clinical Research from 2003-2007, 83% of newly acquired HIV infection was ascribed to homosexual exposure,

²⁰ Ibid See for example rates of infectious syphilis, Table 3.1.9

²¹ Ibid

²² Guiliano, A; American Cancer Society (2006); Kreimer, AR (2005) pgs 467-475; Ryan et al (200) pgs 792- 800; Daling, JR et al (2005) pgs 606 - 616

²³ Guiliano Ibid. cites the figure of 17 times more likely

²⁴ Blacter, J and Palefsky, J (2008)

²⁵ Hillier, J. Mitchell, A. Turner, A. (2005)

- Many young same sex attracted men feel abolishing the stereotype of the ‘gay man’, in both the gay and the wider communities would improve their lives.
- Same sex attracted young people are sexually active earlier than their heterosexual peers. 64% of same sex attracted youth are sexually active. These young people often have sexual partners of both genders. Protection levels are lower than those for opposite sex attracted youth²⁶.
- A recent study of the experiences of gay, lesbian, bisexual and transgender young people in Australia confirmed they have a range of negative experiences due to their sexual and gender identity and face disturbing health outcomes from the impact of heterosexism and homophobia. For example, depression and suicide are two to seven times higher in same sex attracted young people than heterosexual peers²⁷
- Same-sex attracted youth are a particularly over-looked group with poor sexual and reproductive health outcomes.²⁸

Example of work

Victoria

Mind the Gap! Leadership, Resilience & Diversity is a partnership between FPV, the Victorian Community Controlled Aboriginal Health Organisation (VACCHO), and Centre for Adolescent Health and Youth Empowerment Against HIV/AIDS.

It is a rural and Regional Community Engagement Program focusing on primary prevention of HIV and sexually transmitted infections (STI) among young GLBTIQ people aged 25 years and under and their social networks.

‘*Mind the Gap!*’ was selected as a title to reflect the ‘*Close the Gap*’ Federal indigenous health initiative, and to highlight the health inequities that also exist between GLBTIQ communities and the mainstream population. It is both a social justice rallying cry and statement about the current health and well-being of the GLBTIQ communities.

These strategies are designed to appeal to the wider community whilst at the same time offering targeted information, training and resources to GLBTIQ youth and health care providers that address diversity, inclusion and self-care.

The *Mind the Gap!* program focuses on developing the capacity of both the workforce and target population(s) to address the complexities that inform sexual health and well-being, discrimination and diversity within their communities and beyond.

The purpose of this intervention is to collaborate with key partners (agencies, clients and providers) to create social and health actions within regional and rural Victoria to decrease STI and HIV transmission.

²⁶ Ibid

²⁷ *Health & sexual diversity – a health & well-being plan for gay, lesbian, bisexual, transgender & intersex Victorians*, Ministerial Advisory Committee on Gay and Lesbian Health

²⁸ Williams, H. and Davidson, S. (2004) pgs 95-105

Recommendations

Include gay men and men who have sex with men (MSM) as priority marginalised populations in the Men's Health Strategy.

Ensure that mainstream sexual and reproductive health information and education resources are inclusive of same-sex attracted people, as well as developing targeted materials for those populations.

Make free HPV vaccination available for boys and explore the cost effectiveness of a national vaccination program for boys and young men.

Provide focused resources so that sexual health professionals and others such as GPs are supported, through training, to take medical histories in a manner that invites disclosure of same-sex activity.

4.5 Priority population: Rural and Remote Men and Boys

The problem of lack of services in rural and remote Australia is widely acknowledged within government and the Australian community. Rural and remote men's and boys' health outcomes are significantly worse than those of their regional and metropolitan counterparts. Mental health issues and illnesses are also particularly problematic. The issues outlined in the previous section, including isolation, discrimination and access to services, are far greater for men and boys in rural and remote areas.

Young people living in regional or rural areas have an increased risk of untreated sexually transmitted infections (STIs) and unplanned pregnancy due to the shortage of medical services and availability of contraception. This has implications for the entire community, not just young people²⁹.

Recently, the Commonwealth has sought to increase the numbers of GPs and nurse practitioners in rural and remote Australia. One strategy employed has been the tying of practicing certificates for overseas qualified GPs to being located in rural and remote communities. These additional resources are welcome however it is important to support these practitioners to develop sexual and reproductive health services, particularly if there are cultural barriers to discussing sexual health, sexuality and reproduction.

Examples of work

South Australia

Shine SA has developed the Focus Schools Program – a Relationships and sexual health education program in years 8, 9 and 10 of South Australian state secondary schools. Implemented in 2003 as a 3 year pilot called SHARE program with 15 schools, Focus Schools has been expanding since 2006 and now includes 77 participating schools across rural, remote and metropolitan schools.

²⁹ Keys, D et al (2008) pg 19

Recommendations

Develop strategies in concert with SH&FPA, MOs and communities to train nurses and other health workers to perform sexual health and reproductive health clinical services, fund mobile clinics, transporting doctors to underserved areas on a periodic basis and explore telemedicine.

Ensure overseas doctors who obtain practicing certificates because of their willingness to work in under-served areas need to have comprehensive training in sexual and reproductive health by an accredited trainer such as a SH&FPA MO.

4.6 Priority population: Men and Boys with a disability

Men living with a disability have particular needs with regard to sexual and reproductive health relative to the nature and severity of the disability.

Men with an intellectual disability require targeted information and education about sex, sexuality and sexual and reproductive health, while for men with a physical disability, access to appropriate services and to clinicians trained in working with disabilities is a requirement.

Dependency and power relationships with carers are very significant for this population. Statistics indicate that between 50-90% of persons with an intellectual disability will be sexually assaulted in their lifetime³⁰. Dependency and power relationships also impact significantly on access to services, education and information about sexual health and on the possibilities of sexual expression for people living with a disability. On the one hand, there is an imperative to protect vulnerable people from the possibility of exploitation and abuse; on the other hand, intimacy and sexual expression are human needs and indeed human rights.

SH&FPA MOs have become significant providers of education, training and services to the disability service sector as well as people living with a disability.

SH&FPA MOs aim to improve the sexual and reproductive health of people with a disability in Australia by:

- Being a source of education, information and resources about the reproductive and sexual health needs of people with a disability for health workers, clinicians, disability workers and teachers
- Having a profile within the disability and health sectors for advocating with, and on behalf of, people with a disability in relation to their sexual and reproductive health needs
- Providing clinical services that are inclusive of people with a disability and offer a high level of expertise on disability specific reproductive and sexual health issues
- Having staff who are knowledgeable and supportive of the reproductive and sexual rights of people with a disability

Being in long term strategic partnerships that enable a more effective response to the needs of people with a disability.

³⁰ NSW Attorney General's Department, 2007

Examples of work:

Victoria

FPV developed an education and training package, *Sexual Assault and People with an Intellectual Disability*, to increase awareness of referral pathways and improve provision of services to people with a disability who experience sexual assault. FPV has also formed partnerships with the police, Victim of Crime services, Centres Against Sexual Assault (CASAs) and counselors.

Tasmania

FPT offers a one-to-one education and early intervention service for people with disabilities and currently sees more men than women. Clients are usually referred from the Government's Disability Service or through other non-government disability services and schools. The reasons for referral are inappropriate sexualised behaviour, relationships issues, puberty and the need for safe sex information .

South Australia

Shine SA has developed My Sexual Health matters –a resource for people with mental health issues where medication is impacting on their sexual relationships and Friendships and dating – a resource for parents of children and young people with an intellectual disability.

New South Wales

FPNSW produced the health promotion campaign *Love & Kisses* in 2007 which includes a DVD that provides a positive look at the intimate lives of people with a disability. *Love & Kisses* focuses on the issue that that people with a disability have the right to happy, safe and fulfilling relationships. It uses personal stories told through drama and interviews that reveal the joys and heartbreak of love, sex and relationships, and is suitable for people with a disability, teachers, students families and health care providers.

Recommendations

Increase resources to SH&FPA MOs to support the specialist skills necessary to undertake work with the disability sector and men and boys with a disability, in sexual and reproductive health

Fund SH&FPA to facilitate a professional working group of educators and clinicians working in the disability sector and with people with a disability

4.6 Priority population: Men in prisons

Men who are incarcerated face particular risks with regard to their sexual and reproductive health, although those risks are ameliorated by the provision of condoms in prisons in some states. Prisons and juvenile justice centres also present unique opportunities for health promotion interventions in hard-to-reach population groups.

As stated earlier, as Aboriginal and Torres Strait Islander men and boys are disproportionately represented in the prison system, deficiencies in that system have a

high impact on an already vulnerable and disadvantaged population. Having access to good quality, respectful healthcare services while incarcerated is critical, as is access to the preventive tools like condoms and lubricant and clean injecting equipment.

Examples of work

Western Australia

FPWA's community education work has expanded into corrective services over the last few years, recognising the sexual ill health issues affecting this group.

A five-part 'Sexual Health and Wellbeing' program specially adapted to the needs of institutionalised young men covers issues such as safe sex, risk taking, parenting, communication, contraception, STIs and anger management.

The HIP HOP (Health in Prison, Health Outta Prison) program conducted for adult detainees is aimed at reducing blood-borne virus transmission, and provides participants with the skills and knowledge to make safe decisions upon release. Medical staff at one prison reported a significant increase in STI and blood-borne virus testing among inmates after the introduction of HIP HOP.

New South Wales

FPNSW developed the Cobham pilot project in association with its Warehouse Youth Health Service to provide a health promotion outreach service to young men in the juvenile justice system. The project aims to improve young men's knowledge of sexual health, blood borne viruses and sexually transmitted infections and increase access to relevant health information. It does not provide clinical services.

FPNSW holds weekly educational sessions with small groups (six to ten participants). The sessions provide sexual and reproductive health information in a non-clinical setting for participants who are vulnerable, socially and/or geographically isolated and unlikely to access mainstream services. The emphasis is on frank and open discussion on sexual health issues including relationships and participants are encouraged to use youth health services upon release and medical facilities provided by Juvenile Justice while in detention.

Recommendations

Provide resources to SH&FPA MOs to providing sexual and reproductive health outreach services to young people in Juvenile Justice Facilities

Resource SH&FPA MOs to develop on going partnerships between Juvenile Justice and family planning or sexual health services in each jurisdiction to provide specialist training to Juvenile Justice Facilities' staff in sexual and reproductive health issues.

Work with SH&FPA MOs to distribute condoms and water-based lubricant in prisons and juvenile justice facilities in all Australian jurisdictions to protect sexually active prisoners/detainees from STIs and HIV, the failure to do disproportionately affects Aboriginal men, given their high rate of incarceration.

Provision of injecting equipment in prisons should be piloted to address rates on HCV infection in prisons.

4.7 Men and Boys and alcohol and other drug use

The role of excessive alcohol use in injuries, accidents and self-harm is well recognised. Alcohol and other drugs also contribute to poor sexual and reproductive health outcomes and are intimately connected to domestic violence, sexual assault.

Drug and alcohol use can contribute to impaired decision-making about sexual and reproductive health matters. Whether or not to engage in sex, risk assessment with regard to sexual practices, decision-making about contraception and STI protection and perceptions of partner consent can all be impacted upon by drug and alcohol consumption.

Educating men about how the dis-inhibiting properties of alcohol and other drugs can impair sexual decision making, and the potentially grave negative consequences of this for both the man and his partner/s, needs to be part of drug and alcohol programs in schools, in sporting associations, and in the wider community, including being incorporated into Commonwealth health promotion and social marketing campaigns such as the Binge Drinking campaign and Marijuana and other drugs campaign.

Priority populations such as youth, same-sex attracted men, Aboriginal and Torres Strait Islander men may be particularly vulnerable to excessive use of alcohol and other drugs. This increased risk behaviour is compounded by the already high prevalence of STIs in these populations, which exponentially increases the likelihood of acquiring or transmitting an STI.

Evidence of the impact alcohol and other drugs have on sexual and reproductive health outcomes includes:

- In the 2007 National Drug Strategy Household Survey, 19% of young men aged 18-24 years reported that they had engaged in risky/high risk drinking at least once a week during the last 12 months. This was more than twice the comparable rate of risky/high risk drinking in men aged 25 years and older (8%).
- Drinking alcohol lowers sperm counts in men and makes it more difficult for women to get pregnant. Even young women who drink heavily can find that their periods stop altogether³¹.
- The majority (79%) of 18-24-year-old men who were physically assaulted by another male said that the perpetrator had been drinking alcohol or taking drugs³².

Recommendations

Support SH&FPA and MOs in working with drug and alcohol service providers to promote training necessary to foreground the negative sexual reproductive health consequences of alcohol and drug misuse in men.

³¹<http://209.85.173.132/search?q=cache:UmSrpOnTRPUJ:www.tacade.com/pdfs/Briefing%2520Paper%2520no3.pdf+alcohol+drug+use+sexual+reproductive+health&hl=en&clnk&cd=7&gl+au>

³² http://www.acys.info/youth_facts_and_stats/safety_and_risk_2008/risktaking-1

5. Conclusions

SH&FPA welcomes the opportunity to have input into the National Men's Health Policy, and endorses the social view of health adopted in the discussion papers informing this consultation.

A social view of health invites a response that goes beyond the health portfolio, and accordingly SH&FPA calls for a whole-of-government and community-wide response to promoting positive relationships and sexual and reproductive health in men.

The response needs to be evidence based, so ongoing research into the relationships between sexual and reproductive health and social determinants is critical, as is the collection of appropriate demographic data in all health research which might help to uncover or illuminate other relationships.

A primary prevention strategy to address the common risk factors for many sexual and reproductive health issues for men includes targeting men within the priority populations that have been identified as being at risk through their socially and /or economically disadvantaged status – Aboriginal and Torres Strait Islander communities, men with a disability, men who are same-sex attracted or gender diverse, and men from culturally and linguistically diverse communities.

6. Summary of recommendations SH&FPA Men's health submission

1. SH&FPA advocates that the National Men's Health Policy adopts a transformative agenda with respect to harmful gender norms and inequality. The five key principles of gender transformative programming are to:
 - Build equitable social norms and structures:
 - Advance individual gender equitable behaviour
 - Transform gender roles
 - Create more gender equitable relationships
 - Advocate for policy and legislative change to support equitable social systems
2. Articulate a national framework that addresses sexual and reproductive health issues and priorities, which the Men's Health Strategy becomes the implementing arm in relation to specific men's issues
3. SH&FPA is funded to work with FPWA to nationalise their protocol for working with men and boys.
4. The National Men's Health Policy must ensure that adequate research is undertaken in relation to the social determinants of health and population groups impacted, and that such populations remain a priority for service delivery.
5. Provide sustainable resource SH&FPA to raise the profile of sexual and reproductive health and sexuality in the Australia, through advocacy and collaborative partnerships with non government, community (including sporting and cultural groups) and businesses, to reduce the stigma and discrimination associated with these issues.
6. The Commonwealth to work with SH&FPA and MOs to distribute free or low cost condoms to men particularly those in priority populations
7. Fund SH&FPA to support the achievement of equitable access across states and territories, with special consideration given to the needs of people experiencing disability in the setting of socio-economic disadvantage, and people from Aboriginal and CALD backgrounds. (this needs work)
8. Sexual health education, including information on contraception, STIs and health relationships should be provided in all Australian schools, including rural and remote schools, at primary and secondary level.
9. The sections of the Northern Territory *Care & Protection of Children Act* 2007 that mandate reporting of underage sex must be repealed or redefined to support positive sexual health and reproductive health outcomes.

10. Focussed resources for SH&FPA and MOs to strengthen relationships with Aboriginal and Torres Strait Islander national, state and territory non government organisations, to continue to develop culturally appropriate programs.
11. STI screening to become a feature of the regular chronic illness screening and testing undertaken in remote and regional Aboriginal and Torres Strait Islander communities.
12. Adequately resource SH&FPA, MOs, women's and community health centres to work with men on a range of sexual and reproductive health issues, recognising that this work needs to be educative, inclusive and culturally appropriate in order to encourage men and subsequently women to access services.
13. Include gay men and men who have sex with men (MSM) as priority marginalised populations in the Men's Health Strategy.
14. Ensure that mainstream sexual and reproductive health information and education resources are inclusive of same-sex attracted people, as well as developing targeted materials for those populations.
15. Make free HPV vaccination available for boys and explore the cost effectiveness of a national vaccination program for boys and young men.
16. Provide focused resources so that sexual health professionals and others such as GPs are supported, through training, to take medical histories in a manner that invites disclosure of same-sex activity.
17. Develop strategies in concert with SH&FPA, MOs and communities to train nurses and other health workers to perform sexual health and reproductive health clinical services, fund mobile clinics, transporting doctors to underserved areas on a periodic basis and explore telemedicine.
18. Ensure overseas doctors who obtain practicing certificates because of their willingness to work in under-served areas need to have comprehensive training in sexual and reproductive health by an accredited trainer such as a SH&FPA MO.
19. Increase resources to SH&FPA MOs to support the specialist skills necessary to undertake work with the disability sector and men and boys with a disability, in sexual and reproductive health
20. Fund SH&FPA to facilitate a professional working group of educators and clinicians working in the disability sector and with people with a disability.
21. Provide resources to SH&FPA MOs to provide sexual and reproductive health outreach services to young people in Juvenile Justice Facilities

22. Resource SH&FPA MOs to develop on going partnerships between Juvenile Justice and family planning or sexual health services in each jurisdiction to provide specialist training to Juvenile Justice Facilities' staff in sexual and reproductive health issues.
23. Work with SH&FPA MOs to distribute condoms and water-based lubricant in prisons and juvenile justice facilities in all Australian jurisdictions to protect sexually active prisoners/detainees from STIs and HIV, the failure to do disproportionately affects Aboriginal men, given their high rate of incarceration.
24. Provision of injecting equipment in prisons should be piloted to address rates on HCV infection in prisons.
25. Support SH&FPA and MOs in working with drug and alcohol service providers to promote training necessary to foreground the negative sexual reproductive health consequences of alcohol and drug misuse in men.

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