Policy Document

Sexual Health (2021)

Position Statement

The Australian Medical Students' Association (AMSA) is the peak representative body for medical students in Australia. AMSA believes that all communities have the right to all facets of health. As such, AMSA advocates on issues that impact health outcomes, including sexual health.

AMSA believes that:

1. All individuals in society have the right to a safe and pleasurable sexual and reproductive health journey that is free from shame, stigma, violence or abuse.
2. Sexual health is defined not only by the absence of Sexually Transmitted Infections and Blood Borne Viruses, but also overall sexual wellness, safety and pleasure.
3. Sexual health is compromised by inadequate sexual health education, inadequate contraceptive use and sexual health testing, sexual violence, infertility, sexual difficulties, sexual dysfunction, and discrimination based on sexual orientation, gender, and disability
4. Factors that contribute to achieving a high standard of sexual health include having access to information about sexuality, knowledge regarding protective sexual health behaviours and potential adverse consequences of sexual activity, access to high-quality sexual healthcare, and a social environment that promotes sexual health

Policy

AMSA calls upon:

1. Medical schools, specialist medical colleges, the Australian Medical Association (AMA) and academic institutions to:
    a. Recognise the gender disparity and hostile environments in their leadership and workforce and reflect upon the current gender imbalances within their specific institution by:
        i. Publicly acknowledging that many specialities foster a hostile and inflexible environment that may prevent or discourage people of marginalised genders from entering and settling in a specialty;
        ii. Active identification and rectification of this environment through support and engagement with research and open consultancy on the issue.
    b. In application and selection processes, work to:
        i. Create an inclusive, supportive environment for all applicants of marginalised genders;
        ii. Ensure that the selection criteria used are transparent, fair, equitable and that criteria are applied consistently;
        iii. Implement and respect the 40% men, 40% women, 20% open gender balance in keeping with the internal quota set by the AMA, particularly within leadership places;

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iv. Continuously review and scrutinise procedures and processes to ensure criteria offer equitable access to opportunity and reduce barriers that systematically discriminate based on identity.

c. Regarding workplace culture and fostering of opportunities, ensuring that:
   i. People of marginalised genders are actively mentored and given opportunities to engage in upskilling and leadership roles in a consistent, transparent and formalised manner;
   ii. Building upon the AMSA Sex and Gender Equity in Medical Research and Teaching Policy (2018), people of marginalised genders are supported to publish high quality research, sit on peer review panels and share this research with the academic community;
   iii. An inclusive training environment where equitable access to flexible work hours, job sharing and parental leave is facilitated;
   iv. All medical trainees are educated on workplace rights, including anti-discrimination laws;
   v. A culture of gender equity is prioritised and embedded into policy and procedures;
   vi. Reporting processes for gender-based discrimination are clearly communicated, transparent and protect individuals who utilise them.

d. Building upon the AMSA Sex and Gender Equity in Medical Research and Teaching Policy (2018), To regularly review curricula through a lens of gender-equity and make changes to ensure safe and equitable care for patients of all genders. This includes review of teaching and assessment of:
   i. Conditions that are specific to women, transgender and gender diverse patients;
   ii. The differences in clinical presentations between genders;
   iii. History taking and examination of diverse body types;
   iv. Gender as a social determinant of health;
   v. Appropriate use of terminology; - covered by other policy
   vi. Gender inequity in medical leadership and workforce;
   vii. Strategies to counteract casual gender discrimination in workplaces

e. In reference to the research disparity:
   i. Provide research and follow-up on gender-based statistics and experiences within the workforce; particularly around the results of the implemented actions.
   ii. Conduct further research into the presence of TGD people in medical leadership and workforce, barriers to their representation, and solutions to address this gap.

2. Hospitals and other healthcare service providers to:
   a. Publicly acknowledge the gender imbalance in leadership and workforce and work to ensure that people of marginalised genders are represented by
      i. Implementing and respecting the 40-40-20 gender balance quota of the AMA, particularly within leadership positions, when appropriate;

ii. Ensuring equitable opportunities are provided to all employees in the same program or position;

b. Publicly acknowledge the gender pay gap and work to rectify it by:
   i. Ensuring transparent and consistent methods of performance appraisal are used as a guide for pay increases or promotions;
   ii. Establishing transparent remuneration packages based on consistent criteria;
   iii. Providing equal paid parental leave, regardless of gender of parent, and support for employees with children without detrimental impact on employment, including:
      1. Facilitating flexible working hours;
      2. Ensuring equal remuneration based on objective criteria when parents return to work;
      3. Ensuring equitable opportunities and promotions are still given when parents return to work;
c. Prioritise and embed a culture of gender equity into policy and procedures;
d. Establish reporting processes for gender-based discrimination that are clearly communicated, transparent and protect individuals who utilise them.
e. Provide research and follow-up on gender-based statistics and experiences within the workforce; particularly around the consequences of the implemented actions.

3. University Medical Societies to:
   a. Conduct annual reporting into their leadership diversity status;
   b. Deliberate as to why gender-imbalances exist and actively seek to rectify such reasonings. Examples of such actions include:
      i. Implementing positive actions and targets to fast-track participation of people of marginalised genders, by:
         1. Actively encouraging people of marginalised genders to apply for cis-male dominated leadership roles;
         2. Providing training and shadowing opportunities for medical students with the aim to encourage a more diverse applicant pool.
      ii. Establish mentoring and networking opportunities to improve inclusion of TGD individuals in all avenues of medicine;
      iii. Host activities and events that are directed at supporting and encouraging people of marginalised genders in medicine to pursue leadership and workplace opportunities that have suffered from gender imbalances.
   c. Investigate implementation targets across their organisation and recommend them where they see appropriate.

4. AMSA in conjunction with AMSA Gender Equity and AMSA Queer:
   a. To identify organisational gender disparities through:
      i. Conducting annual reports of representation across AMSA volunteers, including, but not limited to, the representation of gender identities, ethnicities and domestic/international status;
      ii. Supporting AMSA members and volunteers to share their diverse lived experiences.

b. To create safe and equitable application and selection processes by:
    i. Creating an inclusive, supportive environment for all applicants of marginalised genders, such as inclusive language in callouts and interviews, increasing titles collected to include 'Mx' or 'No title'
    ii. Ensuring that selection criteria used are transparent, fair, equitable and that criteria are applied consistently;
    iii. Investigating and implementing gender targets across AMSA;
    iv. Reviewing and scrutinising team demographic data, and recruitment procedures/processes annually to ensure criteria offer equitable access to opportunity and reduce barriers that systematically discriminate based on identity.
c. Regarding organisational culture and fostering of opportunities, ensuring that:
    i. People of marginalised genders are given the opportunity to be actively mentored and engage in upskilling and leadership roles in a consistent, transparent and formalised manner;
    ii. A culture of gender equity is prioritised and embedded into policy and procedures;
    iii. AMSA Gender Equity and AMSA Queer are consulted in National Advocacy endeavours as they pertain to issues of gender equity;
    iv. Reporting processes for gender-based discrimination are clearly communicated, transparent and that individuals who utilise them are protected.
d. Strive to create gender safe events and projects by:
    i. Adopting an intersectional approach to diversity and striving to champion a program that reflects the diversity of the general society.
    ii. Ensuring appropriate use of terminology and content warnings;
    iii. Establishing guidelines around acceptable behaviour related to gender;

5. Individual Medical practitioners to:
    a. Reflect upon and self-assess the potential for gender bias in their own hiring practices, remuneration and selection for training if involved in the recruitment process and change their practice accordingly;
    b. Speak out against gender-biased views and actions that do not meet reporting criteria but impact on the leadership potential of people of marginalised genders amongst their colleagues, in colleges, and in professional work spaces;
    c. Actively provide medical students and doctors of marginalised genders with mentoring and leadership opportunities.

AMSA calls upon:

1. The Commonwealth Government of Australia and Australian State & Territory Governments, and NGOs to:
    a. Formulate National, State, and Territory Sexual Health Strategies consistent with the WHO definition of Sexual Health
    b. Increase Sexually Transmitted Infection (STI) and Blood Borne Virus (BBV) education, prevention resources, and public health campaigns, particularly those that:
        i. Emphasise the importance of testing for STIs even when asymptomatic, and the risks associated with long-term untreated STIs
        ii. Provide free access to barrier contraceptives through general practice, sexual health and reproductive health clinics
        iii. Are tailored towards priority populations, through various channels such as social media and locations frequented by priority populations, including but not limited to:
            1. Men who have sex with men
            2. Sex workers
            3. Regional and remote populations
        iv. Provide routine STI and BBV testing in young adults (15-29) for STI prevention
        v. Cater for CALD (Culturally and Linguistically Diverse), refugee, and asylum seeker populations in their preferred language
        vi. Promote the uptake of HPV and Hepatitis B vaccination
        vii. Encourage harm reduction initiatives such as needle and syringe programs
    c. Increase the number of government funded sexual health clinics and service operating hours, particularly in regional and remote areas
    d. Increase the provision of STI services for individuals ineligible for Medicare, including, but not limited to:
        i. Travellers and mobile workers
        ii. People in custodial settings
        iii. Refugees and asylum seekers
    e. Support Aboriginal Community Controlled Health Services and Aboriginal Health workers to provide culturally safe prevention and harm reduction strategies that reduce the transmission and burden of BBVs and STIs among Aboriginal and Torres Strait Islander populations
    f. Increase funding to countries and organisations heavily impacted by the Protecting Life in Global Health Assistance Policy of 2017
    g. Improve awareness of, and access to, psychosexual therapy, allowing for the provision of a multidisciplinary care approach to the treatment of sexual difficulties.
    h. Ensure that political restrictions, crises, and/or emergency powers do not impede on access to sexual health measures including
        i. STI testing
        ii. Family planning measures
        iii. Internationally focused sexual health funding and initiatives
    i. Improve infrastructure to promote menstrual health and hygiene
    j. Develop national standards for sexual health education and resource provision in Australian public high schools, informed by sexual health education experts, and encourage its uptake in all Australian high schools, including:
        i. Consent education
        ii. LGBTQI specific education
        iii. STI prevention

2. Australian Universities and Medical Schools to:

a. Provide holistic sexual health education with a focus on psychosocial aspects of sexuality and essential skills in sexual history taking and counselling, in particular:
    i. Acknowledging the complex intersections that occur in relation to sexual health issues as a result of cross-cultural considerations, priority groups and the spectrum of sexual identities, behaviours and gender identities
    ii. Teaching of patient counselling on correct and consistent contraceptive use and regular STI testing
    iii. Teaching of sexual difficulties from biomedical, psychological and sociocultural perspectives centered on patient experiences
    iv. Reducing negative attitudes and stigma within the medical profession surrounding sexuality and sexual health
    v. Provide dedicated curriculum content which covers sexual pleasure and difficulties
    vi. Provide increased opportunities for student clinical placements in organisations that promote sexual health
b. Create a safe, accepting, and positive learning environment for students who identify as LGBTQIA+ by:
    i. Providing opportunities for students to provide feedback on how sexual health teaching can be made safer
    ii. Working with placement organisations to ensure they create a safe space for such students to express their sexual or gender identity
c. Provide free, youth-friendly, and accessible rapid STI and BBV testing for students at university campuses

3. The Australian Medical Council to:
    a. Develop a standardised and specific set of learning outcomes and competencies, with respect to sexual health education, by which all medical schools must abide; including but not limited to:
        i. A structured and holistic set of topics that must be covered
        ii. Mandated preclinical education in Sexual Health with a focus on training to teach

4. Australian Medical Students to:
    a. Be respectful, sensitive and open-minded in acknowledging diverse sexualities, gender identities, and sexual practices
    b. Challenge bias, stereotyping, heteronormativity, attitudes of shame, embarrassment, and stigma between students, patients, health care staff and other members of the community
    c. Accept those who may have different and diverse sexual, romantic and intimate practices including, but not limited to:
        i. asexual, aromantic, ace/aro spectrum individuals
        ii. consensual non-monogamy practicing
        iii. kink-practicing individuals
    d. Appreciate that sexuality and sexual health are determined by an intersection of biopsychosocial elements, and thus acknowledge the importance of these factors in history taking for sexual health.
    e. Build their sexual health knowledge, and advocate for increased sexual health education in their institutions
    f. Practice culturally-sensitive and respectful attitudes when addressing menstrual health related issues and topics.

5. Medical, Nursing, and Allied Health Professionals to:
    a. Ensure that personal values do not interfere with patient care
    b. Provide a safe space for all patients to share their sexual history and health concerns by actions such as, but not limited to:
        i. Provision of free relevant sexual health education materials

ii. Encourage a safe, judgement-free space for LGBTQIA+ individuals
iii. Reducing personal and workplace stigma surrounding sexual health that persist
iv. Tailored services and resources needed to address the specific and complex needs of individuals from vulnerable populations, including issues relating to culture, language and gender
v. Encourage routine screening for sexual satisfaction and difficulties in sexual health histories

c. Implement a culturally sensitive, appropriate and judicious approach to all sexual health issues including:
   i. Proactivity in the discussion of sexual health issues with patients
   ii. Recommending practitioners to not overlook sexual assessment and sexuality in people with disabilities and elderly people.
   iii. Provision of a safe environment to disclose sexual assault or intimate partner violence
   iv. Avoidance of casual microagressions and deliberate stereotyping, bias or discrimination against sexual minority groups
   v. Maintain lifelong learning of sexuality and sexual health from biomedical, psychological and sociocultural perspectives
   vi. Understand the specific needs and barriers faced by priority populations
   vii. Encourage members of the community to understand and appreciate the value of sexual pleasure in a culturally safe manner
   viii. Encourage protective behaviours during sexual health counselling such as contraceptive use and STI testing
   ix. Address sex toy usage and sharing as a risk factor for STI transmission in a comprehensive sexual health history
   x. Address menstrual health and hygiene-related topics

6. Research Institutions to:
   a. Increase research and reliable data on vulnerable populations including but not limited to, sex workers, culturally and linguistically diverse populations, Aboriginal and Torres Strait Islander people, rural and remote populations, travellers, mobile workers, and thosein custodial settings.
   b. Conduct more research into the state of sexual health education in medical schools and healthcare workers' continuing professional development
   c. Advocate for and pursue research on sexual disorders and sexual pleasure inclusive of the spectrum of gender identities and sexual orientations
   d. Further investigate the acceptability, feasibility and cost-efficacy of free condom distribution programs in tertiary institutions and other public institutions, especially those which cater to priority groups
   e. Increase research into menstrual health and hygiene in various Australian demographics, including homeless individuals, individuals living with disability, rural and remote populations and Aboriginal and Torres Strait Islander populations

Background

What is sexual health?

Sexual health is defined by the World Health Organisation (WHO) as "…a state of physical, emotional, mental and social well-being in relation to sexuality; [it is] not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence". All individuals have the right for their sexual health to be respected, protected and fulfilled.[1].

Sexual Identity

An individual's sexual identity and the way they engage with their sexuality is intrinsically linked with their sexual health and overall well-being [2]. Components of a person's sexual identity include their assigned biological sex, sexual orientation, gender identity and gender expression [3].

Sexual orientation refers to an individual's emotional or sexual attraction to another person. Examples include, but are not limited to, the following identities: heterosexual, gay, lesbian, bisexual, pansexual, asexual, demisexual and same-sex attracted [4]. Estimates of individuals who are gay, lesbian, bisexual, or of other non-heterosexual orientation across different studies and surveys vary from 2.7-8%[5, 6]. Noticeably there are higher rates in younger age groups, which may be due to social factors such as an increased willingness to disclose sexual orientation [5, 6]. It is important to recognise that these groups of individuals face unique physical, psychological, and sexual health risks [6].

Sexuality and Sexual Expression

Sexuality according to the WHO is "…a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction" [1]. To be able to express one's sexuality free of discrimination, so long as it respects the rights of others, is a sexual right, and has been to benefit individuals' health and quality of life [7]. However certain groups, as explored below, may be discriminated against with regards to their sexuality.

Consensual Non-Monogamy

There are various relationship structures beyond the traditional monogamous relationship in which individuals may express their sexuality. These are most broadly categorised under the term consensual non-monogamy (CNM), where partners explicitly agree they can enter romantic and/or sexual relationships with other individuals [8]. Examples of CNMs include open relationships, where couples have an emotionally intimate primary relationship and pursue additional sexual partnerships, and polyamory, which is an identity where individuals agree with and practice consensual multi-partner relationships [8]. Approximately 25.8% of people who practice polyamory have experienced discrimination of some form due to the lack of social acceptance[8]. Healthcare providers have historically been reported to condemn the moral character of patients who engage in CNMs or attempt to force patients to stop practicing CNM [9]. Such behaviour poses a significant barrier to health access for these patients [9]. As such, it is important for healthcare providers to be cognisant of and open-minded towards various forms of consensual sexual partnerships, to ensure every member of society's sexual health needs is equally fulfilled [9].

Kink-practitioners

Kink describes sexual behaviours and identities that involve bondage, discipline, domination, submission, sadism and masochism; collectively known as BDSM, and sexual fetishism [10]. Those who engage in kink practices are susceptible to facing stigma in the healthcare setting [68]. There is scope for sexual health care providers to work toward a vision of kink-aware medical care [11], especially when considering that engaging in BDSM behaviours is no longer deemed to be a mental disorder [12]. Consensual BDSM sexual activity needs to be normalised in a sexual health clinical setting to get a full picture of one's sexuality, practices, relationships, sexual satisfaction and sexual distress [13]. Despite people engaging in kink behaviours wanting and willing to be open with their healthcare provider, many are not due to the anticipation of clinicians confusing their behaviour as intimate partner violence or non-consensual activities [11]. There are genuine health care needs which arise from the engagement of kink, and being able to share this with their healthcare providers without fear of discrimination means they can receive care pertinent to their activities [11]. Clinicians should remove their own personal views on sexual behaviours, orientation, and biases when working with those engaging in kink in a clinical setting, and this comes from education and understanding [14].

Sexuality in elderly people

Barriers against sexual expression in the elderly are particularly prevalent in residential care environments due to factors such as judgemental staff attitudes, lack of privacy, prioritisation of other aspects of health over sexual health and inadequate knowledge or training [6, 15]. In fact engaging in sexual activities may improve physical and psychological well-being; research demonstrates that elderly couples who still engaged in sexual activities had significantly higher self esteem than those who did not [16]. As such, it is important for healthcare services and providers to be informed of and discuss sexuality and sexual health with elderly patients.

Sexuality in those with disabilities

People with disabilities are often deprived of their sexual and reproductive rights by members of society [4]. This is despite more than 15% of the world's population being affected by disability. Social stigma and misconceptions means that these individuals are often infantilised or thought to be unfit sexual partners [17]. Furthermore, a large proportion of people with disability report receiving inadequate information about sexual health or sexuality counselling in the context of their disability[4]. Key factors that have contributed to this are inadequate training and staff resistance to involvement in such education and counselling. Resistance from staff may arise from reasons such as discomfort discussing sexuality-related issues, as well as prioritising other medical and functional issues over sexual health[4]. As such, there needs to be greater institutional support for adequate provision of sexual health care, and further training on sexuality in people with disability for healthcare professionals [4].

STI and BBV Epidemiology

Sexually transmitted infections (STIs) are defined as infections spread predominantly through sexual contact as well as through non-sexual means, including exposure to blood and bodily fluids, and mother to child (vertical transmission) [18]. Blood borne viruses (BBVs) are also commonly transmitted sexually, and will be included in the following discussion.

STIs have substantial physical, psychological and social ramifications and can severely affect quality of life [18]. Some infections are associated with adverse health outcomes such as pelvic inflammatory disorder, cervical cancer, ectopic pregnancy, stillbirth, neonatal death, congenital malformation or infections, and an increased risk of acquiring Human Immunodeficiency Virus (HIV) [18]. STIs can have consequences for

all people regardless of gender, including infertility, Human Papillomavirus (HPV) related cancers of the anus and rectum, and pain during sexual intercourse [19]. STIs are also often asymptomatic; 70% of those with chlamydia and gonorrhoea, 30-40% of those with syphilis, and 50% of those with HPV report no symptoms [20]. This contributes significantly to both the spread of disease within the community, and a lack of testing and screening, particularly where testing resources or access is limited such as in rural and remote areas [20]. Early intervention is cost-effective and substantially reduces the burden of disease, disease spread, and further complications [21]. Therefore, it is vital that all affected individuals be diagnosed rapidly and treated adequately.

Annually there are 357 million incidental cases of the four most common curable STIs; trichomoniasis (156 million), chlamydia (127 million), gonorrhoea (87 million), and syphilis (6 million) [1]. Hepatitis B, Herpes simplex virus, HIV and HPV are the most common viral STIs [18]. Despite the advent of rapid diagnostic tests and affordable, effective treatments, globally there are still high rates of transmission as well as under-diagnosis and under-treatment, particularly in low and middle income countries [18]. Significant barriers to diagnosis and treatment include difficulty accessing testing, social stigma of disease, and lack of sexual health literacy [22]. Factors influencing spread of disease include age, education, poverty, availability of contraception, drug use, gender, and cultural contexts [22].

Rates of notification for the most common STIs and BBVs have risen significantly from 2009 to 2018, with Hepatitis B and C being the most common BBVs within Australia [22]. While chlamydia remains the most frequently notified STI in Australia, gonorrhoea notifications have increased 97% from 2014 to 2018, which is significant in light of increasing antimicrobial resistance [18, 22]. Syphilis notifications increased 146% from 2014 to 2018, and of particular concern is an ongoing infectious syphilis outbreak in remote and regional Australia among Aboriginal and Torres Strait Islander heterosexuals [22]. For both these diseases, the increase in notifications has outpaced levels of STI testing, providing evidence of increasing kki transmission and the need for more widespread testing [22].

Australia boasts a low incidence rate and highly successful screening, diagnosis, and treatment programs for HIV [22]. HIV notifications have decreased significantly from 2014 to 2018, largely due to more people living with HIV knowing their HIV status, earlier commencement of treatment, and widespread uptake of pre-exposure prophylaxis (PrEP) among gay and bisexual men [22]. This has been aided by the listing of PrEP on the pharmaceutical benefits scheme (PBS) in 2018, with 18,530 individuals dispensed PBS subsidised PrEP by the end of 2018 [22].

Contraception

Contraception use is vital in the prevention of unwanted pregnancy and transmission of STIs and BBVs [23]. The condom is the only contraceptive method that simultaneously achieves both purposes [23]. It provides a physical barrier to the passage of sperm and the potential pathogens in these bodily fluids [23]. The condom has a contraceptive efficacy of 97% with perfect use [24]. Since STIs can also be transmitted via pre-ejaculatory fluid or contact between infected mucosal surfaces, condoms should be applied before penetration rather than simply before ejaculation [23]. However 10-15% of condoms are applied after initial genital contact [23], and a range of other issues such as condom breakage and condom slippage may also occur [25]. This means that “typical use” success rates of condoms is only 86% [24]. In addition to correct condom use, consistency across sexual encounters is also important [23]. A 2014 study with 20,094 respondents found that 49% of individuals who had heterosexual vaginal intercourse with casual partners in the 6 months prior to their interview reported that they always used condoms [23]. In the 2018 National Survey of Secondary Students and Sexual Health, only 38.4% of sexually active

students always used condoms over the past year [26]. Therefore, health agencies and health professionals need to continue to promote both consistent and correct use of condoms [23]. This can be achieved by appropriate assessment of condom use and counselling of sexually active patients by healthcare practitioners regarding the importance of condoms in a comprehensive sexual health history as per Australian guidelines [27]. Furthermore, as per the Fourth National Sexually Transmissible Infections Strategy, the provision of free condoms can promote greater uptake of their use [28]. Whilst free condoms are currently distributed in sexual health clinics, other possible venues include universities, given that they are frequented by a vulnerable population of young people, as well as general practice clinics. An exploratory study held in the USA found high acceptability and feasibility of a university-wide condom distribution program via condom dispensers [29]. Further research should be done as to the efficacy and cost-benefit of such an approach in Australian universities as this is a potential method to increase access to and uptake of condom use in young tertiary students, who are a key vulnerable population with regards to STI transmission.

Studies have shown that in regards to anal intercourse, only 30% of heterosexual anal intercourse is protected with condoms [30], despite the higher chance of contracting STIs and BBVs through anal intercourse [31]. Understanding the risky behaviour is made safer by using condoms regardless of the genders engaging in anal intercourse, and the use of lubrication practices are important factors in preventing STIs and BBVs [32].

Since the introduction of PrEP since 2014 onwards, there has been both a significant uptake of PrEP and decreased engagement in consistent condom use during anal intercourse from 2013-2017 [33]. This 2013-2017 study found a statistically significant decline in consistent condom use from 46% in 2013 to 31% in 2017 [33]. Consistent condom use rates by gay and bisexual men in Sydney and Melbourne have been on the decline for over 15 years before this period, and have coincided with other protective sexual health behaviours such as increases in HIV testing, serosorting, and viral suppression through antiviral treatment [33]. Whilst these factors and PrEP use has been demonstrated to reduce HIV transmission, low condom use rates may result in increased incidence of other STIs and BBVs [33]. As a result, health professionals need to be aware of these trends of contraceptive usage in men who have sex with men and adequately counsel them on the benefits of condom use despite uptake of other HIV preventative strategies.

Inserted sex toys present a risk for STI transmission when shared between sexual partners. Sex toys are more frequently used by LGBTQIA+ people, who already face an increased risk of STI transmission particularly by women who have sex with women (WSW), bisexual, and lesbian women [34]. STIs such as HPV have been shown to be detectable up to 24 hours after typical cleaning, although choice of material, sex toy shape, and cleaning technique all had an effect on presence of HPV [35]. Knowledge of potential for STI transmission between women in this group is limited, and use of preventative measures such as washing hands, using rubber gloves, and using condoms on sex toys is uncommon [36]. Sharing of sex toys is also common among WSW and in group sexual encounters, posing a risk for transmission of STIs [36]. Robust education about the hygienic use of sex toys for people who use sex toys, as well as for health professionals is therefore necessary to prevent transmission of STIs.

STI testing

Testing and treating infected individuals minimises the harm of STIs to the individual and reduces the chance of STI transmission [37]. Regular STI testing is recommended for sexually active young people in Australia [37]. Young people between 15 and 24 years old are disproportionately affected by STIs [38] due to high-risk sexual behaviours such as lack of barrier contraception usage, more frequent casual sex, sex with multiple partners, and higher levels of alcohol use [39]. A range of barriers to accessing STI testing exist: These include personal barriers such as underestimating the risk of

STIs, fear of invasive procedures, self-consciousness, or a busy lifestyle [40]. Additionally, structural barriers such as financial cost and clinician attitudes, or social barriers of stigma prevent students accessing testing [40]. Young people express a strong preference for youth-friendly services, as well as provision of a safe environment for LGBTQIA+ youth to disclose their sexual behaviour [41]. Therefore, providing STI and BBV testing services that are free, rapid, confidential, youth-friendly, and conveniently available at university campuses is an effective and targeted approach to minimise STI and BBV transmission.

The five BBV and STI National Strategies of 2018 form a framework for an effective and coordinated national response to BBV and STI in Australia [42,43,44,45,46]. Monitoring, management, and treatment of STIs and BBVs are high priorities, with treatment also regarded as prevention of transmission in most cases [42,43,44,45,46]. Promotion of the uptake of the HPV and Hepatitis B vaccines, encouragement of harm reduction initiatives such as needle and syringe programs, and combining STI and BBV care with alcohol and drug treatment programs where appropriate are key initiatives of the strategies [42,43,44,45,46]. These strategies also explore how improvements could be made from a clinician and research standpoint. These include training greater numbers of the health workforce to diagnose and manage STIs, BBVs and HIV; increasing the use of multidisciplinary teams (MDTs) and shared-care models for chronic infections; reducing barriers to accessing adequate care (especially for vulnerable populations); further surveillance and research evaluation; and increasing PBS access to treatment for STIs, BBVs and HIV in the population [42,43,44,45,46,18].

Australian Priority Populations Epidemiology

Priority populations refers to population groups that are disproportionately affected by STIs and BBVs [47]. Many individuals may identify with more than one priority population, resulting in a diverse range of intersecting risk factors unique to each person [47].

It must be noted that this policy does not discuss an exhaustive list of populations affected disproportionately by STIs and BBVs, but aims to highlight the key populations described in the Fourth National Sexually Transmissible Infections Strategy [47].

Young people aged between 15 and 29 years old

Young people continue to be overrepresented in STI notifications. In 2017, chlamydia and gonorrhoea notification rates were highest in those aged 20-24 years in 2017 [22], and infectious syphilis notification rates were highest in those aged 25-29 years in 2017 [22].

Young people are exposed to a greater range of risk factors for STIs compared to older adults, particularly higher risk behaviours such as engaging in unprotected sexual intercourse [48], drug use [47] and alcohol consumption [47]. There are also other factors that act as barriers to STI prevention, testing and treatment. These barriers to STI prevention, testing and treatment include personal factors such as underestimating the risk or severity of contracting STIs [47] or lacking awareness about asymptomatic STIs [49]. There are also structural barriers including financial costs [47], access to Medicare [47], access to transportation to sexual health services [50], and sexual health service operating hours [50]. Social barriers are also likely to limit the utilisation of sexual health services, and include fear of judgement and stigmatisation (perceived or real) from healthcare workers [50], or feeling uncomfortable disclosing sexual health concerns with their GPs [49].

Therefore, comprehensive sexual health education and inclusive STI services targeted to the needs of this demographic are essential for reducing the burden of STIs in this population.

Aboriginal and Torres Strait Islander People

The notification rates of STIs and BBVs in the Aboriginal and Torres Strait Islander population continue to be disproportionately higher than those in the non-Indigenous population [51]. These STIs and BBVs include HIV (1.6 times), Hepatitis C (4.4 times), Hepatitis B (2.3 times), Chlamydia (5 times), Gonorrhoea (6 times), Infectious syphilis (6 times) and congenital syphilis (18 times).

The elevated syphilis notification rates can be partially attributed to the continuing outbreak of infectious syphilis that has spread to Northern, Central, Western and Southern Australia since January 2011 [52]. The outbreak is of significant concern and affects primarily young Aboriginal and Torres Strait Islander people aged 15 – 29 years [52]. There are considerable efforts underway to contain the syphilis outbreak, including funding targeted towards increasing health promotion initiatives for syphilis and other STIs and BBVs [52].

The disproportionate burden of STIs in Aboriginal and Torres Strait Islander populations are likely to be due to barriers to health service access and equity, including the lack of culturally respectful and responsive prevention, testing, treatment and support services for BBVs and STIs [47,53]. Discrimination and intergenerational trauma resultant of colonisation and the Stolen Generation additionally fosters a sense of distrust towards healthcare services [53], thereby limiting service utilisation. There are also complex sociocultural determinants that limit service access and utilisation, including lower health literacy, cultural barriers, concerns about confidentiality, feelings of stigma and shame, and overrepresentation of Indigenous people in custodial settings [53].

Culturally inclusive and safe approaches tailored to Indigenous populations, as well as partnership with Aboriginal and Torres Strait Islander communities are essential to identifying and remedying the barriers to good sexual health for this population.

Gay men and other men who have sex with men (MSM)

Gay men and other MSM have a higher prevalence of STIs and BBVs, such as syphilis and HIV, compared to the general population [47]. There have been increasing numbers of new chlamydia and gonorrhoea cases amongst gay and bisexual men since 2012 [47].
The transmission of hepatitis A and shigellosis cases during sexual contact via the faecal-oral route is also a serious concern in the MSM population [47].

Gay men and MSM are a high-risk population due to a number of reasons, including higher rates of asymptomatic transmission, the presence of other existing infections resulting in higher vulnerability, and unprotected anal intercourse with casual partners [47]. Barriers to STI control include insufficient frequency of STI testing and incomplete STI testing [54]. Reduced access and utilisation of sexual health services can be attributed to the non-inclusive settings of many health services, including stigma and discrimination [50], as well as heteronormative, cisnormative, exclusionary and other inappropriate language use by healthcare workers [50]. There is also a lack of staff informed sufficiently on current notions of sexual orientation and gender identity, which further discourages MSM from accessing health services [56].

Sex workers

The STI incidence in sex workers in Australia is among the lowest in the world due to effective health promotion programs, despite high numbers of sexual encounters [47]. However, there has been an increased incidence of chlamydia and gonorrhoea among sex workers in recent years, as well as specific barriers to sexual health services pertaining to sex workers that result in this population being listed as a priority population [47]. These specific barriers include stigma and discrimination associated with sex work, as well as regulatory and legal issues, such as criminalisation [47]. These

can hinder access and utilisation of health services critical for the prevention, testing and treatment of STIs, resulting in a higher risk of STIs for sex workers [47].

Culturally and linguistically diverse people (CALD)

Australia's CALD population encompasses a diverse range of people who have different cultural identities, lived experiences and are born in different countries [56]. The STI prevalence among Australia's CALD population remains unknown due to a lack of data, however, there is some evidence that has demonstrated an increased prevalence of certain STIs in this population [47].

Barriers to sexual health service access and utilisation include language and cultural barriers, stigma and fear, financial barriers and insufficient knowledge of STIs [47]. CALD people may also have negative perceptions of healthcare workers [50]. Health services have also been shown to be ineffective for CALD people due to the lack of awareness and understanding of issues specific to CALD populations amongst healthcare workers, such as fear of deportation and institutional barriers [58].

Australia's CALD population is continually expanding [47], emphasising the need for tailored approaches and services to address the specific cultural and language barriers to health service access and utilisation in this population.

Travellers and mobile workers

The increasing movement of people through domestic and global travel increases the opportunities for rapid STI transmission [47]. This is particularly problematic when considering the movement of individuals to and from areas with high incidences of certain STI categories, including drug-resistant strains that are challenging to treat [47]. Furthermore, there is evidence that people are more likely to engage in risky sexual behaviour when they travel, increasing the risk of STI transmission [47]. Ineligibility for Medicare further limits access to health services for travellers and international students, and may contribute to the high-risk status of traveller and mobile workers [47].

People in custodial settings

While there is still limited data on the prevalence of STIs in people within custodial settings in Australia, evidence from international research demonstrates that higher numbers of STI infections are acquired in custodial settings. Notably, more than 20% of the Australian prison population tested positive for hepatitis C in 2016 [58].

There is a higher risk for STI transmission due to the intersection with other priority populations, including Aboriginal and Torres Strait Islander peoples and sex workers [47,59]. Needle sharing for intravenous drug use and unsafe tattooing [60] additionally contribute to the increased burden of BBVs in this population.

Barriers to STI control in prison entrants include limited access to education and tools for STI prevention [47]. Ineligibility for Medicare and the Pharmaceutical Benefits Scheme (PBS), further limits access to health services and treatment for STIs [61]. Some prison entrants may also have had negative past experiences with the healthcare system [61], discouraging them from engaging with health services.

In order to provide a tailored response to this population, there is a need to investigate and provide consistent and comparable data on the prevalence and transmission risks of STIs and BBVs within custodial settings in Australia.

Regional and remote populations

Regional and remote populations experience specific barriers to health service access and equity compared to urban populations. These barriers include limited physical accessibility to health services, specialist STI services, recruitment and retention of staff, limited clinical capacity of staff, longer waiting times for GP appointments, delivery of test results, financial costs and concerns about confidentiality [47, 60].

Sexual Wellness: Promoting Sexual Pleasure and Acknowledging Sexual Difficulties

Promoting sexual wellness across the entirety of the life course through a biopsychosocial model is vital to provide sexual healthcare consistent with the WHO's definition of sexual health [1]. Physical and emotional wellbeing as related to sexual health and intimacy are impacted by the complex interplay of societal norms, cultural upbringing, previous sexual experiences/knowledge and biological determinants which allow for a fulfilling and safe sexual life [62,63,64]. However, not all individuals are able to achieve sexual pleasure or satisfaction. Sexual difficulties fall within four broad categories: lack of arousal, pain, orgasmic disorders and desire disorders [65,66].

Estimates of sexual difficulties within the Australian population among women and men are 41% and 34% respectively [67].While patterns of sexual difficulties reported alter across the life-course, women are more likely to experience challenges achieving orgasm, whereas men more often report erectile dysfunction [66,68]. As more than one third of the Australian population are impacted by sexual difficulties, there is an increasing need for clinicians to appreciate the implications of sexual difficulties and pleasure on their patient's lives [62,63,66, 67]. Routinely screening for sexual satisfaction, pleasure, and difficulties may elicit general and/or sexual health issues, prevent STIs, and promote sexual pleasure [69,70]. However, predominantly heteronormative narratives and lack of holistic sexual healthcare within curriculum, limits the assessment and multidisciplinary management of sexual difficulties and/or wellness in practice [69]. These barriers to adequate care are further compounded by society's heavy emphasis on penetrative sex and orgasm, leaving many individuals with sexual difficulties feeling isolated [71]. As intimacy within a relationship may positively or negatively influence one's sexual health, initiatives to increase access to psychosexual counselling are recommended [72].

Furthermore, one in three women globally will suffer inter-partner and/or sexual violence in her lifetime [73]. This is consistent with Australian data which reports 1 in 5 Australian women have suffered sexual violence [74]. The lasting negative impacts of sexual violence can lead to chronic pelvic pain and anatomical damage, difficulties forming and maintaining intimate partner relationships, exposure to STIs and unwanted pregnancy; all negatively impacting sexual health and wellness [75].

Sexual Health Education

In Australian medical schools sexual health education appears to be a minimal focus, although there is currently only a limited body of evidence to suggest this. A 2011 study found that the content taught and time spent on sexual health education varied greatly across medical schools, and that "training to teach" was a major unmet need of sexual health specialists [76]. Additionally, the teaching of sexual health issues affecting the LGBTQIA+ community is varied and often deficient, mainly focusing on how to differentiate between sexual behaviour and identity and obtain information about intercourse with same-sex partners, but neglecting to provide adequate instruction on sensitive communication skills and sexual history taking [77].

Despite the dearth of research into sexual health education in Australian medical schools, several studies exist abroad which depict a clear lack of quality sexual health education. A 2018 US survey found that only half of its medical schools mandate formal sexual health education [78]. 70% of study participants failed in four of six sexual health knowledge categories as well as overall in the quizzes disseminated in the survey, and a third of medical students considered pornography a source of sexuality education. An earlier US study indicated that even in universities with dedicated sexual health subjects, the focus remains largely on endocrinology and STIs, despite students advocating for more education on sexual development, child sexual abuse, healthy sexuality, and sexual dysfunction[79]. Students in this survey were found

to be less comfortable discussing sexual health issues with younger patients and those of the opposite sex, findings corroborated universally [79,80]. Noted barriers to implementation of adequate sexual health curricula in medical schools include lack of curriculum space, lack of perceived importance of sexual health education, religious influences, discomfort with sexuality and unqualified teaching staff [79,81].

Many Australian doctors do not seem to possess the required knowledge, skills, and attitudes to effectively address their patients' sexual health issues. General practitioners often neglect to elicit a sexual history from patients regardless of their sexuality [82,83,84]. Women who have sex with women have lower satisfaction with and continuity of GP care than heterosexual women [85], and patients who are MSM as well as those with a history of one or more STIs are less likely to seek sexual healthcare [86]. Many physicians lack confidence in offering sexual healthcare to refugee and migrant women, especially in relation to menopause, with major issues including lack of consult time, training, and knowledge, as well as cultural and linguistic barriers [86,87]. Most GPs believe the responsibility of initiating sexual health discussions rests with the patient [87]. As such, opportunities to screen for sexual health issues and gauge sexual wellness are often missed.

In tertiary institutions, more space in the curriculum should be allocated to sexual health education, with more opportunities to practice sexual history taking and experience sexual health-related placements. However, it should be noted that although this produces significant improvements in sexual history taking skills and knowledge, it does little to induce personal attitude changes about sexuality, highlighting the importance of inclusive and non-judgemental sexual health education from a young age [88]. Furthermore, whilst the biomedical aspects of sexual health are important, tertiary education should also emphasise its psychosocial aspects, creating a more inclusive environment for those medical students who identify as gender and sexuality diverse. Training should be made available for current practitioners to help them provide better sexual healthcare, especially to priority groups such as migrants, the elderly, and LGBTQIA+ individuals. Finally, more research must be conducted into the state of sexual health education in the Australian medical sector, to better guide future curriculum changes.

Sexual Health Stigma

Whilst contemporary social reality is such that overt discrimination has largely become socially unacceptable, it is evident that stigmatising ideologies persist in the Australian community[89,90]. For example, a 2010 US survey found that many sexuality and gender diverse medical students choose to conceal their identity in medical school [91]. Although the most common reason provided was that it was "nobody's business" (61.3%), a significant proportion of respondents cited fear of discrimination (43.5%) and societal or cultural norms (40.9%) as grounds for concealing their identity. Further, around 40% of HIV positive individuals note negative reactions from community members upon learning their HIV positive status [90]. Women in particular experience forms of HIV-related violence, such as sexual and non-sexual physical violence, emotional abuse, and forms of child sexual abuse [90]. These examples demonstrate that while explicit discrimination of sexuality and sexual preference has been socially rebuked, implicit bias, or implicit perceived stigma against sexuality, sexual identity and/or STI-status remains pervasive [92,93].

Stigma against individuals with active STIs, particularly by healthcare workers, has been a detriment [92] in encouraging individuals to access healthcare and other support services. Stigma has been perpetuated by harmful negative social perceptions, due to a lack of public knowledge surrounding STI transmission. Some of these include: misconceptions of STI-positive individuals being excessively promiscuous and engaging in unsafe sexual practices. Additionally, trepidation towards painful examination [91], inappropriate patient-blaming of sexual deviance [89,90,93,94,95]

and use of stigmatising, exclusive and heteronormative language [50] all decrease the quality of care able to be provided to individuals who do seek care [92].

Stigma stands as a powerful barrier to obtaining quality care for sexual health for individuals. Reducing stigma towards STIs should be regarded as a key activity in enhancing sexual health throughout a global landscape as it facilitates uptake of STI services and improves sexual health, including equitability to sexual health access, sexual health promotion, education and greater connection between service providers and patients [92,96,97].

NGOs and Sexual Health Providers

The 1984 Mexico City Policy is an American federal policy that has been extremely detrimental towards the ability of NGOs that receive US funding to provide robust sexual and reproductive health measures. Whilst it is a policy that revolved around 'Abortion', it has had wide ranging implications on the provision of sexual health services from NGOs as a whole. The policy is colloquially known as the global gag rule (GGR), and NGOs must use their own funds not from the United States to provide abortion services, but away from abortions and family planning. The Policy has caused the deterioration of entire organisations that provide sexual health measures [98]. In 2017 President Trump reinstated the Mexico City Policy, renaming it as 'Protecting Life in Global Health Assistance' which to this day impacts and impedes funding for sexual health issues including HIV, gender-based violence, and sanitation and hygiene. While President Biden repealed the policy in 2021, there is still extensive correction into NGOs that needs to occur, and to ensure the global gag rule is not implemented again a permanent policy needs to be created to support sexual and reproductive health internationally. To overcome the continued resistance to sexual health rights, alliances between NGOs are suggested to build a stronger community [99], as the gains in sexual health have been undermined by various religious and conservative groups, particularly since the early 2000s [100].

The Australian Government through the Department of Foreign Affairs and Trade (DFAT) contributes to Global Sexual Health Initiatives through the International Planned Parenthood Federation with a core contribution of $3.6 Million [101]. IPPF provided 252.3 million Sexual and Reproductive Health Services in 2019, the latest available data [101]. DFAT provided an additional $825000 to strengthen the COVID response in an attempt to provide continuing services during lockdown to the IPPF. DFAT also contributes a core contribution of $4.5 million towards the Joint United Nations Programme on HIV/AIDS, and a blanket $12.4 to the World Health Organisation that contributes towards some elements of sexual health in the global community [101]. It is clear that Australia does not contribute significantly towards global Sexual Health initiatives.

COVID-19 impacts on Sexual Health-What we can learn for future health crises

The COVID-19 pandemic has presented the world of sexual health with many opportunities and challenges, predominantly dictated through the accessibility and availability to take up innovation. In the United Kingdom, Marie Stopes International readily adopted the use of telemedicine and within Australia telehealth sexual health services were established and subsided by the Australian Government [102]. However in many countries these services were constrained by shortcomings of regulation, finances, poor infrastructure and lack of political will [103].

The nature of lockdowns impacted all nations and their sexual health services with the number of absolute attendees to sexual health clinics in Australia declining due to the prioritisation of the pandemic over one's sexual health [104]. While there are reports of reduced STI incidence, there is insufficient data to determine whether this is real or due

to a huge decline in patient attendance at sexual health clinics [22]. Decreased STI testing during the pandemic may be due to social restrictions (leading to reduced sex with casual partners), fear of contracting COVID-19 in healthcare settings despite the presence of STI symptoms, or reluctance to use telehealth services to discuss sexual health matters [105].

The physicality issue of the pandemic has been the most impactful on developing nations, where the travel restrictions and the barring of movement limited access of impacted frontline healthcare providers to from physically accessing those most vulnerable[106]. Furthermore, global , and global supply chains for sexual health commodities have been severely impacted for all countries but most poignantly in nations reliant on NGOs for such resources [103]. The pandemic has elucidated the fragile nature of sexual health measures from domestic to global scales. We must ensure political restrictions and crises do not impact on access to sexual health measures in the future.

Menstrual health and hygiene

Menstrual health and hygiene (MHH) is an ongoing global issue which is linked to gender inequity, global health and poverty and exacerbated by]the lack of knowledge on menstruation, and insufficiency in essential health interventions, including sanitation and hygiene [107].

MHH is defined by a state of complete physical, mental, and social well-being and not merely the absence of disease related to the menstrual cycle [107]. All individuals who experience a menstrual cycle should be able to access age-appropriate information regarding menstruation and changes associated with puberty alongside appropriate access to hygiene and health services and privacy [108]. Additionally, individuals should be able to experience a respectful environment without stigma and psychological distress free from menstrual-related exclusion, discrimination, coercion and/or violence [108].

While the removal of the Goods and Services Tax on feminine hygiene products shows a public acknowledgement of the necessity of MHH [109], Australia has not done enough to improve access to menstrual hygiene tools, enhance menstrual education and reduce menstrual-related stigma, hence period poverty persists rampantly throughout the Australian community. Inaccessibility to hygiene products, whether by cost, unawareness or by lack of materials, has been shown to lead individuals into using unhygienic materials, such as rags, which is unfortunately also associated with increased risk of genitourinary infection [108]. Further, research within Indigenous Australian populations also identifies deficits in privacy, pain management resources, puberty education and access to facilities such as sanitary bins [109].

South Australia's recent introduction of free sanitary products in South Australian public schools can be recognised as positive movements towards period poverty eradication [110,111]. The trial showed that the provision of free menstrual hygiene products, which could be accessed discreetly, improved school attendance and student satisfaction [110,111].

Furthermore, an investigation into MHH interventions in Uganda included training teachers to provide puberty education, use of a menstrual kit, pain management and sanitation and hygiene facility improvements [112]. The results found students reported less menstruation anxiety (58.6% to 34.4%) and more effective pain management from 91.4% of menstruating students, as opposed to the prior 76.8%. Students also felt more comfortable with managing menstruation with improved facilities [112]. These results highlight proper education and access to sanitary products as viable solutions in combating menstrual-related stigma and improving menstrual awareness.

Overall, crucial understanding into the state of MHH across diverse populations within Australia is inadequate, particularly regarding individuals from diverse financial backgrounds, homeless individuals, individuals living with disability, rural and remote populations in addition to Aboriginal and Torres Strait Islander populations [109]. From a primary level, multifaceted invention into public sanitation facilities and culturally-sensitive education are acceptable and feasible methods as an initial step in addressing MHH insufficiencies and barriers [109].

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Policy Details

Name: Sexual Health (2021)

Category: G – Global Health

History:

Reviewed, Council 2, 2021
Alessia Zen, Ally Yates, Anton Vellnagel, Angela Lan, Sally Yang, Maryanne Li, Kai Matsumoto, Robert Oakenshott (Policy Mentor), Sally Boardman (Global Health Policy Officer)

Reviewed, Council 1, 2018
L Taylor, AM Plant, M Cherry, R Horn, K Elliott, N Tomar, R Mahesh

Adopted, Council 2, 2016
Amalgamation of Sexual Health (2014) and HIV/AIDS (2014) Policies