Australian Government
Department of Health, Disability and Ageing

National Women's Health Advisory Council

National Women's Health Strategy 2020-30 Monitoring and Reporting Framework Baseline report

National Women's Health Strategy 2020-30 Monitoring and Reporting Framework

Baseline report

Department of Health and Aged Care

August 2024

Minister's foreword

I am very excited to be appointed the Assistant Minister for Health and Aged Care, Assistant Minister for Indigenous Health, and the Assistant Minister for Women as part of a Government that has a strong commitment to improving health outcomes for women and girls in Australia.

The National Women's Health Advisory Council (the council) that provides advice to Government on the implementation of the National Women's Health Strategy 2020-2030 (the strategy), suggested a Monitoring and Reporting Framework for the strategy be developed. This document is the initial baseline assessment; it helps us understand the progress made in implementing the strategy from its commencement in 2020 to May 2024.

The assessment shows significant progress and effort being made by delivery partners to support the health outcomes for Australian women. I am grateful to the many stakeholders who have contributed to these efforts.

The baseline assessment also identified areas for improvement, including addressing sexual and reproductive health workforce shortages in rural areas, improving menopause-related health care, and increasing investment in chronic conditions and primary prevention services. Since the baseline assessment was undertaken, the further investments the Australian Government has announced will help to address some of these gaps in care.

As part of the 2025-26 Budget, the Australian Government is making a $792.9 million investment in women's health for increased support for perimenopause and menopause, and sexual and reproductive health. This includes:

- $443.4 million for more medicine listings on the Pharmaceutical Benefits Scheme to increase access to cheaper medicines for women to manage menopause and endometriosis, and provide more oral contraceptive pill options.
- $159.9 million to make it easier for women in Australia to access and afford long-acting reversible contraception (LARCs).
- $109.1 million to support Women's Health Trials through pharmacist services for the treatment of uncomplicated urinary tract infections and to access contraceptives.
- $64.5 million to improve access to high-quality models of care for endometriosis and pelvic pain, and perimenopause and menopause management and support.
- $16 million for continuity of maternity services to support women and their babies.

I look forward to delivering these important government commitments and working in partnership with the sector to continue to drive progress toward our shared goals.

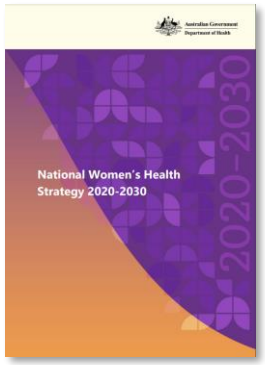
The Hon Rebecca White MP
Chair, National Women's Health Advisory Council
Assistant Minister for Women
Assistant Minister for Indigenous Health
Assistant Minister for Health and Aged Care

About this report

This is the third and final deliverable, following on from the finalisation of a Monitoring and Reporting Framework and interim report.

The National Women's Health Strategy 2020-2030

The National Women's Health Strategy (the strategy) outlines Australia's national approach to improving the health of women and girls – particularly those at greatest risk of poor health – and to reducing inequities between different groups.



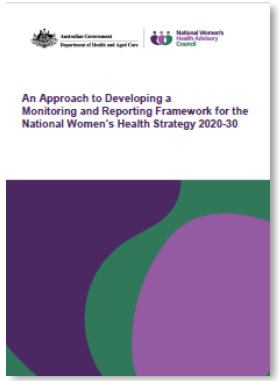
The Strategy identifies the current policy gaps and emerging health issues in women's health in Australia, with the aim of informing targeted and coordinated action at the national and jurisdictional levels to address the priority health needs of women and girls in Australia.

The strategy outlines five key priority areas (listed on the right) with a suite of actions mapped to each priority area. Key measures of success (i.e. population health outcomes) are identified for each priority area.

- Maternal, sexual and reproductive health
- Healthy ageing
- Chronic conditions and preventive health
- Mental health
- Health impacts of violence against women

A Monitoring and Reporting Framework for the National Women's Health Strategy

Deloitte Access Economics was engaged by the Department of Health, Disability and Ageing (the Department) to develop a Monitoring and Reporting Framework that outlines an approach to evaluating the implementation and outcomes of the strategy.



The purpose of the framework is to enable an assessment of the extent to which key stakeholders have implemented activities in alignment with the strategy, and to monitor change in outcomes measures. To enable this assessment, this framework is structured across two components:

- Implementation monitoring
- Outcome monitoring

Monitoring and Reporting for the strategy | Baseline report (this document)

The framework will start being implemented through a baseline assessment. This baseline report (and an accompanying scorecard/dashboard) summarises the findings of this baseline assessment.

The purpose of this baseline report is to provide a current state summary on the extent to which key stakeholders have implemented activities in alignment with the strategy (focusing on the period from 2020 to May 2024) and to monitor changes in population health outcomes for women and girls over time (focusing on the last five or ten years of data, depending on data availability across outcomes).

- Implementation progress is assessed with a criteria-led approach, drawing on stakeholder consultation and a desktop review of key aligned activities.
- Outcome progress is assessed through trend analysis of key data indicators, using publicly available data sources.

Contents

Acronyms

Acronym	Full name
ABS	Australian Bureau of Statistics
ACD	Australian Cancer Database
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
ALSWH	Australian Longitudinal Study on Women's Health
AMA	Australian Medical Association
BoC	Birthing on Country
CALD	Culturally and linguistically diverse
COCP	Combined Oral Contraceptive Pill
COPE	Centre for Perinatal Excellence
CVD	Cardiovascular disease
DFSV	Domestic, Family, and Sexual Violence
GP	General Practitioner
HILDA	Household Income Labour Dynamics in Australia
IUD	Intrauterine device
LARC	Long-Acting Reversible Contraception
LBTI	Lesbian (and gay), bisexual, transgender and intersex people
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual
MBS	Medicare Benefit Schedule
MTOP	Medical Termination of Pregnancy
NACCHO	National Aboriginal Community Controlled Health Organisations

Acronym	Full name
NASS	National Ambulance Surveillance System
NBCSP	National Bowel Cancer Screening Program
NCSP	National Cervical Screening Program
NCSR	National Cancer Screening Register
NHMD	National Hospital Morbidity Database
NHMRC	National Health and Medical Research Council
NMDB	National Mortality Database
NNDSS	National Notifiable Disease Surveillance System
NPDC	National Perinatal Data Collection
NSMHW	National Survey of Mental Health and Wellbeing
Strategy	National Women's Health Strategy
PBS	Pharmaceutical Benefits Scheme
PSS	Personal Safety Survey
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SES	Socioeconomic status
SRH	Sexual and reproductive health
TGA	Therapeutic Goods Administration
WHO	World Health Organization

1 | Executive Summary

This section summarises the key findings in this Baseline report of the National Women's Health Strategy

Executive summary | Context

Context to the strategy

Since the release of the strategy, the landscape for women's health has changed significantly. In 2020 – the year the strategy commenced, the COVID-19 pandemic spread across the globe, disrupting routine health care services, and absorbing the attention of policymakers and the health system. Not only did the emergence of COVID-19 pull attention from the strategy, but it also aggravated the challenges identified in the strategy, including workforce shortages and inequitable access to services across priority groups.

In 2023, the Australian Government continued to support the work of the strategy, forming the National Women's Health Advisory Council (the council). The council provides strategic advice to the Government on improving Australia's health system for women and girls and offers recommendations on the implementation of the strategy. Since its inception, the council has undertaken a range of actions to support women's health, including conducting the #EndGenderBias survey in 2023 to better understand lived experiences of gender bias in health care.

An ongoing challenge for the strategy is the lack of data available on women's health, including access to care and service use. For decades, women's health and experiences with the health care system have been under-researched and underfunded. Prior to the 1990s, many major research bodies excluded women from medical trials altogether. As a result, when the strategy was created, large data gaps existed in women's health. Many of these data gaps remain, complicating efforts to understand the influence of the strategy and progress of women's health more broadly. This report aims to use the data available to provide a baseline of women's health outcomes for future monitoring.

Executive summary | Background

This report

The National Women's Health Strategy (strategy) outlines Australia's national approach to improving health for all women and girls in Australia. Deloitte Access Economics was engaged by the Department of Health, Disability and Ageing to develop a:

1. Monitoring and Reporting Framework (the framework) that outlines an approach to evaluating the implementation and outcomes of the strategy
2. Baseline report to provide a current state assessment of the strategy based on the approach outlined in the framework.

This report is the baseline report. Its purpose is to provide a current state summary on the extent to which key stakeholders have implemented activities in alignment with the strategy (progress of the strategy's inputs and activities) and to monitor changes in population health outcomes for women and girls over time (the outputs and outcomes of the strategy). The baseline report is structured across two components:

1. Implementation monitoring and reporting. The report uses a criteria-led approach to assess the strategy's implementation progress at a priority area level, informed by stakeholder consultation and desktop review evidence of key activities.
2. Outcome monitoring and reporting. For each key measure of success outlined in the strategy, key data indicators are identified and mapped to publicly available data sources. These indicators are presented in this report as well as a visual dashboard.

For this baseline report, Deloitte Access Economics consulted stakeholders, reviewed Department of Health, Disability and Ageing documents, completed extensive desktop research and analysed available data on women's health. Importantly, this report is not intended to attribute progress in women's health actions or outcomes to the strategy, but rather, to consider whether stakeholders have implemented activities in alignment with the strategy and whether progress has been achieved in women's health more broadly. Particularly for actions, this report is not exhaustive with respect to all the initiatives being implemented across Australia that might align with the strategy.

This report covers the period 2020 to May 2024. Since this assessment was undertaken, the Australian Government announced as part of the 2025-26 Budget a $792.9 million investment in women's health to deliver improved health care access and affordability for women and girls. This investment included:

- measures to make it easier for women to access and afford long-acting reversible contraception (LARCs)
- a range of measures to support women during peri-menopause and menopause, including a public awareness campaign and the development of national clinical guidelines
- more endometriosis and pelvic pain clinics, and the scope of the network expanding to include specialist support menopause and perimenopause
- listing a number of medicines for women and the Pharmaceutical Benefits Scheme (PBS) including oral contraception and menopausal hormone therapy (MHTs)
- support for Women's Health Trials for the treatment of uncomplicated urinary tract infections (UTIs) and supply of hormonal contraceptives under the eighth Community Pharmacy Agreement.

Executive summary | Progress in women's health

Since 2020, stakeholders indicated that **public awareness around women's health has grown**, reflecting increased grassroots efforts, advocacy by non-government organisations, scientific advancements, understanding of the impacts of family violence, visibility around the gender pay gap and unpaid work, and increased effort by government. This growth in awareness relates to specific health conditions, such as endometriosis, as well as a broader understanding that women's health is distinct from men's health and requires substantive investment.

However, **it will take time** for this increased awareness to translate into action and for action **to produce a meaningful change in outcomes.** For example, preventive efforts to improve women's health are realised over the lifetime rather than at a point of implementation. Correcting for the systemic under-funding and lack of research into women's health, as well as ongoing biases in delivery, will be a lengthy process requiring sustained investment. Stakeholders cautioned that meaningful changes in outcomes targeted by the Monitoring and Reporting Framework may not be apparent until after the strategy ends in 2030.

Importantly, this should not discount the fact that some system changes can be (and in some cases have been) implemented with immediate impacts – for example, changing the Medicare Benefits Schedule (MBS) to avoid disincentivising long consults (with the introduction of the new item E consultation introduced in November 2023), improving the integration of technology in cancer screenings for General Practitioners (GPs) and increasing links between GPs and domestic, family and sexual violence (DFSV) workers.

Meaningful change will require that a **gender lens is applied across all priority areas**. This report has identified that, at present, a gender lens is rarely considered in relation to healthy ageing, chronic conditions and preventive health, and mental health. Government investments and health care practitioners have historically overlooked how sex- and gender-specific factors, such as biological differences and social norms, can impact an individual's health and experience with the health care system. For example, there is limited evidence of gender-specific investments that address the conditions faced by women as they age, such as dementia.

Further, improvements in women's health outcomes will also depend on **tackling gender bias**, which remains prevalent across health care and social services. Gender bias in health care is responsible for a range of disparities between men and women, across diagnosis, treatment and access to care. For example, women are consistently provided with less support for pain management than men, despite reporting higher levels of it, due to a perception that they are "more sensitive."[1] Addressing gender bias will require an increase in the capacity of the health care system to address the complexity of women's health across all care settings. For instance, Australian general practitioners (GPs) are financially incentivised to keep appointments short despite a recent poll finding that 65% of doctors agree that the most pressing change needed for female patients is more time.[3] Notably, racism within the health care system is also prevalent (and well-documented for Indigenous Australians, for example), can exacerbate bias for women of colour and needs to be addressed.[2]

Importantly, the health outcomes of women differ significantly based on identity, with particularly **large gaps in outcomes experienced by First Nations peoples.** Across all priority areas, First Nations peoples continue to have significantly poorer health outcomes than the general population, reflecting the ongoing impacts of colonisation, as well as economic marginalisation, geographic barriers, discrimination from within the health care system and cultural barriers. While some positive progress has been made since 2020, such as *Birthing on Country* initiatives, more substantive efforts will be required to close these gaps. Where data has been available for this report, it has also made clear that **other groups of women also face poor health outcomes** – including women in regional, rural and remote areas, women who are non-English speaking or born overseas, and women from lower socio-economic groups. For other priority populations identified in the strategy, such as LGBTIQA+ women and gender diverse people, young women or women with disabilities, there is rarely any data available; however stakeholders emphasised the poor health experiences and outcomes of these cohorts.

The next page highlights five key improvements and five key gaps identified across all the priority areas in the strategy, with the following pages presenting findings by priority area.

Executive summary | Five improvements and five gaps

Five improvements

1. Action on abortion and long-acting reversible contraception (LARC)

Government and non-government agencies alike are taking action to increase the access to abortion services and LARC. Since 2020, the Australian Government has funded trials into pharmacist and nurse-led LARC services in 32 regional areas, the Therapeutic Goods Administration has deregulated the prescription of MS-2 step, and Western Australia has decriminalised abortions.

2. *Birthing on Country* (BoC) initiatives

BoC centres, First Nations community-controlled maternity services, continue to be rolled out across Australia; for example, the Australian Government invested $22.5 million in building a *BOC* centre in Nowra, NSW, in 2022. BOC centres have been found to significantly improve the health of the infant and birthing parent.

3. Funding for endometriosis research, awareness and care

In 2022-23, the Australian Government announced a $58.1 million package for endometriosis and pelvic pain. This funding is being used to establish 22 dedicated *Endometriosis and Pelvic Pain Clinics* across Australia, develop an *Endometriosis Management Plan* for patients in primary care and close research gaps.

4. Investment in tackling eating disorders

Since 2020, governments have made significant investments in addressing the impacts of eating disorders. For example, in 2023, the Australian Government committed $20 million to improve eating disorder services, education health professionals, and support patients, their families and carers.

5. The *Statement on Sex, Gender, Variation of Sex Characteristics and Sexual Orientation in Health and Medical Research* (the Statement)

In July 2024, the NHMRC and the Department of Health, Disability and Ageing released the final Statement, which provides guidance on the consideration of sex, gender, variations of sex characteristics and sexual orientation throughout the design, conduct, analysis, reporting, translation and implementation of all research.

Five gaps

1. Sexual and reproductive workforce shortages in rural areas

The 2023 Commonwealth Senate *Inquiry into Universal Sexual and Reproductive Health Access* found that workforce shortages in sexual and reproductive health care has led to a 'postcode lottery.' While investments have been made since the *Inquiry*, further funding will be required to sufficiently upskill and staff regional Australia. Stakeholders also noted that individuals in these areas are normally employed on year-to-year term-based contracts, leasing to high turnover and uncertainty in the provision of these services.

2. Substandard menopause-related health care

Stakeholders revealed that menopause management, including menopausal hormone therapy (MHT), is undermined by a lack of evidence and clinician knowledge (particularly in primary care), poor access to services, negative attitudes and lagging research.

3. Insufficient investment in chronic conditions, including pain

While significant investments in endometriosis care have been made since 2020, similar investments are needed in the treatment of other chronic conditions, including those related to pain. For example, stakeholders revealed that services for women experiencing anaemia and osteoporosis are underfunded.

4. Ad hoc primary prevention and long-term recovery services for domestic, family and sexual violence (DFSV)

Services that address the health impacts of DFSV have been systematically underfunded over time. In recent years, efforts to address these impacts have been primarily focused on immediate crisis support. As a result, the current delivery of primary prevention services and long-term supports (such as, redress services) is inconsistent and insufficient.

5. Lack of data disaggregated by priority group status

There is very limited disaggregation of women's health data by priority group status (including First Nations, CALD, disability, LGBTIQA+). As a result, it is difficult to assess the health care needs, service use and outcomes of these groups.

Executive summary | Progress against priority areas and the ongoing role of the strategy

At a priority level, evidence collected for this report indicates that there is a need for dedicated focus to progress many of the actions listed in the strategy. The progress assessment found that 7 out of 20 priorities (35%) are rated as 'requiring stronger focus' and 10 out of 20 priorities (50%) are rated as 'some progress.' However, there are pockets of meaningful progress, with 3 out of 20 priorities (15%) rated as 'meaningful progress.' Below is an evidence summary on the implementation progress of each priority area.

- Priority Area 1 – Maternal, sexual & reproductive health: Public awareness and understanding has improved due to a range of educational initiatives. Access to sexual and reproductive health care, including abortion and LARC, has increased. The models of care of maternity services delivered to First Nations peoples have increased with the expansion of BOC centres. However, far more action is required to ensure equitable access across priority groups, particularly in regional and remote areas, and in response to the recent reduction in some maternal, sexual, and reproductive health services nationally.

- Priority Area 2 – Healthy ageing: There is evidence that the health sector is increasingly adopting a life course approach to healthy ageing, and of growing awareness and action in specific areas (such as menopause and dementia). However, there is confusion among health providers around how a life course approach to healthy ageing differs for women relative to men and, as a result, limited evidence of a gender-specific approach being applied.

- Priority Area 3 – Chronic conditions and preventive health: There is evidence of greater efforts to raise awareness and improve primary prevention of chronic diseases – but for the general population, rather than specifically focusing on women (some exceptions exist, such as awareness campaigns on heart disease risk factors for women). Stakeholders noted clear implementation progress for endometriosis, without significant action on other chronic pain conditions. For most chronic conditions, health services and measures are rarely tailored to the unique needs of women.

- Priority Area 4 – Mental health: Stakeholders noted increased awareness and reduced stigma related to mental health issues and supports – however without a gender-specific lens. Similarly, progress was identified in eating disorder awareness and support, such as in schools, and other areas of service delivery, but often without a gender or priority population lens. Concerns were raised in consultation about the lack of focus on preventive mental health care, poor access to specialist mental health services (including psychiatrists), the fragmentation of care across providers and a lack of integration with other health care services.

- Priority Area 5 – Health impacts of violence against women: Stakeholders noted that action against this priority area largely relates to violence against women, as compared to the associated health impacts. Regardless, positive examples were provided of training provided to health professionals to manage the health impacts of violence against women, and co-designed and trauma-informed models of care.

- Investing in Research: While there have been improvements in the disaggregation of data by sex and gender, significant blackspots remain – including for chronic fatigue and incontinence. Further, there is very limited data disaggregated by priority group status including by First Nations and culturally and linguistically diverse (CALD) status. As such it is difficult to assess the health care needs, service use and outcomes of these groups. Researchers identified that there is low awareness of existing datasets and insufficient investment in data analysis, leading to missed opportunities and duplication.

Executive summary | Progress against priority areas (1/2)

Priority 1 – Maternal, Sexual and Reproductive Health

Actions	Requires stronger focus	Some progress	Meaningful progress
Increase access to sexual and reproductive health care information, diagnosis, treatment	○	●	○
Increase health promotion activity to enhance and support preconception and perinatal health	●	○	○
Support enhanced access to maternal and perinatal health care services	○	●	○

Outcomes	Score
Decrease in the notification rates of sexually transmissible infections	No observable change
Increase in the availability and uptake of Long-Acting Reversible Contraception	Positive upward trend
Equitable access to pregnancy termination services	No observable change
A continued increase in the rate of vaccinations under the national HPV program	No observable change
Increased early access to antenatal services by Aboriginal and Torres Strait Islander women and CALD women	Positive upward trend
De-stigmatisation of urinary and faecal incontinence and improved access for women to care for these conditions, including pelvic floor physiotherapy	Insufficient data available
Improved access to counselling and care of adult women with sexual function concerns	Insufficient data available

Priority 2 - Healthy Ageing

Actions	Requires stronger focus	Some progress	Meaningful progress
Adopt a life course approach to healthy ageing for women	●	○	○
Address key risk factors that reduce quality of life for women as they age	○	●	○
Better manage the needs of an ageing population	●	○	○

Outcomes	Score
Reduction in the number of preventable and avoidable deaths	Positive downward trend
Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease	No observable change
Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity	Positive upward trend

Priority 3 – Chronic Disease and Preventive Health

Actions	Requires stronger focus	Some progress	Meaningful progress
Increase awareness and primary prevention of chronic conditions and associated risk factors for women and girls and embed a life course approach in policy and practice	●	○	○
Invest in targeted prevention, timely detection and intervention of chronic conditions affecting women and girls	○	●	○
Tailor health services to meet the needs of all women and girls	●	○	○
Reduce the prevalence and impact of endometriosis and associated chronic pelvic pain	○	○	●

Outcomes	Score
Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women	No observable change
Lower incidence of cancer	Negative upward trend
Improved rates of breast, cervical and bowel cancer screening for under-screened populations	No observable change
Decrease in prevalence of chronic conditions in women	Positive downward trend
Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and manageing these conditions	Positive upward trend

Executive summary | Progress against priority areas (2/2)

Priority 4 – Mental Health

Actions	Requires stronger focus	Some progress	Meaningful progress
Enhance gender-specific mental health education, awareness and primary prevention	●	○	○
Focus on early intervention, diagnosis, integration and access to mental health care services	○	●	○
Invest in service delivery for priority populations	○	●	○
Adopt a multi-faceted approach to support women and girls with eating disorders	○	○	●
Raise awareness and embed practices to reduce stigma and discrimination associated with mental ill-health	○	●	○

Outcomes	Score
Lower incidents of mental health reporting, self-harm and suicide	No observable change
A reduction in mental health related illness	Negative downward trend
Increase in the number of mental health services and ability for priority populations to access	Positive upward trend
Greater integration of mental and physical health care	Insufficient data available

Priority 5 – Health impacts of violence against women

Actions	Requires stronger focus	Some progress	Meaningful progress
Raise awareness of the health impacts of violence against women and girls	●	○	○
Address health and related impacts of family and sexual violence	○	●	○
Co-design and deliver safe and accessible services for women experiencing family, intimate partner and/or sexual violence	○	●	○

Outcomes	Score
Increase in number of services available, and women accessing these services	No observable change
Decrease in deaths from physical violence on women	No observable change
Reduction in the proportion of women who have experienced abuse or trauma in their life	No observable change
Reduction in the rate of reproductive coercion	Insufficient data available
Reduction in the gap in mental and physical health trajectories between women who have and have not experienced violence	No observable change

Investing in research

Actions	Requires stronger focus	Some progress	Meaningful progress
Strengthen and diversify research and data collection across identified health priorities for women and girls	○	●	○
Build research capacity and capability in women's health	○	○	●

2 | Introduction

This section explains the context and methodology of this Baseline report for the National Women's Health Strategy

Introduction | Structure of actions and outcomes in the National Women's Health Strategy

The National Women's Health Strategy is organised into five priority areas with an additional section on Research, which each outline a series of sub-priorities and actions, and are associated with a set of outcomes (with the exception of Research).

Priority area 1: Maternal Sexual and Reproductive Health

- **Priority 1.1:** Increase access to sexual and reproductive health care information, diagnosis, treatment and services
- **Priority 1.2**: Increase health promotion activity to enhance and support preconception and perinatal health
- **Priority 1.3**: Support enhanced access to maternal and perinatal health care services

Priority area 2: Healthy ageing

- **Priority 2.1**: Adopt a life course approach to healthy ageing for women
- **Priority 2.2**: Address key risk factors that reduce quality of life for women as they age
- **Priority 2.3**: Better manage the needs of an ageing population

Priority area 3: Chronic conditions

- **Priority 3.1**: Increase awareness and primary prevention of chronic conditions and associated risk factors for women and girls and embed a life course approach in policy and practice
- **Priority 3.2**: Invest in targeted prevention, timely detection and intervention of chronic conditions affecting women and girls
- **Priority 3.3**: Tailor health services to meet the needs of all women and girls
- **Priority 3.4**: Reduce the prevalence and impact of endometriosis and associated chronic pelvic pain

Priority area 4: Mental Health

- **Priority 4.1**: Enhance gender-specific mental health education, awareness and primary prevention
- **Priority 4.2**: Focus on early intervention, diagnosis, integration and access to mental health care services
- **Priority 4.3**: Invest in service delivery for priority populations
- **Priority 4.4**: Adopt a multi-faceted approach to support women and girls with eating disorders
- **Priority 4.5**: Raise awareness and embed practices to reduce stigma and discrimination associated with mental ill-health

Priority area 5: Health impacts of violence against women

- **Priority 5.1**: Raise awareness of the health impacts of violence against women and girls
- **Priority 5.2**: Address health and related impacts of family and sexual violence
- **Priority 5.3**: Co-design and deliver safe and accessible services for women experiencing family, intimate partner and/or sexual violence

Investing in research

- **1:** Strengthen and diversify research and data collection across identified health priorities for women and girls
- **2**: Build research capacity and capability in women's health

Priority area 2: Healthy ageing

<u>Actions are organised at the priority level</u>

Priority area → Priority

Healthy Ageing

Example:
Adopt a life course approach to healthy ageing for women

Actions:

- Build awareness that healthy ageing starts with young women and girls to embed a preventive and health promotion approach throughout life
- Acknowledge the need for targeted conversations and interventions relating to healthy ageing at different points in the life course and across priority populations

<u>Outcomes are organised at the priority area level</u>

Priority area

Healthy Ageing

Outcomes:*

- Reduction in the number of preventable and avoidable deaths
- Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease
- Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity

*Outcomes are denoted 'Key measures of success' in the strategy.

Introduction | Assessment of actions and outcomes in this baseline report

This report mirrors the structure of the National Women's Health Strategy. It is organised by priority area. The current state assessment of actions is conducted at a priority level. Outcomes are reported at the priority area level, depicting trends before and after baseline (the release of the strategy in 2020).

Five priority areas

- Priority area 1: Maternal Sexual and Reproductive Health
- Priority area 2: Healthy ageing
- Priority area 3: Chronic conditions
- Priority area 4: Mental Health
- Priority area 5: Health impacts of violence against women
- Investing in research

Priority area 2: Healthy ageing

Actions are organised at the priority level

Priority area → **Priority**

Healthy Ageing

Example:
Adopt a life course approach to healthy ageing for women

Actions:

- Build awareness that healthy ageing starts with young women and girls to embed a preventive and health promotion approach throughout life
- Acknowledge the need for targeted conversations and interventions relating to healthy ageing at different points in the life course and across priority populations

Outcomes are organised at the priority area level

Priority area

Healthy Ageing

Outcomes:*

- Reduction in the number of preventable and avoidable deaths
- Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease
- Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity

*Outcomes are denoted 'Key measures of success' in the strategy.

Current state assessment

Actions are assessed at the priority level, with consideration of underlying actions

Priority area → **Priority**

Healthy Ageing

Example:
Adopt a life course approach to healthy ageing for women

Outcomes are assessed at the priority area level, with relevant data indicator/s mapped to each outcome

Priority area

Healthy Ageing

Example
Reduction in the number of preventable and avoidable deaths

Introduction | Background

The National Women's Health Strategy (strategy) outlines Australia's national approach to improving the health of all women and girls in Australia. This strategy builds on the National Women's Health Policy 2010 that adopts a dual priority approach, namely of (1) maintaining and developing health services and prevention programs to treat and avoid disease through targeting health issues that will have the greatest impact over the next two decades, and (2) aiming to address health inequities through broader reforms addressing the social determinants of health.

The strategy sought to identify the policy gaps and emerging health issues in women's health in Australia that were prevalent at the time of writing, with the aim of informing targeted and coordinated action at the national and jurisdictional levels to address the priority health needs of women and girls in Australia. To this end, the strategy is not itself a delivery vehicle for specific activities, rather it provides relevant government and non-government stakeholders across Australia with a guide to inform focus areas and actions that will improve the health and wellbeing of all women and girls in Australia.

Aligning with the National Women's Health Policy 2010, the strategy adopts a whole of life view of a woman's life course, recognising that women and girls can experience a range of diverse health needs and risks that evolve and change across their lifespan. The life stages are categorised as shown in Figure 1.

Figure 1: Priority populations as outlined in the strategy

Improving health equity for women and girls requires consideration of priority population groups, due to differing health needs for different groups. Further, many women and girls fall into more than one of the identified priority population groups which can have a compounding effect on health needs and outcomes. The strategy focuses on the following priority population groups:

- pregnant women and their children
- women and girls from rural and remote areas
- Aboriginal and Torres Strait Islander women and girls
- women and girls from low socio-economic backgrounds and older women with low financial assets
- women and girls living with disability and carers
- culturally and linguistically diverse women and girls
- members of LBTI communities
- women and girls who experience violence and/or abuse
- women and girls affected by the criminal justice system
- women veterans of Australia's armed services.

Describing priority groups

The term **CALD** is used in this report to align with the strategy. This document acknowledges that are several terms that can be used to describe cultural and linguistic background and that CALD captures a large and diverse group of Australians, with many differing experiences. **First Nations** is used to describe individuals of Aboriginal or Torres Strait Islander descent to align with current best practice. Other terms are used in this report (such as 'Indigenous') when directly referencing sources that use these other terms.

Defining sex, gender diversity and variations in sex characteristics.

This report refers to 'women and girls' to align with the terminology used in the strategy. This definition encompasses women with diverse sexual orientations, transgender people, people with variations of sex characteristics (sometimes known as 'intersex') and gender diverse people.

- This document acknowledges that the current domain of women's health revolves primarily around cisgender and heterosexual women and does not adequately acknowledge and address the health concerns of all LGBTIQA+ individuals. Acknowledging diverse gender, sexual orientations, and variations of sex characteristics is important in the context of a health strategy as it can be associated with a higher health burden, but also because of the prejudice and discrimination these individuals face which can affect their health and wellbeing.
- The 10 Year National Action Plan for the Health and Wellbeing of LGBTIQA+ people, set to be published in late 2024, aims to coordinate efforts to achieve better health, wellbeing, and mental health outcomes for LGBTIQA+ people.
- There is a future need for broader conversations on where the health of trans men and non-binary people assigned female at birth sits and how this is managed over time.

Introduction | Scope and purpose of this baseline report

Deloitte Access Economics was engaged by the Department of Health, Disability and Ageing to develop a:

1. Monitoring and Reporting Framework (the framework) that outlines an approach to evaluating the implementation and outcomes of the strategy
2. Baseline report to provide a current state assessment of the strategy based on the approach outlined in the framework.

Implementation of the framework (through this baseline report and future monitoring and evaluation activities) will provide the Department of Health, Disability and Ageing and the National Women's Health Advisory Council (the council) with an understanding of the strategy's implementation progress, and performance against the key measures of success. The Department of Health, Disability and Ageing and the council can then use this information to adapt and innovate on a real-time basis, as the monitoring and reporting activities will identify gaps and highlight areas that require targeted focus over the next ten years. The framework is not intended to be used to evaluate discrete programs or initiatives.

The purpose of *this* baseline report is to provide a current state summary on the extent to which key stakeholders have implemented activities in alignment with the strategy (progress of the strategy's inputs and activities) and to monitor changes in population health outcomes for women and girls over time (the outputs and outcomes of the strategy). The baseline report builds on the approach developed in the Monitoring and Reporting Framework, particularly the data sources identified as indicators for the outcome measures in the framework (Figure 1).

To enable this assessment, the baseline report is structured across two components:

1. Implementation monitoring and reporting. The report uses a criteria-led approach to assess the strategy's implementation progress at a priority area level, informed by stakeholder consultation and desktop review evidence of key activities (see page 19 for more detail).
2. Outcome monitoring and reporting. For each key measure of success outlined in the strategy, key data indicators are identified and mapped to publicly available data sources (see page 20 for more detail). These indicators are presented in this report as well as a visual dashboard (Figure 2).

The scope of this work is to assess progress on implementation and outcomes over the period of 2020 (when the strategy was released) to 2023. Following the baseline report, it is proposed the implementation monitoring component is conducted at semi-regular intervals to track progress and to guide implementation. The outcome monitoring component may be conducted again at the five-year mark and again at the ten-year mark – to coincide with the planned evaluation points proposed within the strategy itself (including the end of the 10-year strategy).

Figure 1: Data indicators identified for outcomes listed in the strategy (Monitoring and Reporting Framework)

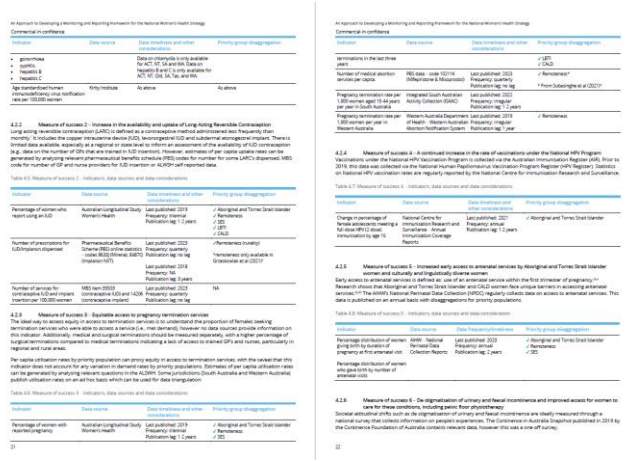
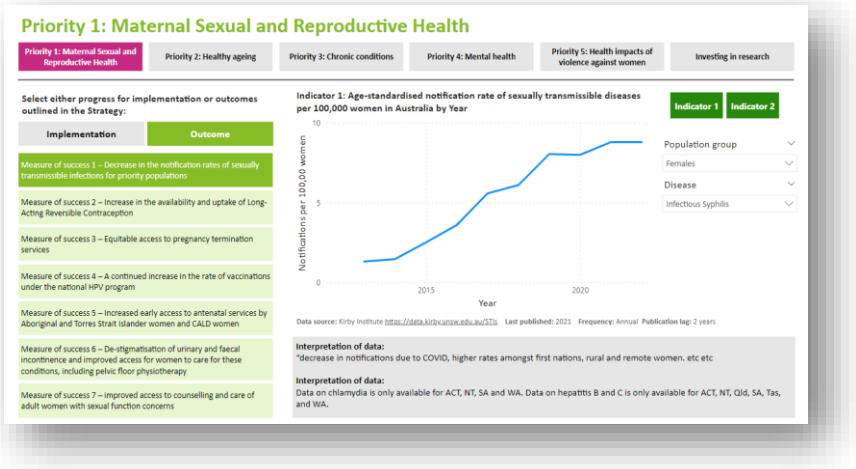


Figure 2: Visual dashboard mock up



Methodology | Implementation monitoring and reporting

Implementation monitoring and reporting

To assess the strategy's implementation progress, the following four steps were taken as outlined in the Monitoring and Reporting Framework:

Step 1: Identify stakeholders aligned to each priority in the strategy (stakeholder implementation partners)

Stakeholder implementation partners, including government and non-governmental organisations, were identified for each priority area in the strategy. This list was developed based on desktop research and advice from the Department and the council, with all council member organisations included.

Step 2: Assess the implementation of each priority by undertaking evidence gathering through stakeholder consultation with implementation partners, supplemented by desktop review

Consultation was designed to aid understanding of initiatives implemented in line with the strategy's priorities since its inception, the extent to which identified outcomes have been achieved, as well as awareness and utilisation of the strategy across the health sector. The list of consulted stakeholders is shown in the Appendix. The following questions were tested by either an individual semi-structured interview, focus group or survey.

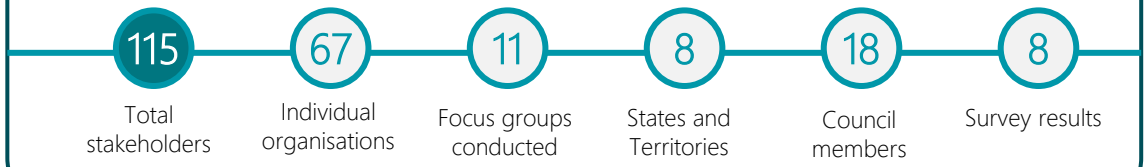
- *Awareness and utilisation* – to what extent are stakeholders aware of and utilising the strategy?
- *Implementation assessment* – to what extent have stakeholders implemented activities in alignment with the priorities and actions?
- *Outcome assessment* – what are the changes in women's health outcomes since the inception of the strategy?

Step 3: For each priority, gather and thematically organise the findings from the desktop review and stakeholder consultation

Step 4: Use the evidence gathered in Step 3 to rate each priority on a scale from *Requires stronger focus* to *Evidence of meaningful progress* (see right). Use the ratings to inform an implementation scorecard across all priorities in the strategy.

The evidence gathered for this report consists of initiatives delivered by the government and the not-for-profit sector. It is acknowledged that many not-for-profits receive government funding to deliver initiatives.

Key statistics of stakeholder consultation process



Measuring implementation progress

Step 4 involves rating each priority against a standardised 3-point scale as outlined below. The evidence collected from stakeholder consultation and the desktop review guided these ratings. The scale ranges from *Requires stronger focus* to *Evidence of meaningful progress*.

Requires stronger focus

There is minimal progress across this priority area, highlighting the need for a more concentrated effort in the future.

Some progress observed

There is indication of some progress within this priority area across some, but not all, outlined priority populations or jurisdictions.

Evidence of meaningful progress

There is evidence of meaningful progress (including services and investment) aligned to this priority area, sufficiently addressing most relevant priority populations / actions.

The report does not seek to provide a comprehensive or exhaustive list of programs and initiatives that are being implemented that align (whether deliberately or tangentially) with the strategy. Instead, this monitoring and reporting framework identifies key areas of investment and areas where there is reportedly less investment.

Methodology | Outcome monitoring and reporting

Outcome monitoring and reporting

Outcomes (the 'key measures of success' in the strategy) relate to the desired results or effects of implementation of the actions listed in the strategy.

The Monitoring and Reporting Framework included an outcomes indicator framework, where each outcome was mapped to key indicators and publicly available data sources. The framework included an assessment of data sources against three factors: data availability, data frequency/timeliness, and priority group disaggregation.

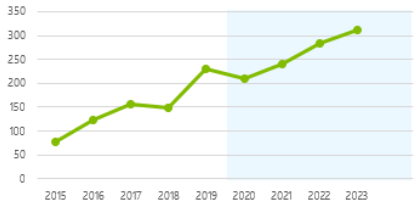
The Monitoring and Reporting Framework found that high quality data is available to inform indicators related to change in uptake rates or physical health. Data availability is more limited for the assessment of indicators related to change in access rates (for example, to what extent is someone in need of a service able to access that service?) and attitudinal shifts (for example, de-stigmatisation of urinary and faecal incontinence). In cases where ideal data types were unavailable, proxy indicators were proposed.

This baseline report includes the first 'implementation' of the Monitoring and Reporting Framework, with identified data sources extracted and trend analysis of indicators undertaken.

Trend analysis is intended to enable a future assessment of how outcome indicators were trending before and after the release of the strategy in 2020. As such, each graph includes blue shading for 2020 and onwards to enable this comparison (noting trend changes in outcomes cannot necessarily be attributed to the strategy). Notably, the intent was to include data for up to 10 years before 2020, but varying availability and frequency of data sources has meant that the time period presented differs for each indicator.

Similarly, priority group disaggregations are presented wherever data is available; with the significant variation in quality and quantity of this data a key finding in itself of where future investment is needed.

Example: trend analysis graph



Common data sources

The most common sources used in this outcome assessment include:

- The Australian Longitudinal Study on Women's Health (ALSWH)
- Australian Institute of Health and Welfare Reports and Summary Statistics
- Australian Bureau of Statistics (ABS) National Health Survey 2017-18 and 2022
- ABS National Aboriginal and Torres Strait Islander Survey
- ABS Patient Experiences Survey
- ABS National Survey of Mental Health and Wellbeing
- Medicare and Pharmaceutical Benefits Schedule
- National Perinatal Data Collection

Measuring outcome progress

Identified indicators were analysed at an aggregate outcome level over the last five or 10 year period depending on the most recent data publication and data availability. Below is the assessment framework used to measure progress in the trend of the outcome.

Outcome rating	Definition
	Positive trend - There is a pronounced trend, either upward or downward, which is consistent with the specified direction in the measure of success.
	No trend – There is a weak or inconclusive trend for the indicator (no clear upward or downward direction).
	Negative trend - There is a pronounced trend, either upward or downward, which is inconsistent with the specified direction in the measure of success.
	There is insufficient data available to determine the trend.

Data quality assessment

Definition	Data availability	Data frequency/timeliness	Priority group disaggregation
	No data available	Data reporting is highly irregular	Data does not disaggregate into priority groups
	Partial data available	The frequency and lag of data release is >3 years	Some priority groups are available
	Ideal data available	The frequency and lag of data release is < 3 years	All relevant priority groups are available

Limitations of this report

The assessment of implementation and outcomes progress in this baseline report is limited by the following factors.

Absence of implementation plan for the strategy	Stakeholders in the consultation process emphasised the absence of an implementation plan or creation of a steering group to execute an implementation plan. Lack of an implementation plan has impacted the implementation assessment in this report in the following key ways: • Lack of ownership of actions and insufficient specificity of actions – actions do not have assigned ownership to specific implementation partners. As a result, this baseline assessment has sought to capture any aligned initiatives undertaken across government and non-government stakeholders since the strategy was released in 2020. However, the evidence gathered could never capture every single initiative implemented in line with the actions listed in the strategy, given the broad nature of the listed actions. The assessment is therefore not systematic, as much as every best endeavour was taken through consultation and desktop analysis to uncover aligned activities. • Lack of accountability, timeframes and targets – there are no accountability mechanisms to govern the timeframes against which actions should be undertaken, and targets to define success for each measure. As such, the assessment of whether there has been progress against each action is not systematic across all actions, or undertaken against a clear target and specific timeframe. Instead, this baseline report provides a progress rating for each priority based on the quantity and quality of evidence that activities have been implemented since 2020 in line with the intent of each priority.
Gaps in gender disaggregated data	Lack of regularly reported datasets in many areas hinders outcome measurement and progress tracking of the strategy. Outcomes that were classified as no meaningful change were more a reflection of the lack of data rather than no progress in the outcome itself. Key data gaps that impede comprehensive monitoring of outcomes in the strategy include: • Underreporting and misclassification pose challenges in accurately tracking and addressing women's mental and physical health issues within the context of domestic violence and sexual violence. • There are limitations in data collection for LGBTIQA+ communities which hinders visibility and progress tracking. Progress has been made in this area; for example, the ABS developed the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables in 2020 (2020 Standard), to standardise the collection and dissemination of data relating to LGBTIQA+ people. The ABS is also collaborating with an LGBTIQ+ Expert Advisory Committee to enhance the 2026 Census. However, it is not yet known whether the 2020 Standard will be applied to the 2026 Census. Separately, the 2020 Standard has been used in AIHW's national health and wellbeing surveys, including the National Health Survey 2022. All the data sources identified in this report could be improved by the application of the 2020 Standard. • Data gaps in understanding violence against women, chronic disease (for example, lack of historical gender-based research), and mental health (women often underrepresented in autism/ADHD data). • Data gaps for priority groups, including migrant and refugee women, CALD women, and First Nations women. • Data gaps in understanding access to services for women, and their experiences of the health system and outcomes. • Many data points are held in state or territory databases, and are not publicly available. For example, data on access to continence nurse advisors, or nurse practitioners working in women's health. It is important to acknowledge that despite these data limitations, there is a wealth of detailed data resources available from the ALSWH, for example on incontinence, and chronic conditions. The focus of this baseline report was to leverage publicly available data where possible to improve the ease of tracking outcomes over time. However, future iterations of reporting against the monitoring and reporting framework could consider the incorporation of ALSWH's range of longitudinal datasets with linked health records and data governance protocols.
Assigning attribution	Typically, evaluation seeks to understand the causal relationship between a program or initiative (in this case, the strategy itself) and outcomes. However, attribution is not considered to be the central role of the Monitoring and Reporting Framework or this baseline report. As noted on Page 8 of the strategy, the strategy 'is designed to provide a gender-specific approach to activities already underway and to guide the development of new and innovative policies and approaches to address specific health needs of women.' To this end, the Monitoring and Reporting Framework is not intended to attribute outcomes to the strategy, but to enable an assessment of the extent to which government and key stakeholders have implemented activities in alignment with the strategy, and to monitor change in population level health outcomes measures for women and girls over time. However, because of this, it is important that the findings in this report are interpreted correctly; implementation activities and changes in outcomes largely cannot be causally linked back to the strategy.
COVID-19 considerations	The strategy was launched during the COVID-19 pandemic, when access to services was limited. This had an impact on diagnosis, treatment, and infection rates. Consequently, it is challenging to interpret baseline data over 2020 and 2021 in particular, to determine whether changes in indicators are genuine in reflecting outcomes, or have been influenced by COVID-19 and the resulting lockdowns.

3 | Current state review

This section provides a current state assessment of progress against actions and outcomes in the National Women's Health Strategy

Priority 1 – Maternal, Sexual and Reproductive Health

Summary insights | Maternal, sexual and reproductive health

Implementation progress

Sub-priority	Summary	Progress Rating		
		Requires stronger focus	Some progress	Meaningful progress
Increase access to sexual and reproductive health care information, diagnosis, treatment	Evidence supports improved access to sexual and reproductive health information and education, alongside improved access to abortion and contraceptive care services. However, access remains unequal, with rural and remote women (among other groups) disproportionately affected.	○	●	○
Increase health promotion activity to enhance and support preconception and perinatal health	There is some evidence to suggest there has been increased health promotion activity to support people making informed decisions regarding preconception and perinatal health. However, overall, stakeholders in consultation noted an insufficient focus on promotion of preconception and perinatal health.	●	○	○
Support enhanced access to maternal and perinatal health care services	Access to maternal and perinatal services for First Nations women has improved, notably through Birthing on Country Initiatives and support for perinatal mental health care services and breastfeeding. However, gaps in national standards, workforce and data in maternity health were noted to be an area that requires further continual focus.	○	●	○

Trend in outcomes in past five years

Measure of success	Summary	Trend
Decrease in the notification rates of STIs	STI notification rates have remained relatively stable since 2013, however the trend among First Nations woman has declined moderately until 2022. Recent national syphilis quarterly reports show an increase in syphilis notification rates for First Nations women. The effect of COVID-19 on notification rates is unclear.	No observable change
Increase in the availability and uptake of LARCS	Evidence suggests an increase in uptake of LARCs,, notably an increase in young women opting for the Copper IUD, Kyleena and Mirena, alongside a decrease in Implanon usage. Notably, the Copper IUD is not granted any government subsidies.	Positive upward trend
Equitable access to pregnancy termination services	There is evidence of an increase in surgical abortion and self-reported medical termination of pregnancy (MTOP) services per 100,000 women in total women and an increase in proportion of women who reported a termination over their lifetime. MTOP has improved access and equity of abortion services in the community. However, there is a lack of evidence demonstrating improved access to MTOP provision for priority populations.	No observable change
Continued increase in the rate of HPV vaccinations	The proportion of girls meeting HPV immunisation requirements by age 15 increased slightly since 2012, decreasing slightly between 2020-22 possibly due to COVID-19 pandemic impacts. First Nations and remote areas had lower rates.	No observable change
Increased early access to antenatal services	There has been a steady increase in service utilisation of antenatal services prior to 20 weeks pregnancy in women, reported in both First Nations and CALD women. However, this is noted to be based off hospital records and may not reflect services in all primary care nor access in the community.	Positive upward trend
De-stigmatisation of urinary and faecal incontinence and improved access	Limited data is available on access to continence care. A 2019 survey found that 34% of Australians would not discuss incontinence due to stigma.	Insufficient data
Improved access to counselling and care of adult women with sexual function concerns	There is insufficient data to accurately measure this outcome.	Insufficient data

ACTION

OUTCOME

Priority 1.1 | Increase access to sexual and reproductive health care information, diagnosis, treatment and services (1 of 2)

Evidence supports improved access to sexual and reproductive health information and education, alongside an increase in access to abortion and contraceptive care services. However, access remains unequal, with rural and remote women (among other groups) disproportionately affected.

Key aligned activities

Awareness raising of issues and treatment pathways among students

- State and Territory education departments are increasingly embedding respectful relationships, consent programs in secondary schools.
- The Australian Government launched the *National Beforeplay* campaign in January 2024 to promote safe sex practices among young people and women of reproductive age, including regular testing, safe behaviours, and seeking credible information.[1]

Information, education and self-management tools

- Healthdirect Australia offers a range of resources including an advice page, service finder tool, and a self-assessment symptom checker tool, which can support women with sexual and reproductive health (SRH) issues.[2]
- Jean Hailes for Women's Health provides evidence-based information on a broad range of sexual and reproductive health matters and offers a variety of user-friendly materials and services for addressing SRH concerns. They promote inclusivity by translating key information into multiple languages.[3]
- The 2024-25 Federal Budget committed $5.6 million, to be provided to Multicultural Centre for Women's Health from 1 July 2024 to 30 June 2025, to continue and expand the Health in My Language program to provide SRH education to women by trained bicultural health educators, in person and in language.

Access to treatment and services

Inequitable access to SRH services across Australia prompted the 2023 Senate Inquiry into Universal Access to Sexual and Reproductive Healthcare[4]. The inquiry concluded that access to abortion, LARCs, sexual health care, maternity services and related telehealth services remains uneven across Australia and is a 'postcode lottery'. The strategy served as a pivotal reference for this inquiry. There are several other recently implemented initiatives aiming to reduce barriers to early medical abortions. For example:

- In 2023, the Commonwealth funded the SPHERE Centre for Research Excellence to conduct trials into pharmacist and nurse-led contraception and the medical abortion prescriber model was trialled in 32 rural and regional GPs.[5]
- The ACT government committed more than $4 million over four years to provide all residents free abortion services.[6]
- The TGA deregulated the prescription and distribution of MS-2 step (mifepristone and mifepristone) for medical termination of pregnancy (MTOP).[7]
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) released evidence-based clinical guidelines for abortion care, backing early medical abortion (up to 10 weeks).[8]
- In March 2023, Western Australia enacted new laws to decriminalise abortions, removing unnecessary barriers for women seeking abortions and reduces administrative burdens on health care providers, aligning the state with laws in other states and territories.[9]
- As part of the 2024-25 Federal Budget, $5.2m over 3 years will be provided to fund training opportunities for health professionals, including regional and remote practitioners, to undertake training in the insertion and removal of LARCs, supporting greater access to this contraception option.[10]
- A review will be undertaken of the Medicare Benefits Schedule (MBS) items used for LARC insertion and removal and gendered differences in MBS items on diagnostic imaging services through the MBS Continuous Review Program. As part of the review, consideration will be given to the appropriateness of the items to support equitable and affordable access for women to high quality, safe services provided by appropriately trained health practitioners, including doctors, and nurses.[11]

Areas for attention

- *Ensuring equitable access in rural and remote communities* – The Senate Inquiry to Universal Access to Sexual and Reproductive Healthcare recommended substantial alterations to Australia's health system to enhance accessibility to contraception and abortion. Stakeholders highlighted the need for government action to improve LARC access, particularly in rural and regional areas. This could include expanding PBS subsides to cover all LARCs.
- *Workforce considerations* – The workforce was identified as a crucial area requiring attention to improve access to essential treatments and services. Disparities between rural and urban health care are growing, further hindering access to services. This was referenced to be due to the lack of incentives for specialist in rural areas and high costs associated with locum services.
- *Equitable access to First Nations women* – Stakeholders highlighted that there is not currently a strong Aboriginal community voice to address and advocate issues for abortion and contraception. This has also not been a focus of any government initiatives to date.
- *Increasing awareness in young women and adolescents* – Although there is progress towards raising awareness and promoting access to services, youth and adolescent SRH was noted as an area that required greater attention.
- *Continual focus on emerging STI outbreaks* – Stakeholders noted that action is needed to combat a recent but notable rise in syphilis, which poses a disproportionate risk on First Nations women. This has not been picked up in data yet (page 30) due to data collection lags.
- *Equitable Access to Oral Contraception* – while progress has been made in increasing the availability of LARCs, equitable access to the combined oral contraceptive pill (COCP) remains unaddressed. A study of 6,600 women found that, for women aged 18-39 years and using contraception for any purpose, 63% used COCPs, with one-third using pills with anti-androgenic effects.[13] However, not all COCPs are subsidised under the PBS. Non-PBS listed pills can result in out-of-pocket expenses of up to $120 for four months, creating significant health care access inequities for many young women.[14]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION

OUTCOME

Priority 1.1 | Increase access to sexual and reproductive health care information, diagnosis, treatment and services (2 of 2)

Evidence supports improved access to sexual and reproductive health information and education, alongside improved increase access to abortion and contraceptive care services. However, access remains unequal, with rural and remote women (among other groups) disproportionately affected.

Key aligned activities

Further, recent efforts to strengthen Medicare, including the development of MyMedicare – a voluntary patient registration model – have improved women's access to treatment and services. By enabling women to see the same GP regularly, MyMedicare aims to advance the health outcomes of particularly vulnerable women including women with chronic disease and those in priority groups.

Medical colleges like RANZCOG and RACGP have also developed education programs and guidelines to improve member skills in diagnosing and treating endometriosis and menopause. RANZCOG has also recently mapped rural maternity services to help identify GP and maternity services.[12]

STI service provision and response measures

The Australian Government's Fifth National STI Strategy 2024- 2030 is in its final stages of development and will aim to increase awareness and understanding of STI as part of sexual and reproductive health including within maternal health services. It will have a focus on access and provision of sexual health services, for timely diagnosis and treatment.[15]

The Australian Government has also delivered the National Blood Borne Virus and Sexually Transmissible Infections (BBVSTI) program ($20.3m) and the Enhanced Syphilis Response ($23.4m), over 2021-2024, which includes health promotion and sexual health staff in Aboriginal Community Controlled Health Services; and the TTANGO (Test Treat ANd GO) trial which has run since 2013 and now scaled up to 85 sites to deliver STI Point of care testing (chlamydia, gonorrhoea, trichomoniasis) in rural and remote services.[10]

Investments in sexual and reproductive health dataset

- $5.5 million over 3 years will be provided by the Australian Government to fund the Australian Institute of Health and Welfare (AIHW) to develop a national sexual and reproductive health dataset. The dataset will identify sexual and reproductive health care needs across the life course, explore equity in care, and identify priority population groups and service use. The data set will inform sexual and reproductive health policy and improve health care access outcomes.[10]
- A further $1 million over two years will be provided for the AIHW to undertake a miscarriage data scoping study. The study will support work to better understand miscarriage and help to improve the support offered to women and their families.[10]

Other investments in pregnancy and miscarriage awareness

- The Australian Government has allocated $1.5 million over two years for a national Audit of Early Pregnancy Assessment Service (EPAS) clinics. Improved information on EPAS clinics can also be used by GPs and other health professionals to ensure women experiencing pregnancy loss and other early pregnancy complications are referred to specialised services where feasible. The outcomes of the audit will also be used to collate information to develop a service directory that can be used by GPs and other health professionals to refer clients to EPAS clinics, including information on location and hours of operation, accessibility, services offered etc.[10]
- An additional $1.5 million will be provided to develop miscarriage education and awareness resources, including a public awareness and education program, and an information pack for parents and families who have experienced miscarriage. The information pack will contain evidence-based information, acknowledgement, and advice regarding miscarriage, including what to expect following miscarriage, how to care for yourself, physical recovery and where to find support.[10]

Areas for attention

- *Risk of blood born viruses (Hepatitis B)* – Historically, Hepatitis B virus was transmitted in Australia through vertical transmission (pregnant person to child) and horizontal transmission (between children and family members), particularly affecting Aboriginal and Torres Strait islander peoples and people from culturally, ethnically, and linguistically diverse backgrounds. Vertical and horizontal transmission are both less common now. Other routes of transmission include the use of unsterile injecting equipment and sexual contact without using preventive measures, for example, condoms and lubrication.
- *Risk of blood born viruses (Hepatitis C)* - Hepatitis C virus is transmitted through blood-to-blood contact, and in Australia is most commonly transmitted through the use of unsterile injecting equipment, and less commonly through unprotected sex. There are heightened risks for transmission in custodial settings due to higher rates of chronic infection, increased prevalence of risk factors, higher rates of exposure and transmission, reinfection of hepatitis C, and an ongoing failure to offer an equivalence of care to people in prison (including comprehensive access to evidence-based harm reduction including sterile injecting equipment as means of prevention).

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION OUTCOME

Priority 1.2 | Increase health promotion activity to enhance and support preconception and perinatal health

There is some evidence to suggest there has been increased health promotion activity to support people making informed decisions regarding preconception and perinatal health. However, overall, stakeholders in consultation noted an insufficient focus on promotion of preconception and perinatal health.

Key aligned activities

Awareness raising and resources to support good preconception and perinatal health

- Medical colleges RACGP and the RANZCOG have published resources aimed at supporting woman to make informed decisions about when and if to have children, with guidance covering preconception care, preventive health screening, and management. However, a recent systematic review concluded that these guidelines would benefit from more practical implementation advice.[1]
- Jean Hailes for Women's Health provides online resources to educate and support new and expecting parents, with advice to support decision-making and guidance on referral pathways across and between perinatal and maternal health services. Some resources are tailored to meet the cultural safety needs of certain priority populations. The information contained in these resources is regularly updated based on routine surveys of women to understand their preconception and perinatal information needs.[2]
- Centre for Perinatal Excellence (COPE) also provides online resources and has recently published the app '*Ready to Cope*', funded by the Australian Government (see right).[3]
- *Australia's National Obesity Strategy, 2022-32* outlines preconception as a critical life phase for obesity prevention, with recommendations to embed support for healthy eating, sleeping and physical activity into standard maternal health services before, during and after pregnancy.[4]
- The recently established SPHERE - The Centre of Research Excellence in Sexual and Reproductive Health for Women has recently received grant funding to investigate the use of online tools in enhancing access to preconception information and services.[5]

Messaging and service delivery for priority populations

Many States and Territories have introduced Birthing on Country (BoC) services to promote culturally safe maternal and perinatal services for First Nations women. Some BoC centres, such as the Institute for Urban Indigenous Health (IUIH) BoC centres in Queensland, staff dedicated community engagement roles to promote safe preconception and perinatal health practices within local First Nations communities. Stakeholders highlighted the BoC centres as a major success in facilitating culturally safe maternal care for First Nations woman.[6] Moreover, consultation with stakeholders revealed that recent efforts to build a stronger Medicare, including additional Medicare rebates, have led to some improvements in service delivery for priority populations.

National Awareness Campaign for Pregnancy and Breastfeeding Women

- The Every Moment Matters campaign is a national campaign sharing the latest evidence-based information about alcohol during pregnancy, while planning a pregnancy and breastfeeding. It was developed by the Foundation for Alcohol Research and Education (FARE) with the support of health professionals and communities across Australia.[7]
- The Australian Government has allocated $32.4 million (from 30 November 2021) for the campaign. This includes a $5 million extension as part of the 2024-25 Federal Budget.[8]
- As well as the mainstream campaign across television, radio, billboards and social media, there are targeted materials for health professionals and vulnerable groups, including alcohol-dependent women. Materials for rural and remote First Nations communities launched in February 2023 under the Strong Born component of the campaign. The 2023-24 Budget announced a further $1.4 million to expand the reach of First Nations materials, including into more urban settings. This expansion is funded directly with NACCHO.[7]
- A final evaluation of the national campaign, concluding at the end of 2024, found that more Australians are aware of fetal alcohol spectrum disorder and understand that there is no safe time to consume alcohol during pregnancy. The campaign has also influenced behavioural intentions, increasing the proportion of women who would abstain from alcohol during pregnancy.[7]

Areas for attention

- To improve health promotion of preconception and perinatal health, stakeholders noted opportunities to optimise reach and engagement of women by embedding information and educational resources within schools, workplaces and community.
- Stakeholders believe that the priority area should encompass more than just pre-conception and perinatal health with a need for broader health promotion and health literacy efforts. There is a particular role in primary prevention for GPs, who are the primary interface women have with the health system when managing their maternal health. For GPs to be adequately supported in delivering this care, there needs to be models of renumeration that support complex and time-intensive care provision. There has been some progress towards this in the 2024-25 Federal Budget measures alongside myMedicare initiatives.
- There is also a lack of a strong consumer voice in preconception and perinatal health (aside from miscarriage). This contrasts with communities such as endometriosis and breast cancer that have large drive from patient experiences. There is an opportunity to establish a greater government role in preconception and perinatal health.
- There are opportunities to build on the success of BoC centres, by staffing these centres with non-clinical community engagement roles promoting safe preconception and perinatal health practices, where these roles do not already exist.

Box 1.2.1: Ready to COPE

Centre for Perinatal Excellence (COPE) created a free **'Ready to Cope'** app for expectant and new parents, extended to mums, dads, non-birthing parents, First Nations people, and available in 10 languages. The app is reported to receive 100-120 downloads a day, with a customer engagement rate of 91%.[9]

Progress rating

ACTION

OUTCOME

Priority 1.3 | Support enhanced access to maternal and perinatal health care services (1 of 2)

Access to maternal and perinatal services for First Nations women has improved, notably through Birthing on Country Initiatives and support for perinatal mental health care services and breastfeeding. However, gaps in national standards, workforce and data in maternity health were noted to be an area that requires further continual focus.

Key aligned activities

Access to maternal and perinatal health care services for First Nations women

- Birthing on Country (BoC) models of care are currently being delivered across five states and territories in Australia, see Box 1.3.1 right). Under the 2021 Healthy Mums Healthy Bubs budget measure, the Australian Government has funded nine organisations, including ACCHOs and universities, for BoC activities. Some sites such as the Institute for Urban Indigenous Health in Queensland, have staff dedicated to community engagement roles to promote safe preconception and perinatal health practices within local First Nations communities. Stakeholders highlighted BoC models of care as a major success in facilitating culturally safe maternal care for First Nations women. The Commonwealth has invested $22.5 million over three years to build a dedicated BoC centre of excellence in Nowra, NSW.[1] Flexible midwifery care models, such as the Baggarook Program for First Nations Women at The Royal Women's Hospital and other hospitals around Victoria, also aim to improve services for First Nations Women through providing the support of familiar midwives.
- The Queensland Government delivered the *Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy (2019-2025)* to improve maternity services for Indigenous women.[2]

Access to services to prevent reoccurrence of pre-existing conditions

- The Victorian Government's Healthy Mothers, Healthy Babies Program supports pregnant women who have greater health risks or are unable to access antenatal care. The program provides assistance during pregnancy and up to 4-6 weeks postpartum to address maternal risk behaviours and improve health outcomes.[3]

Integration of mental health services through maternal and perinatal health care services

- 'Ready to Cope' app by Centre for Perinatal Excellence (COPE) for expecting, new, and growing families.[4]
- Perinatal Anxiety & Depression Australia (PANDA) offers a helpline for individuals, families and health providers and access to counselling and information support. In the 2022-23 budget, PANDA received a share of $43.9 million allocated to ensure perinatal health service delivery across Australia.[1] Under the Perinatal Mental Health and Wellbeing Program, several initiatives such as ForWhen, Mumspace and Gidget Perinatal Mental Health Centres have also received funding to ensure perinatal health service delivery across Australia.[1]
- Perinatal and Infant Mental Health Services provides support in NSW for pregnant women and parents with a mental illness.[5]
- The Yana Bul Nhar-Gee Dhar program supports the mental health of the Bagarrokok Yurrongi community through online and in-person services. The program focuses on grounding of mental states in preparation for a new baby.[6]

Areas for attention

- The shortage of maternal health professionals poses a significant barrier to accessing maternal and perinatal health services, especially given the widening rural-urban health care gap. This challenge is heightened by the specialised nature of maternal health, which contrasts with general rural workforce trends. However, access to fertility services is relatively better, primarily due to the unregulated private sector.
- Additional recognition, skills and support for GPs is needed to ensure they can provide the full range of maternity services, especially in rural and remote areas. GPs should continue to be supported to provide antenatal and postnatal services to ensure continuity of care and that care is accessible, holistic, and equitable.
- Gaps in data collection in women's health, especially in primary care and general practice are hindering evaluation of services to assess equity in access barriers. Notably, statewide databases are likely to hold this data, including on women's health nurse-led services.

Box 1.3.1: Birthing on country

BoC returns maternity services to First Nations community control and provides culturally safe continuous midwifery care to women pregnant with a First Nations baby. Where trialled, research shows that BoC contributes to better health outcomes for First Nations mothers and babies, including a 50% reduction in preterm birth rates; reductions in child protection involvement and removals of First Nations babies.[10]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION OUTCOME

Priority 1.3 | Support enhanced access to maternal and perinatal health care services (2 of 2)

Access to maternal and perinatal services for First Nations women has improved, notably through Birthing on Country Initiatives and support for perinatal mental health care services and breastfeeding. However, gaps in national standards, workforce and data in maternity health were noted to be an area that requires further continual focus.

Key aligned activities

Support for women's capacity to breastfeed

- The *Australian National Breastfeeding Strategy: 2019 and Beyond* backs the well-being of infants, kids, women, and families by providing support for breastfeeding. The strategy targets 40% of babies aged 6 months to be exclusively breastfed by 2022. Although slightly below the goal, 37.5% of babies achieved exclusive breastfeeding, in 2022 up from 29.1% in 2017-18.[7]
- The Australian Government allocated $5.3 million in the 2023-24 budget to support the Australian Breastfeeding Association's (ABA's) National Breastfeeding hotline. The hotline supports more than 60,000 calls a year.[8]

Woman-centred care Strategy

- The Australian Government developed the Woman-centred Care Strategy to provide strategic directions to support Australia's maternity care system aligning it with contemporary practice, evidence, and international standards.[9]

Areas for attention

- Emphasis is needed on creating sustainable national accreditation criteria, measurements, and standards for maternal and perinatal care, including consistent implementation of best practice guidelines and further engagement with peak bodies.
- The success of BoC models of care and the AFPP present opportunities for the broader health sector, such as the value of holistic, wrap-around services, and non-clinical community-engagement roles promoting safe preconception and perinatal health practices.
- Significant gaps exist in analysing environmental effects (such as air pollution) on maternal and perinatal health outcomes. A 2021 study conducted in Sydney aimed to clarify association between air pollution and stillbirths, however consistent evidence of this association was not found.[11]
- The rise in congenital syphilis cases highlights inequities in antenatal care access. Despite testing being mandatory in first antenatal appointments, 79% of congenital syphilis cases since 2016 were diagnosed late in pregnancy. 2023 had the highest cases of congenital syphilis since 1995. This ongoing issue is particularly prevalent among Aboriginal and Torres Strait Islander infants, who account for over half of the cases since 2016.[12]

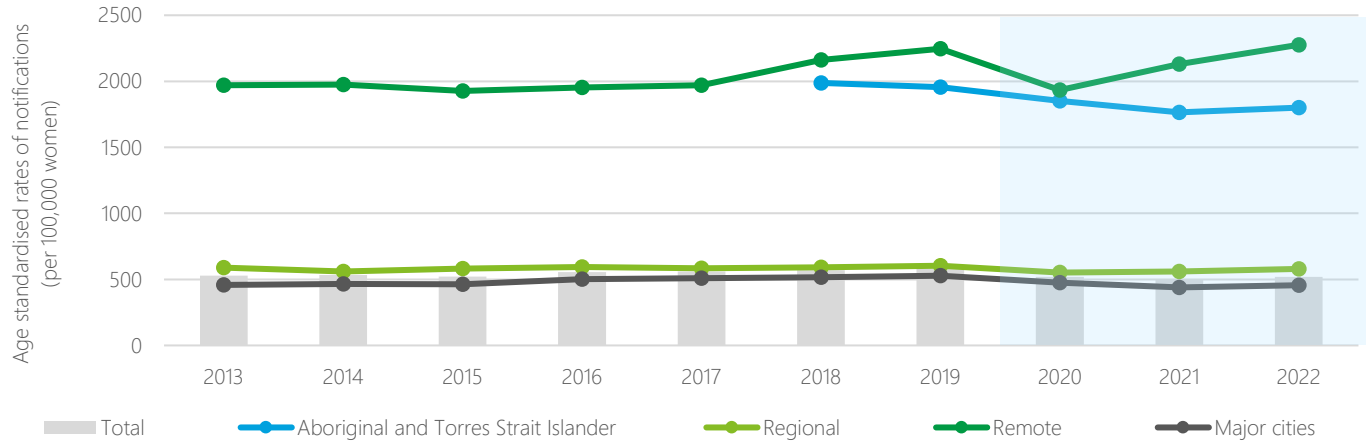
Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Measure 1.1 | Decrease in the notification rates of sexually transmissible infections (1 of 2)

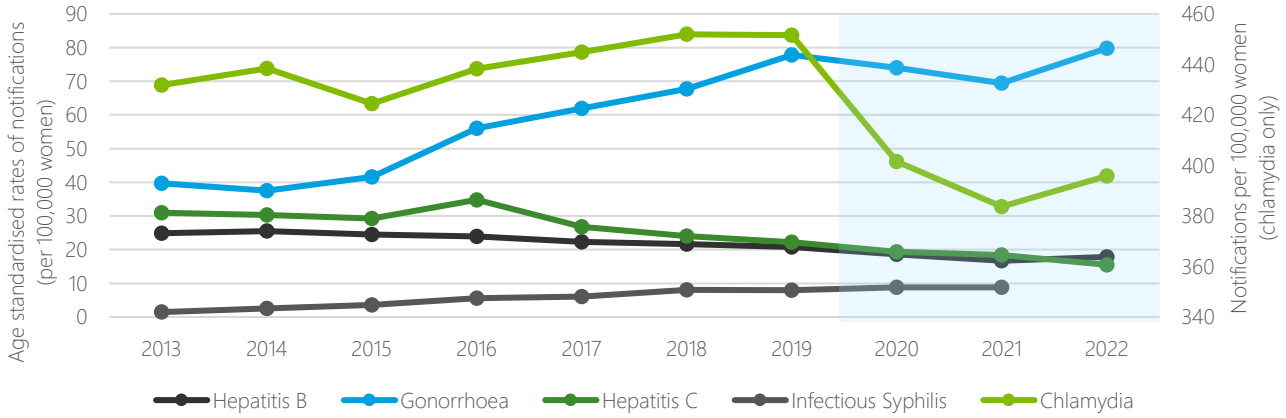
INDICATOR 1.1.1: Age standardised notification rate of sexually transmissible diseases (chlamydia, gonorrhoea, syphilis, hepatitis B*, hepatitis C*, HIV) per 100,000 women

Figure 1.1.1.A: Age standardised notifications of STIs per 100,000 women, by priority group



Source: Kirby Institute (using National Notifiable Diseases Surveillance System)[1]

Figure 1.1.1.B: Age standardised notifications of STIs per 100,000 women, by disease



Source: Kirby Institute (using National Notifiable Diseases Surveillance System)[1]

* Note, both hepatitis B and C are also blood borne viruses.

Key takeaways

- Overall, STI notification rates have remained relatively stable since 2013; around 500 cases per 100,000 women (Figure 1.1.1.A).
- Relative to average, notification rates are higher among First Nations women and women from remote areas (Figure 1.1.1.A).
- Notification rates are primarily driven by notifications for chlamydia; however, rates for chlamydia have declined sharply since 2019; whilst a sharp rise in gonorrhoea since 2015 which has continued to trend upward (Figure 1.1.1.B).
- Stakeholders noted that recent years have seen an uptick in syphilis, which is not picked up in datasets yet due to data collection lags. Updated statistics can be found in the National syphilis surveillance quarterly report – October to December 2023.[2] This data has not been released publicly beyond the contents of this quarterly report.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*All relevant priority groups disaggregated*

Trend Rating

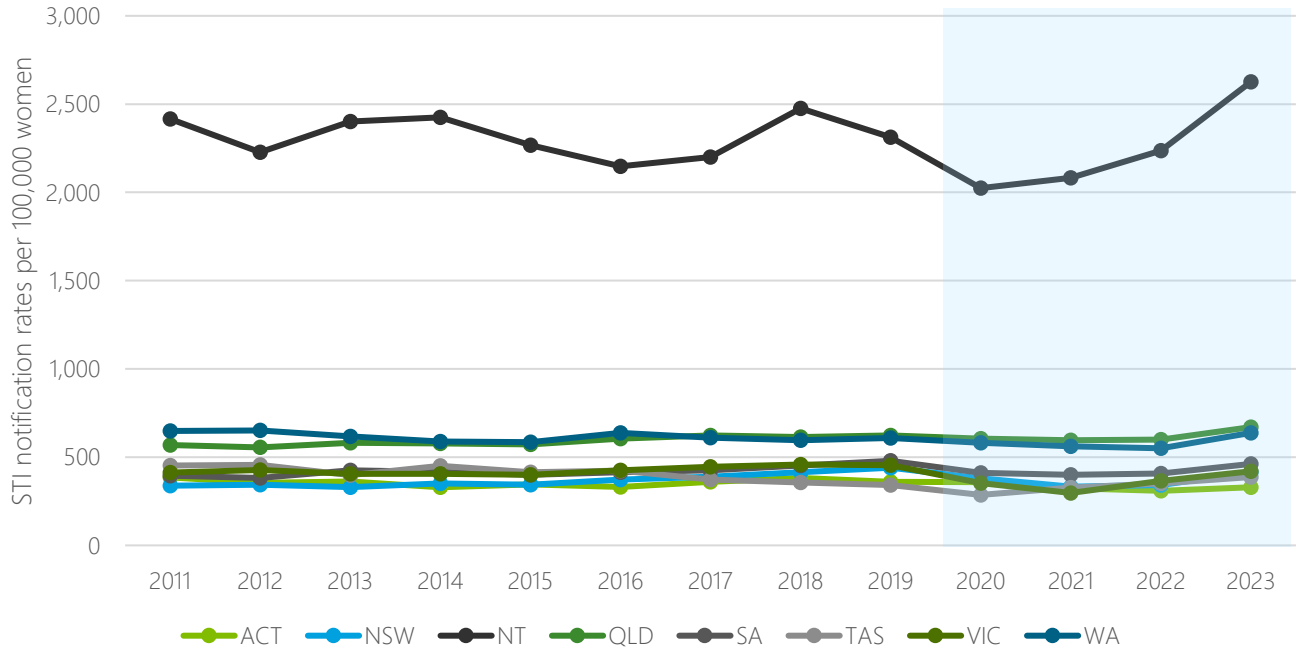
Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 1.1 | Decrease in the notification rates of sexually transmissible infections (2 of 2)

INDICATOR 1.1.1: Age standardised notification rate of sexually transmissible diseases (chlamydia, gonorrhoea, syphilis, hepatitis B, hepatitis C, HIV) per 100,000 women

Figure 1.1.1.C: Notifications of STIs per 100,000 women, by jurisdiction



Source: Department of Health and Aged Care – National Notifiable Disease Surveillance System (2024)[3]

Box 1.1.1: Transmission of Blood Born Virus (BBV) considerations

Hepatitis B and C are both blood born viruses. The rise in the transmission of BBVs is not necessarily attributed to sexual contact. In Australia, most chronic Hepatitis B cases stem from infections at birth or early childhood in other countries. Hepatitis C spreads primarily through unsterile injecting equipment, as well as via health care settings, non-sterile tattoos or piercings. It rarely transmits through unprotected sex.

Key takeaways

- By jurisdiction, there has been a slight increase in STI notifications per 100,000 women between 2011 and 2023. (Figure 1.1.1.C)
- The Northern Territory has a significantly higher rate of STI notifications per 100,000 women, almost 4 times as high as the other states.
- Since 2020, there has been a rise in STI notifications in all jurisdictions, with a significant increase in Northern Territory, considered to be driven by rising rates of Syphilis, especially among Aboriginal and Torres Strait Islander people.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*All relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

ACTION OUTCOMES

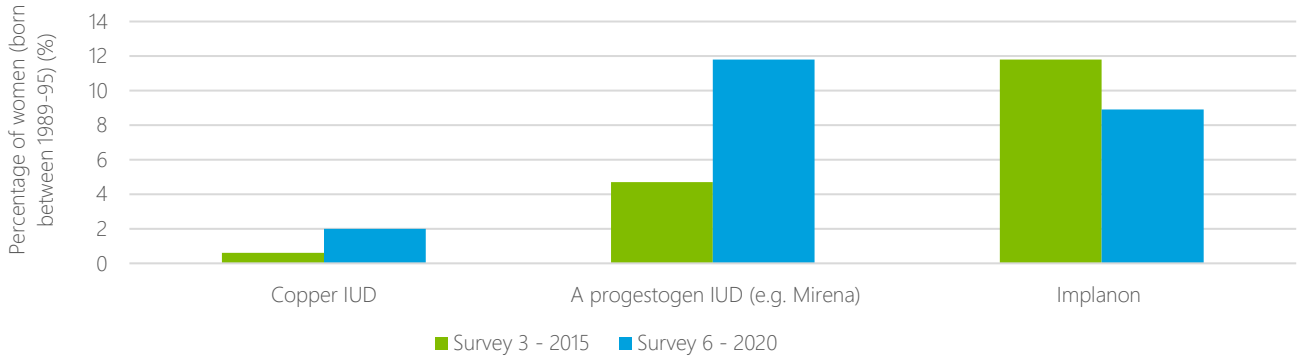
Box 1.2.1: Definition of Long-acting reversible contraception (LARCs)

- LARCs are birth control methods that provide long-lasting protection against pregnancy.
- Examples of LARCs include intrauterine contraceptive devices (IUCDs) and contraceptive implants.

Measure 1.2 | Increase in the availability and uptake of Long-Acting Reversible Contraception

INDICATOR 1.2.1: Percentage of women who report using contraception, by type (born between 1989 and 1995)

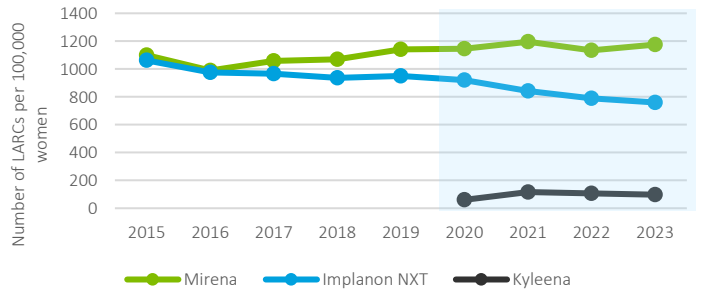
Figure 1.2.1.A: **Prevalence of contraception methods used by women in the 1989-85 cohort from survey 3 (2015) and 6 (2020)**



Source: ALSWH- Cohort 1989-1995 – survey 3 and 6[1]

INDICATOR 1.2.2: Number of prescriptions dispensed for LARCs for all patient types per 100,000 women

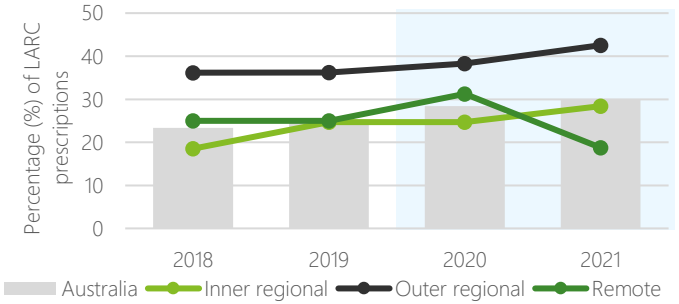
Figure 1.2.2.A: **Number of prescriptions dispensed for available LARC types per 100,000 women between 2015-23**



Source: Prescriptions of Mirena & Implanon & Kyleena from PBS online statistics codes 8633J (Mirena), 8487Q (Implanon NXT), 11909T (Kyleena)[2] and ABS Estimated Resident Population data (using June of every year)[3]

INDICATOR 1.2.3: Proportion of LARC prescribing by nurse practitioners and midwives,

Figure 1.2.3.A: **Percentage of LARC prescribing by nurse practitioners and midwives between 2018-21, by regionality**



Source: James, S., Kunnel, A., Tomnay, J., Mazza, D., & Grzeskowiak, L. (2023). Long-acting reversible contraception prescribing coverage by nurse practitioners and midwives in Australia. Collegian, 30(4), 627-632. https://doi.org/10.1016/j.colegn.2023.04.004[4]
Regionality defined by using Australian Bureau of Statistics level 3 statistical area (SA3) during the calendar years of 2018-21.

Key takeaways

- There is evidence of an increase in utilisation of various contraception forms (Figure 1.2.1.A), with the ALSWH reporting an increase of young women using the IUCD and a decrease in usage of an Implanon over this period, despite IUCD not being subsided.
- Based on PBS prescriptions (Figure 1.2.2.A), there has been a slight increase in Mirena and a slight decrease in Implanon utilisation since 2014, consistent with Indicator 1. 2020 also saw a rise in the availability of LARC on the PBS, with Kyleena (Levongesterol) being introduced as the first LARC listed on the PBS in 15 years.
- The percentage of LARC prescriptions issued by nurses and midwives rose between 2018 and 2021, especially in regional areas (Figure 1.2.3.B). This suggests improved coverage and potentially greater accessibility to LARC, particularly in regional areas. However, a recent study found that despite an overall increase in prescriptions by nurse practitioners and midwives, the number remains low and coverage across remote areas is lacking.[4] A core reason for this is a limited number of nurse practitioners in women's health, for example stakeholders noted that there are only two nurse practitioners working in the NSW public health system and none in South Australia. There are also no upcoming positions or succession planning in this area of specialty.
- It is unclear what proportion of LARCs uptake relate to protection against pregnancy, compared to treatment of conditions such as endometriosis.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

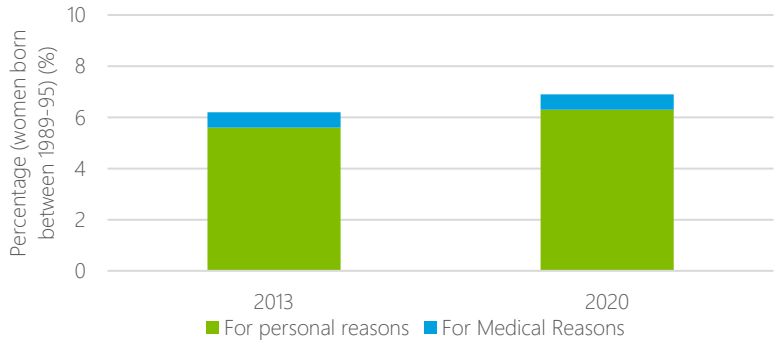
Positive trend in outcome	No observable change	Negative trend in outcome	Insufficient data available

ACTION OUTCOMES

Measure 1.3 | Equitable access to pregnancy termination services

INDICATOR 1.3.1: Percentage of women who have ever reported pregnancy

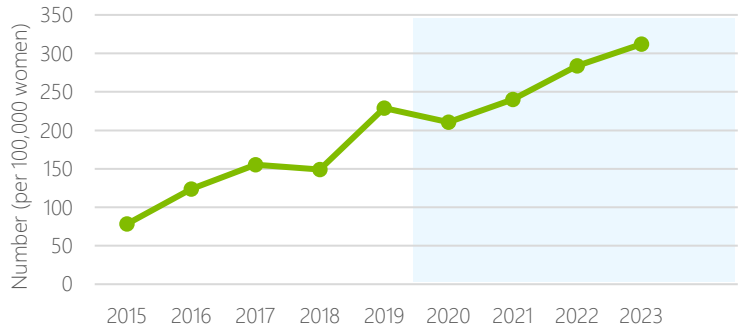
Figure 1.3.1.A: Percentage of women who have ever reported pregnancy terminations, for both personal and medical reasons



Source: ALSWH– Cohort 1989-95 Survey 1 and Survey 6[1]

INDICATOR 1.3.2: Number of medical termination of pregnancy services used per 100,000 women

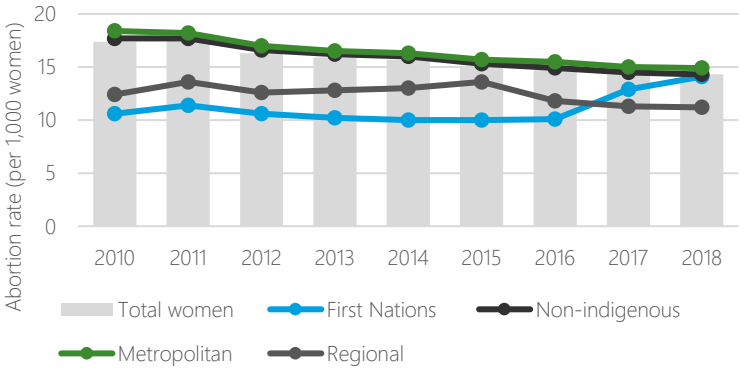
Figure 1.3.2.A: Number of medical termination of pregnancy services per 100,000 women from 2015 to 2023



Source: PBS online statistics codes 10211K (Mifepristone & Misoprostol)[2] and ABS estimated resident population[3]

INDICATOR 1.3.3: Pregnancy termination rate per 1,000 women per year

Figure 1.3.3.A: Pregnancy termination rate per 1,000 women in WA between 2010-18



Source: WA Department of Health – Abortion Notification System report 2016-18[4]

Box 1.3.1: Some improvement in regional access

A recent study examined factors associated with induced abortion history among women giving birth in Victoria, revealing **disparities across geographic regions, with lower rates in regional areas**. They noted an increase in reported abortions in non-urban areas over time, possibly linked to limited access to LARCs and health care professionals outside major cities.[5]

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Key takeaways

- The ideal way to assess equity in access to termination services is to understand the proportion of females seeking termination services who were able to access a service (i.e., met demand), and the distance they needed to travel to do so. In the absence of a national abortion registry, it is unclear whether access is equitable and which factors influence provision of abortion care.
- As shown in Figure 1.3.1.A, ALSWH data shows that the proportion of surveyed women who have ever had an abortion increased slightly between 2013 and 2020. The number of medical termination of pregnancy (MTOP) services per 100,000 women from 2015 to 2023 also increased (Figure 1.3.2.A).
- There are access disparities across geographic regions. For example, data on priority populations available in Western Australia (Figure 1.3.3.A) evidences lower abortions rates in regional areas and for First Nations women between 2010 and 2018. Studies on this topic indicate it may be related to limited access to abortion services, LARC provision and prescribing workforce professionals outside major cities.[2]
- Stakeholders also noted that there are "slow and steady improvements in the number of medical abortion providers". However, data on providers is not currently available.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Moderate publication frequency and lag*	*Some relevant priority groups disaggregated*

Measure 1.4 | A continued increase in the rate of vaccinations under the national HPV program

INDICATOR 1.4.1: Change in percentage of female adolescents meeting full dose HPV immunisation by age 15

Figure 1.4.1.A: Percentage of female adolescents meeting full dose requirements between 2012-22

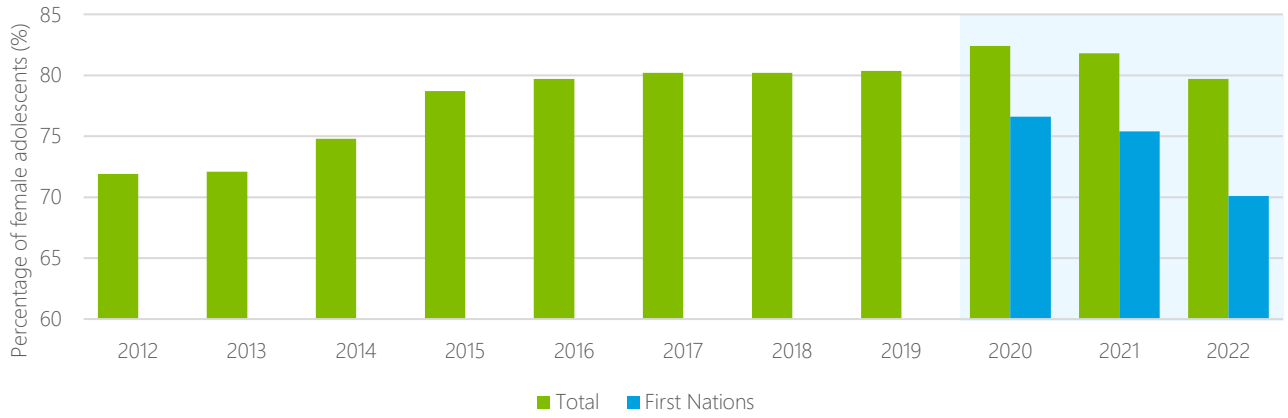
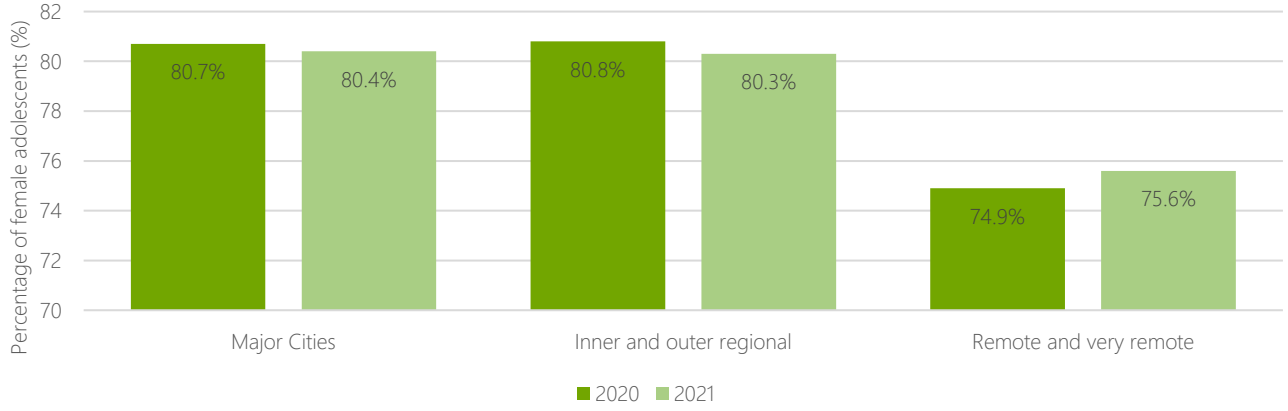


Figure 1.4.1.B: Percentage of female adolescents meeting full dose requirements between 2020-21, by regionality



Source: Australian Immunisation Register (AIR) from National Centre for Immunisation Research and Surveillance annual report.[1]
For priority groups, data is only available post 2020, due to the transition of the HPV vaccination data from the National HPV Program Register to state and/or territory school-based systems to Australian Immunisation Register (AIR).

Key takeaways

- Since 2012, there has been an increase in the proportion of female adolescents who have met full dose HPV immunisation requirements by the age of 15. In 2021, approximately 80% of females were fully vaccinated (Figure 1.4.1.A).
- First Nations women and women from remote and very remote areas have significantly lower rates of HPV vaccinations (Figure 1.4.1.A).
- Between 2020 and 2022, overall vaccination rates slightly decreased (Figure 1.4.1.B). The COVID-19 pandemic and lockdowns could be a contributing factor to this decline.
- It was also noted that the introduction of self-sampling for cervical screening tests has increased the rates of cervical screening in rural, remote and First Nations women.[2]

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Regular and timely publication of data*	*All relevant priority groups disaggregated*

Trend Rating

Legend

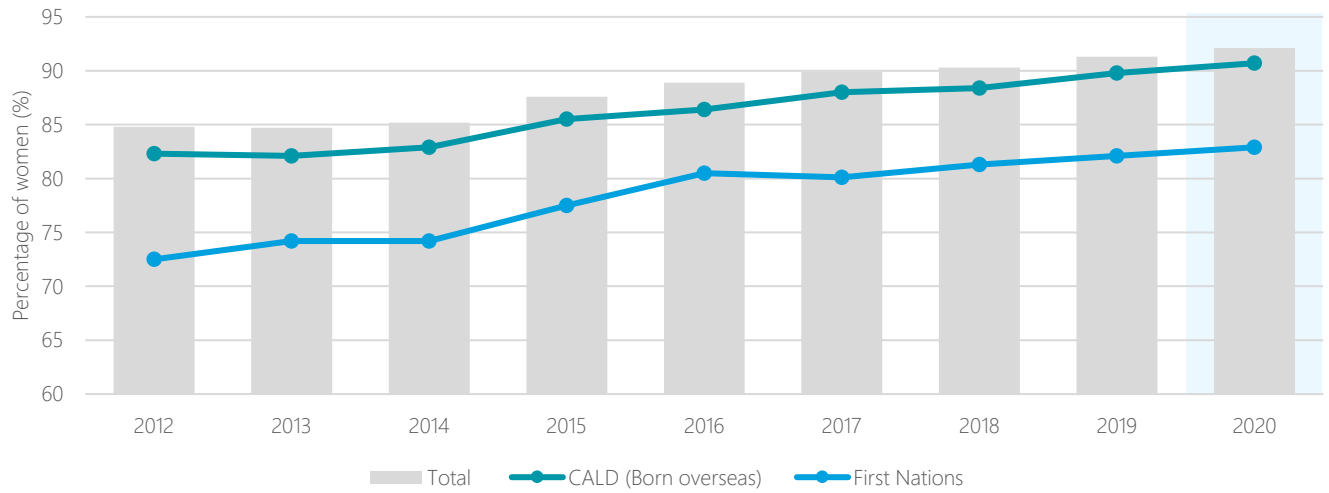
Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

ACTION OUTCOMES

Measure 1.5 | Increased early access to antenatal services by Aboriginal and Torres Strait Islander women and CALD women

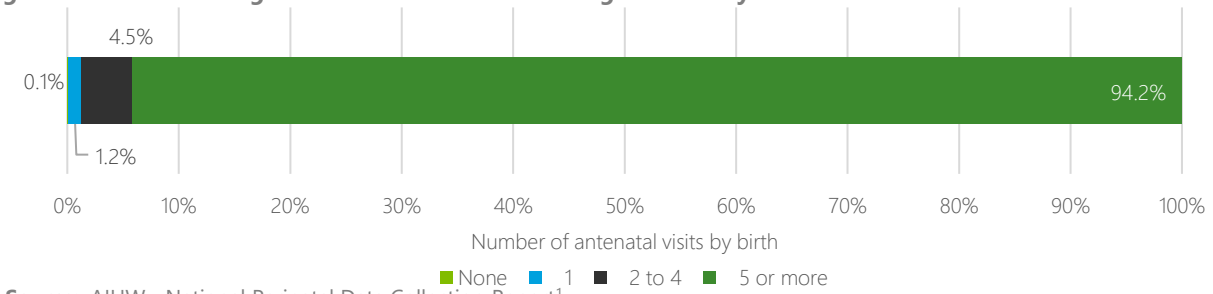
INDICATOR 1.5.1: Percentage of women accessing antenatal care before 20 weeks pregnancy

Figure 1.5.1.A: Percentage of women accessing antenatal care before 20 weeks pregnancy, by priority group



Source: AIHW - National Perinatal Data Collection Report[1]
The numbers provided are derived from hospital records and do not represent the volume of visits to general practitioners during the same timeframe. It's important to note that these hospital figures might indicate limited access to health care services in the community.
Although there is no specific data available regarding CALD women, an indirect indicator can be found in the statistics *of women born overseas. While this doesn't directly correspond to the CALD population, it serves as a proxy measure. It is likely to be still an underestimate*

Figure 1.5.1.B: Percentage distribution of women who gave birth by number of antenatal visits



Source: AIHW - National Perinatal Data Collection Report[1]

Key takeaways

- Since 2012, there has been a steady increase in the proportion of First Nations and CALD women accessing antenatal care at hospitals before 20 weeks of pregnancy (Figure 1.5.1.A).
- In 2020, 83% of First Nations and 90% women born overseas accessed this antenatal care compared to 92% of all women (a difference of 9 and 1.5 percentage points) (Figure 1.5.1.A).
- According to the National Perinatal Data Collection Report (2019), 94% of women give birth after visiting antenatal services five or more times, while only 0.1% of women do not visit any antenatal services (Figure 1.5.1.B). Based on the limited disaggregated data available, there is no evidence of a disparity among priority groups. This data is not currently available over time.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Moderate publication frequency and lag*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome	No observable change	Negative trend in outcome	Insufficient data available

Measure 1.6 | De-stigmatisation of urinary and faecal incontinence and improved access for women to care for these conditions, including pelvic floor physiotherapy

INDICATOR 1.6.1: Percentage of adult women who experience stigma related to incontinence

In 2019...

At least 1 in 3 women are affected by incontinence (compared to 1 in 10 men).
Prevalence of urinary and faecal incontinence for women is estimated to be 42% and 21% respectively.[2]

61% of women who have given birth have experienced incontinence.

29% of women contacted a health professional about their incontinence

34% of adult Australians would not discuss incontinence with their family or friends

63% Believe that incontinence is inevitable after childbirth

48% Believe that incontinence is an inevitable part of ageing

Source (unless otherwise indicated): Continence Foundation of Australia – Continence in Australia snapshot (2019).[1]

Key takeaways

- Another study estimated incontinence prevalence for women aged 24-80 years to be 42%, assessed by a validated questionnaire.[2]
- Societal attitudinal shifts such as de-stigmatisation of urinary and faecal incontinence are ideally measured through a national survey that collects information on people's experiences.
- There is limited publicly available data to measure access to continence care, which covers a range of services including continence nurse advisors, pelvic floor physiotherapy, surgery procedures, medication, and consumer products. Continence nurse advisors or practitioners in particular are typically the first point of call, but may not be visible as many operate in this role as an adjunct to their substantive role.
- In 2019, a national survey of 1,997 adults, commissioned by the Continence Foundation of Australia, assessed Australian's experience of incontinence, awareness of the condition and attitudes towards it.
- Approximately 34% of all Australians would not discuss incontinence with their family or friends, indicating the prevalence of underlying stigma, with many believing that incontinence is inevitable after childbirth (63%) and through ageing (48%).

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Data quality

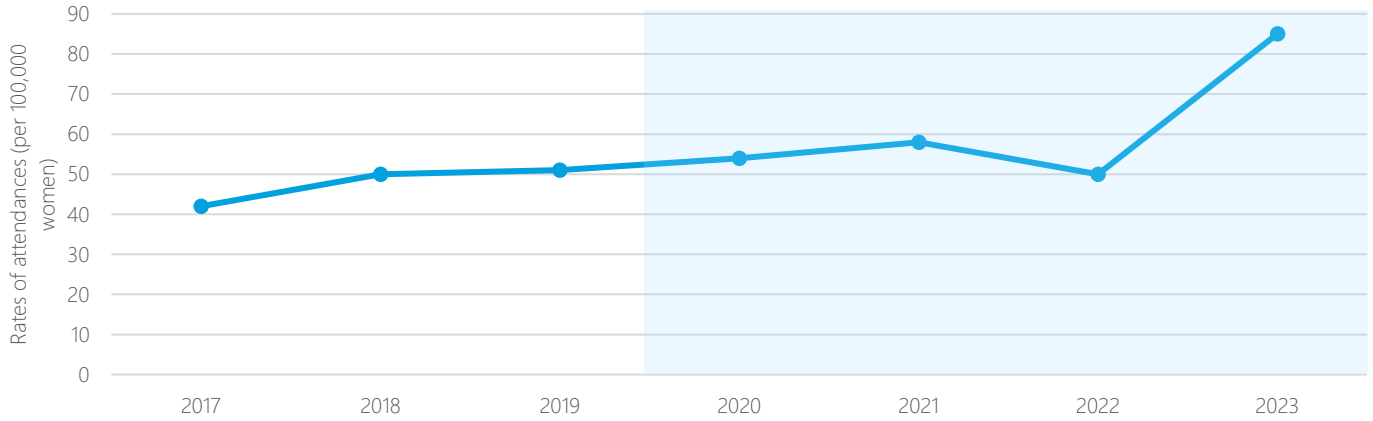
Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Data reporting is highly irregular*	*No priority groups disaggregated*

ACTION OUTCOMES

Measure 1.7 | Improved access to counselling and care of adult women with sexual function concerns

INDICATOR 1.7.1: Rate of sexual health medicine attendances per 100,000 women

Figure 1.7.1.A: **Rate of sexual health medicine attendance per 100,000 women between 2017-23**



Source: Medicare Australia online statistics – Aggregate of MBS Items 6051, 6052, 6057 & 6058 & 6059 & 6060[1]

Key takeaways

- Measuring access to counselling and care of adult women with sexual function concerns is difficult.
- Access can be partially proxied by per capita utilisation rates of sexual health physician consultation MBS items. However, there are two limitations of this approach:
  1. *Only some sexual function concerns are addressed by sexual health physicians; the majority are addressed by GPs using standard attendance MBS item numbers.*
  2. *The majority of sexual health physician encounters are related to communicable diseases (for example STIs) rather than broader sexual function issues.*
- There is an overall increase in MBS codes related to sexual health physician consultations since 2017 (Figure 1.7.1.A).

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
No accurate data is available	*Moderate publication frequency and lag*	*No priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Priority 2 – Healthy Ageing

Summary insights | Healthy Ageing

Implementation progress

Sub-priority	Summary	Progress Rating		
		Requires stronger focus	Some progress	Meaningful progress
Priority 2.1: Adopt a life course approach to healthy ageing for women	The health sector is increasingly adopting the language of a 'life course approach' and 'healthy ageing'. However, there is limited evidence of a gender-specific approach being applied in practice.	●	○	○
Priority 2.2: Address key risk factors that reduce quality of life for women as they age	While there is significant investment in the conditions that reduce quality of life for women as they age, much of this investment is not gender-specific or targeted to risk factors. Importantly, awareness of incontinence and the effects of menopause have increased strongly since the release of the strategy in 2020.	○	●	○
Priority 2.3: Better manage the needs of an ageing population	There is limited evidence of investment in managing the needs of Australia's ageing population, especially from a dedicated gender perspective. A lack of support for aged care workers and limited access to supports in regional areas were highlighted as key gaps in consultation.	●	○	○

Trend in outcomes in past five years

Measure of success	Summary	Trend
Reduction in the number of preventable and avoidable deaths	Preventable death rates have steadily declined since 2006, but First Nations women continue to experience persistently high rates, with no significant decrease since 2012. Common causes of death for women include Coronary Heart Disease and stroke.	Positive downward trend
Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease	Heart Health Checks saw a substantial increase in uptake from 2019 to 2023, particularly among women aged 75 and over. However, there was a temporary decline in screening services between 2020 and 2022, likely due to the impact of COVID-19. Overall, GP visit rates declined in 2022 and 2023, especially in remote areas.	No observable change
Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity	In recent years, there has been an increase in women meeting WHO physical activity guidelines, especially among older age groups (50+ years).	Positive upward trend

Priority 2.1 | Adopt a life course approach to healthy ageing for women

The health sector is increasingly adopting the language of a 'life course approach' and 'healthy ageing'. However, there is limited evidence of a gender-specific approach being applied in practice.

Key aligned activities

Awareness that healthy ageing starts young

- The Australian Government has incorporated language associated with healthy and/or positive ageing in its strategies and digital communications. For example, the Department of Health, Disability and Ageing provides a suite of online resources under a heading of 'positive ageing,' which aim to assist individuals in staying healthy and independent for longer.[1]
- Several NGOs and state health departments have adopted a life-course approach in their strategies. For example, Queensland Health has adopted a life course approach in the *Queensland Women and Girls Health Strategy*.[2]
- According to stakeholders, over the last 10 years, health care practitioners and the aged care sector have increasingly utilised the language of healthy ageing and reablement in communications and policy. RACGP adopts the WHO's definition of healthy ageing – the 'process of developing and maintaining functional ability that enables wellbeing in older age.[3]
- The *National Preventive Health Strategy 2021-2030* (NPHS), which aims to prevent risk factors of chronic conditions and support protective behaviours, recognises that preventive health measures need to consider gender inequities and to address health at all stages of the life course.[4] The Department of Health, Disability and Ageing is developing an Implementation and Evaluation Plan to support the NPHS.

Acknowledgement of need for targeted interventions

- State and territory governments have also acknowledged the need for interventions relating to healthy ageing. For example, in 2022, Safer Care Victoria consulted with the Senior Victorians Advisory Group on how to change health service design to better include older consumers' voices.[5]
- The not-for-profit, LiveUp, provides free information, local activities and assistive products for women and men as they age. Users can also access LifeCurve, an online assessment tool that provides personalised advice on how to improve mobility and regain independence. The tool tracks users' abilities and compares them with other users of a similar age.[6]
- Jean Hailes refers to healthy ageing as a key priority area and provides a range of digital resources tailored to women. These resources include information on the role of bone health, physical activity, social connection and heart health in healthy ageing. The organisation also produces and delivers evidence-based knowledge on healthy ageing for women to the health industry and offers high-quality care for women from two established clinics.[7]

Areas for attention

- There is a lack of clarity among health care bodies around the terms 'healthy ageing' and 'life course.' Several stakeholders struggled to define these terms.
- There is a lack of disaggregated data available on the health outcomes of people as they age by priority groups.
- There is confusion among providers around how a life course approach to healthy ageing differs for women relative to men. Often stakeholders are not taking a gendered approach to healthy ageing. For example, the Department of Health, Disability and Ageing's *Choose health, be active* guide to physical activity for older Australians does not specify the differing physical health requirements for women and men.
- Consultation and desktop review provided limited evidence of action against this priority area since the creation of the strategy. Examples of initiatives relating to priority groups (for example, First Nations women) were particularly difficult to locate.

Box 2.1.1 Jean Hailes for Women's Health

Jean Hailes refers to healthy ageing as a key priority area and provides a range of digital resources tailored to women. These resources include information on the role of bone health, physical activity, social connection and heart health in healthy ageing. The organisation also produces and delivers evidence-based knowledge on healthy ageing for women to the health industry and offers high-quality care for women from two established clinics.[8]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 2.2 | Address key risk factors that reduce quality of life for women as they age

While there is significant investment in the conditions that reduce quality of life for women as they age, much of this investment is not gender-specific or targeted to risk factors. Importantly, awareness of incontinence and the effects of menopause have increased strongly since the creation of the strategy.

Key aligned activities

Effects of menopause

- Awareness of the symptoms and health impacts of menopause has increased dramatically. However, stakeholders believe this is primarily due to grassroots movements (for example women sharing their own experiences online) rather than organised efforts.
- The Australasian Menopause Society (AMS), a network of doctors and other health care professionals who have a special interest in menopause and healthy ageing, have been sharing information, conducting advocacy work and hosting events. For example, AMS hosted *Menopause Down Under 2024* to upskill health professionals on the management of menopause.[1]
- Several state health departments have a focus on menopause and peri-menopause, such as the *Queensland Women and Girls' Health Strategy.*[2] This strategy identified a lack of access to information and supports for perimenopause and menopause as key health care gaps and aims to "increase awareness of and introduce new services for women to access early advice on and supports for [menopause]."
- The New South Wales Government partnered with Jean Hailes to deliver both the *Perimenopause and Menopause Symptom Checklist* and the *Menopause Checklist Podcast*, which included 10 episodes exploring the range of symptoms women may experience during menopause.
- On 6 November 2023, the Senate referred an Inquiry into the issues related to perimenopause and menopause to the Community Affairs Senate References Committee. The report is due on 17 September 2024 and will cover the economic, physical, emotional, and mental health impacts.
- The Australian Government is providing funding to support training for health practitioners to address women's health during menopause.

Dementia across the life course

- Stakeholders revealed that, while the diagnosis of dementia is improving, further education for medical professionals on diagnosing and managing dementia is required. For example, some medical professionals fail to recognise the early warning signs of dementia because they mistake the symptoms for menopause-related 'brain fog.'
- The 10-year *National Dementia Action Plan* is expected to be released in late 2024.[3] The consultation paper for the plan identifies specific gender impacts of dementia, for example it recognises that dementia is the leading cause of death for women and that women make up nearly three in four primary carers of people with dementia.
- So far, the Australian Government has allocated a total of $60.1 million to improve the quality and experience of dementia respite through the Improving respite care for people with dementia and their carers program. The program provides access to carer education and wellbeing supports, respite care planning and dementia-specific respite training to enhance the skills and strengthen the capacity of the aged care sector.[4]

Awareness around incontinence and fall prevention

- State and territory governments have also been acting to improve the capability of the health sector in responding to incontinence. For example, the Aged and Community Care Providers Association (ACCPA) has teamed up with the Queensland Government to offer free incontinence training for nurses and care workers. The training will focus on incontinence assessment, care planning and prevention strategies.[5]
- The Continence Foundation of Australia enhances continence care and awareness through the *National Continence Program*. The Program addresses the needs of women, particularly in relation to pregnancy, childbirth, and menopause, and provides education, support, and advocacy to improve access to treatments and reduce the stigma associated with incontinence.
- Active Ageing Australia, a registered not-for-profit that promotes physical activity over the lifetime, provides training, online resources and opportunities for collaboration among organisations focused on healthy ageing. The organisation responds to the intersecting needs of women as they age, with a focus on movement and fall prevention.[6]

Areas for attention

- Stakeholders revealed that a gender-lens is rarely applied to healthy ageing and the treatment of conditions like dementia, and cardiovascular disease.
- Training for health professionals in menopause is still insufficient. Many health care professionals lack the skills and/or confidence to deliver appropriate care, leading to misdiagnoses. Menopause treatment, including menopausal hormone therapy (MHT), is undermined by a lack of clinician knowledge (particularly in primary care), poor access to services, negative attitudes and lagging research. Further, the commercialisation of menopause has exposed women to untested treatments.
- Public awareness of the risk factors of dementia is low. However, the scope of Dementia Australia's awareness raising activities was recently expanded to improve awareness of Dementia Australia's early intervention and post-diagnostic services amongst GPs and health professionals.
- Only 15 of the 35 specialist dementia units the Australian Government committed to delivering by 2023 are operational, with an additional 8 to become operational in 2024-25. These specialist units were announced in 2016 under the Specialist Dementia Care Program (SDCP).
- Stakeholders noted that incontinence has increased over recent years, particularly in postnatal checks. However, there is limited data collection and access to pelvic floor physiotherapy in the public system. See Measure 6 for more.
- Older women with low financial assets are increasingly at risk of homelessness, which can impede healthy ageing.

Box 2.2.1 Queensland Women and Girls' Health Strategy 2032

A key aim of the strategy is to improve awareness and support for women experiencing menopause. As part of the strategy, the Queensland Government has committed to $2.33 million in funding to deliver peer support group programs with a focus on women's health conditions including menopause and has promised to deliver a Women's Health Clinical Showcase to promote best practice menopause management.[7]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 2.3 | Better manage the needs of an ageing population

There was limited evidence of investment in managing the needs of Australia's ageing population. A lack of support for aged care workers and access to supports in regional areas were highlighted as key gaps in consultation.

Key aligned activities

Capacity within health system

- As part of Australian Primary Health Care Nurses Association's *Nursing in Primary Health Care* Program, Building Nurse Capacity Clinics delivered specialised training on chronic disease management and healthy ageing for women, including diagnosing cardiovascular disease and dementia. The first phase of the Program went from 2018-19 to 2022-23 and the second phase started on 30 June 2023.[1]
- The establishment of a new Australian Research Council centre – the *Industrial Transformation Training Centre in Optimal Ageing* – in 2023 aims to boost research capacity within the health system to support Australia's ageing population. Its main focus is enhancing cognition, promoting independence and sustaining connectedness by developing and implementing digital robotics and sensor-based technologies.[2]

Loneliness as a key issue for older women

- In 2022, the RACGP launched a dedicated Specific Interests group to encourage GPs to engage in social prescribing (supporting patients to access social and community services). This reflects that many GPs are using social prescribing as a tool to address mental health concerns and combat loneliness.
- In 2023, NHMRC granted four research teams over $5.5 million to investigate ways to identify and support people with chronic disease who are experiencing loneliness and social isolation.[3]
- In 2024, the Queensland Government invested an additional $12.5 million in 42 Seniors Social Isolation Services. This builds on the existing $20.5 million allocated over the next five years.[4] In 2022-23, Seniors Social Isolation Services engaged with around 79,000 elderly Queensland residents. These Services provide social and physical activities, as well as information and referral support, to elderly people experiencing isolation and loneliness.

Role of carers

- In the 2021-22 Federal Budget, the Australian Government committed $798.3 million to supporting informal and family carers of senior Australians, including for those caring for people living with dementia.[5]
- In 2023, Carers Victoria introduced a 'Connecting Carers in their Community' grants program to provide support for organisations which support unpaid carers in their local community. 25 organisations received a one-off grant of between $20,000 to $40,000.[6]
- In 2023, the Australian Government granted $1.7 million to GreenCare Respite Project, funded under the Commonwealth investment towards dementia respite (see Priority 2.2). It is an Australian-first initiative that provides nature-based escapes to people with early-stage dementia and their caregivers.[7] The GreenCare Respite initiative involves therapeutic activities, day programs, and overnight stays for people with early-stage dementia while offering respite for caregivers.
- The Commonwealth Home Support Programme (CHSP) provides entry level support to older Australians who require assistance to continue living independently. Services available include transport, meals, domestic assistance, personal care, nursing, allied health and respite care. Additional funding was made available throughout 2022–23 and 2023-24, to enable CHSP providers to effectively respond to increases in service demand, innovations, and emergency circumstances.[8] Home Care Packages (HCPs) provide older Australians with more complex needs access to clinical care, personal care, and support services, assisting them with undertaking day to day activities whilst living at home. Increased allocations of HCPs not only benefit the people who receive them, but also their family members, friends, and carers as their care obligations are complimented by the care delivered through the HCP Program.

Areas for attention

- There is a lack of gender-specific initiatives focused on meeting the needs on an ageing population. As women outlive men, have higher rates of chronic disease and experience ageing and caring differently, it is critical that health care services are tailored to their needs.
- During consultation, no specific initiatives aimed at better managing the needs of an ageing population were mentioned. The initiatives listed in this report were identified using Department documents and desktop review. This suggests that there needs to be significantly more investment in managing the increasing complexity and health needs of older women.
- There needs to be greater integration between GPs and social workers, and social prescribing available to women through GPs, to ensure women can access support for the complex issues that impact their health.
- There is a lack of recognition, focus and support on aged care workers, many of whom are CALD women. These workers play a key role in healthy ageing.
- The number of GPs has declined significantly in rural and remote Australia, limiting the ability of older women in these regions to access support.

Box 2.3.1 Building Nurse Capacity Clinics

The Australian Government funded Building Nurse Capacity Clinics to provide training to nurses in primary health care settings. The training was focused on healthy ageing (for example, assessing cardiovascular disease and dementia) and targeted women and other priority populations. The Australian Government continued funding the Nursing in Primary Health Care program from July 2023 to 30 June 2026. [9]

Progress rating

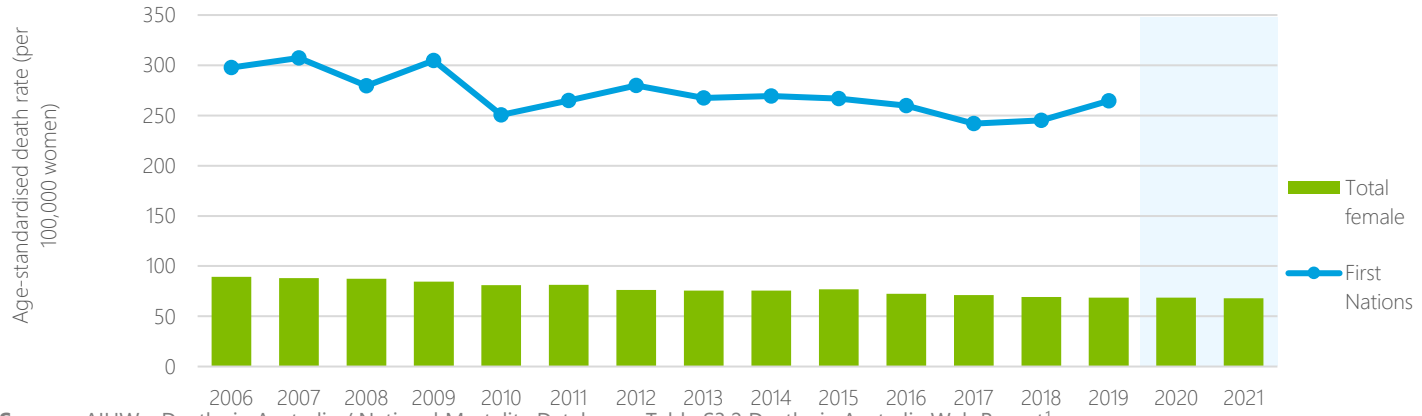
Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION OUTCOMES

Measure 2.1 | Reduction in the number of preventable and avoidable deaths

INDICATOR 2.1.1: Age-standardised death rate of potentially avoidable deaths among women aged less than 75 per 100,000 women

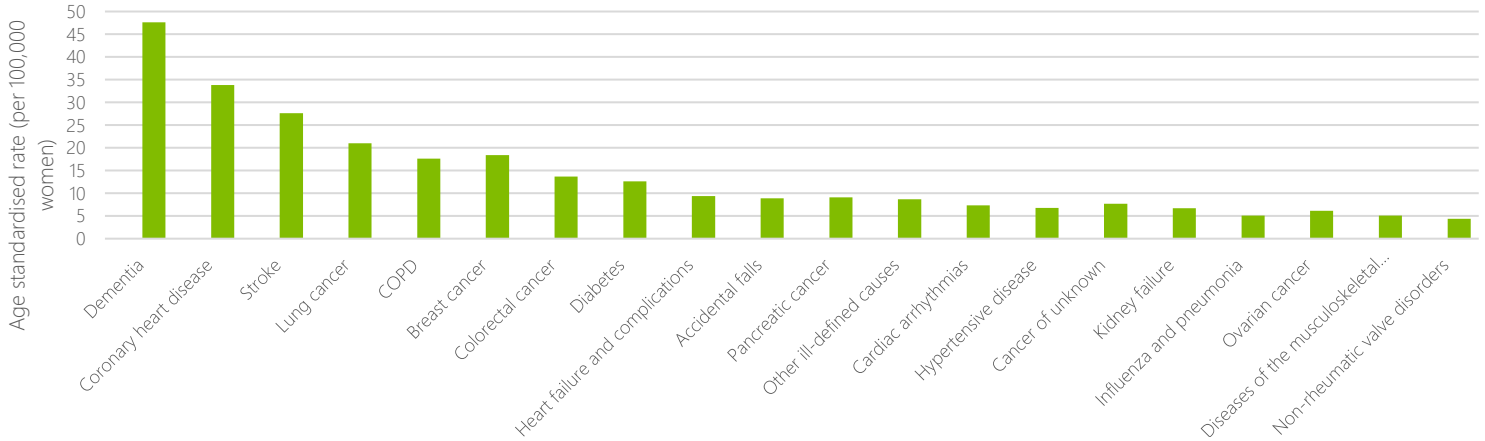
Figure 2.1.1.A: Age-standardised death rate of potentially avoidable deaths among women aged 75 years or less



Source: AIHW – Deaths in Australia / National Mortality Database - Table S3.2 Deaths in Australia Web Report[1]

INDICATOR 2.1.2: Leading underlying causes of death, number and age-standardised death rates (deaths per 100,000 women), 2021

Figure 2.1.2.A: Leading underlying causes of death in women, 2021



Source: AIHW – Deaths in Australia / National Mortality Database - Table S3.1Deaths in Australia Web Report[1]

Key takeaways

- Age standardised rates of avoidable deaths have on the whole decreased since 2006, with the current rate at 68 per 100,000 women in 2021 (Figure 2.1.1.A).
- However, among First Nations women, the rate remains high at 264 per 100,000 women, with no significant reduction since 2012 and no data published since 2019 (Figure 2.1.1.A).
- The leading causes of death for women include Dementia, Coronary Heart Disease and Stroke (Figure 2.1.2.A)

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

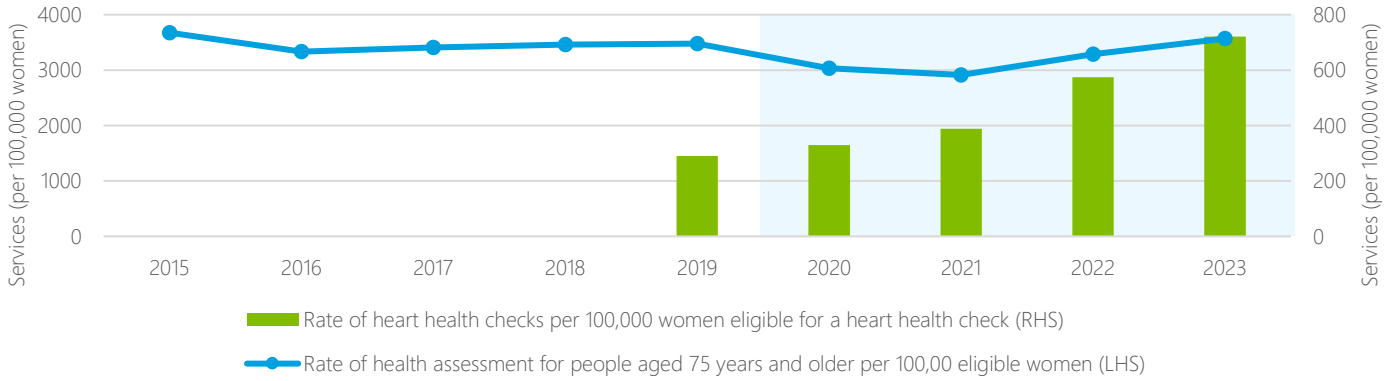
Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 2.2 | Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease

INDICATOR 2.2.1: Rate of Heart Health Checks per 100,000 women eligible for a heart health check
INDICATOR 2.2.2: Rate of health assessment for people aged 75 years and older per 100,00 eligible women

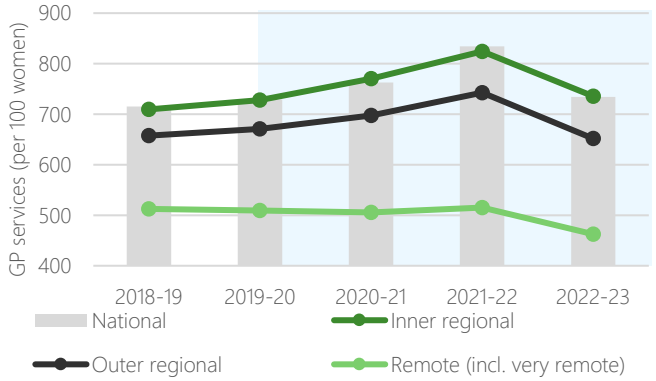
Figure 2.2.1.A: Services per 100,000 women for Heart Health Checks and health assessments for people aged 75 years and over



Source: Indicator 1: MBS online statistics - item codes 699 and 177, Indicator 2: MBS online statistics – item codes 701, 703, 705, 707[1]

INDICATOR 2.2.3: Rate of GP visits per 100 women in the past 12 months

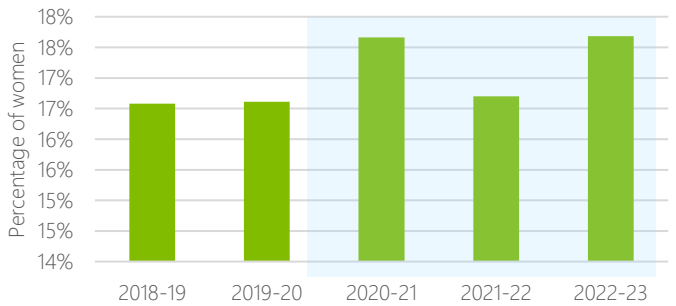
Figure 2.2.3.A: Rate of GP visits by women in the last 12 months per 100 women



Source: AIHW – Medicare-subsidised GP, allied health and specialist health care[2]

INDICATOR 2.2.4: Percentage of adult women who saw a GP for chronic disease management in past 12 months

Figure 2.2.4.A: Percentage of adult women who saw a GP for chronic disease management in the last 12 months



Source: AIHW – Medicare-subsidised GP, allied health and specialist health care[2]

Key takeaways

- "Heart Health Checks" is an assessment of CVD risk factors in adults aged 45+ years, First Nations peoples aged 30+ years, and people with diabetes aged 30+ years. The rate of these checks undertaken in general practice has increased by 148% from 2019 to 2023 (Figure 2.2.1.A).
- MBS claims data for 'Health Assessments' in women aged 75+ can be used to screen for CVD and cognition. Indicator 2.2.2 shows these increased by 3,500 per 100,000 women from 2020 to 2023. The decrease in health assessments between 2020 and 2022 is likely due to the COVID-19 pandemic.
- The rates of overall GP visits declined from 2021-22 to 2022-23, compared to the steady increase observed from 2018-19 to 2021-22 (Figure 2.2.3.A). Remote areas have significantly lower rates per women (Figure 2.2.3.A).
- The percentage of adult women who saw a GP for chronic disease management in the past 12 months fluctuated between 17% and 18% during 2018 to 2023 (Figure 2.2.4.A).
  Identified limitations of measuring screening via MBS item codes include:
  - *Assessments for cardiovascular and cognitive health may also be addressed by standard attendances and broader health assessment activities within general practice.*
  - *MBS assessment items for Aboriginal and Torres Strait Islander older persons aged 55+ are excluded from reporting, despite assessing cognition and cardiovascular condition.*

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

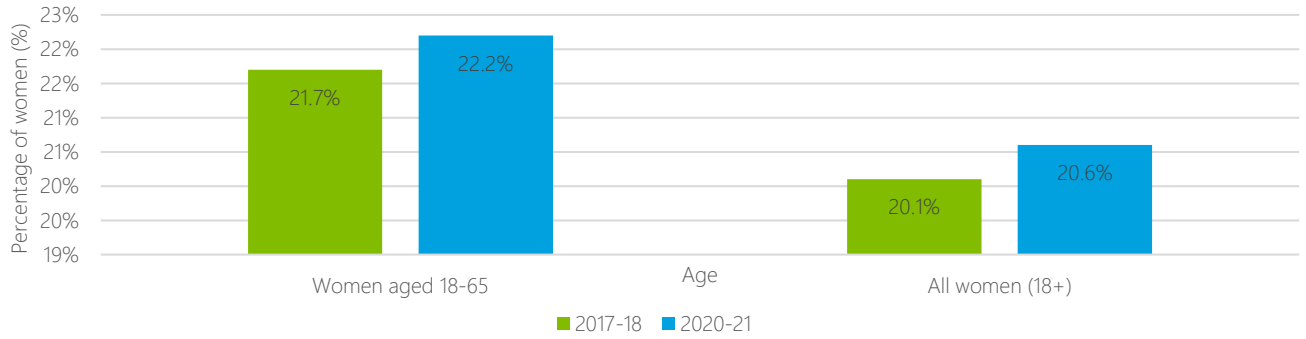
Positive trend in outcome	No observable change	Negative trend in outcome	Insufficient data available

ACTION OUTCOMES

Measure 2.3 | Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity

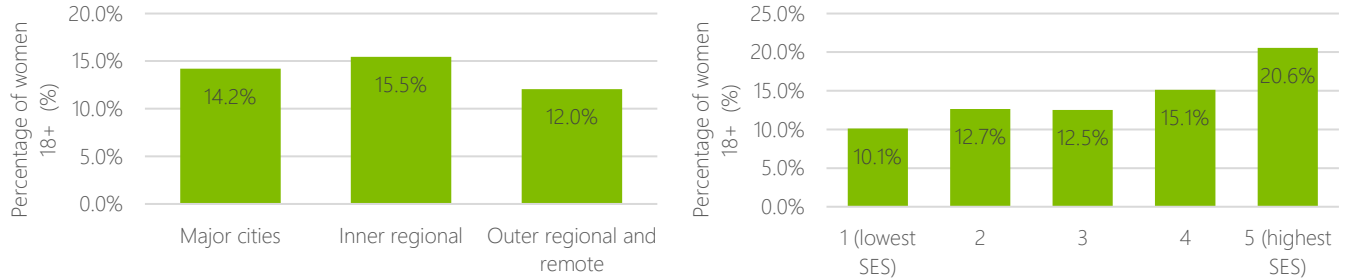
INDICATOR 2.3.1: Percentage of women who meet the criteria for 'sufficient physical activity'

Figure 2.3.1.A: Percentage of women who meet criteria for 'sufficient physical activity' , by age



Source: Australian Institute of Health and Welfare. (2023). Physical activity.[1]

Figure 2.3.1.B: Percentage of women who meet criteria for 'sufficient physical activity', by remoteness and socioeconomic area, 2017-18



Source: Australian Institute of Health and Welfare. (2023). Physical activity[1]

Box 2.3.1.: Sufficient physical activity[2] for both genders is defined as:

- For children aged 2-17: a minimum of 60 minutes per day of physical activity daily.
- For adults aged 18-64: a minimum of 150 minutes of moderate to vigorous activity each week.
- For adults aged 65 and over: a minimum of 30 minutes or more of physical activity on most, preferably all, days.

Key takeaways

- Women are increasingly meeting physical activity guidelines. Among women aged 18-65 and 18+ years of age, there has been an increase of 0.5 percentage points in women meeting physical activity guidelines (Figure 2.3.1.A).
- In 2017-18, women residing in outer and regional areas had a lower percentage (12%) of meeting the criteria. Similarly, women from lower socioeconomic areas also reported lower rates of meeting the criteria, with 10.1% in the lowest quintile and 12.7% in the second lowest quintile, compared to 20.6% in the highest quintile (Figure 2.3.1.B).
- It is unclear to what extent the COVID-19 pandemic has impacted physical exercise rates in the period after 2020.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Some data lag and irregular frequency of reporting*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Priority 3 – Chronic Conditions and preventive health

Summary insights | Chronic Conditions and preventive health

Implementation progress

Sub-priority	Summary	Progress Rating		
		Requires stronger focus	Some progress	Meaningful progress
Priority 3.1: Increase awareness and primary prevention of chronic conditions and associated risk factors for women and girls and embed a life course approach in policy and practice	Evidence supports initiatives raising awareness of chronic conditions and advocating primary prevention in women. However, most lack a gender lens and integration into policy and practice.	●	○	○
Priority 3.2: Invest in targeted prevention, timely detection and intervention of chronic conditions affecting women and girls	Some evidence suggests that initiatives targeting chronic disease risk factors like cardiovascular disease and timely cancer detection (through national screening campaigns) for women and girls have improved, but challenges with culturally and linguistically targeted programs remain.	○	●	○
Priority 3.3: Tailor health services to meet the needs of all women and girls	There has been limited progress in delivering comprehensive and widespread tailoring of health services to meet the needs of all women and girls. NGOs have been driving progress in tailoring programs to suit different priority population needs to increase health literacy, but sustainable funding is often scarce and inconsistent.	●	○	○
Priority 3.4: Reduce the prevalence and impact of endometriosis and associated chronic pelvic pain	Significant progress has been made in addressing endometriosis, including substantial Commonwealth investment into research, awareness, education and clinical management and care. However, evidence of progress towards other chronic pelvic pain and causes is limited.	○	○	●

Trend in outcomes in past five years

Measure of success	Summary	Trend
Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women	The percentage of women living with overweight or obesity has steadily increased from 2012 to 2022, with a marked increase for non-Indigenous women. Conversely, smoking rates have decreased. Rates of drinking at levels that may increase the risks of harm among women has remained relatively stable, with the exception of increased rates in younger women between 2019 and 2022-23. No discernible improvement can be seen for the rates of women meeting recommended dietary guidelines (fruit and vegetable intake)	No observable change
Lower incidence of cancer	Since 2010, there has been a continual increase in cancer incidence among women, with breast cancer consistently the most common cancer. However, the increase in breast cancer incidence coincided with an expansion of the breast cancer screening program in 2013 to include women aged 70-74 years Distinct trends in cancer incidence, beyond a significant jump in breast cancer in 2013, are harder to establish.	Negative upward trend
Improved rates of breast, cervical and bowel cancer screening for under-screened populations	BreastScreen participation rates have declined, with First Nations, remote, and non-English-speaking women showing lower rates. Cervical Cancer Screening rates have increased. Bowel cancer screening participation has remained stable since 2015-16.	No observable change
Decrease in prevalence of chronic conditions in women	There has been a general decrease in most of the top 10 chronic conditions, except for diabetes. Osteoporosis experienced the largest decrease, followed by cardiovascular disease. However, there has been an increase in the prevalence of multimorbidity among women.	Positive downward trend
Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and manageing these conditions	The proportion of women diagnosed with endometriosis has increased notably between 2014 and 2020, with reasons for this rise remaining unclear. Diagnosis of endometriosis typically occurs after a significant delay from the onset of symptoms, indicating potential improvements in detection methods. There is minimal data available to measure the detection of other hidden conditions including chronic pelvic pain.	Positive upward trend

Priority 3.1 | Increased awareness and primary prevention of chronic conditions and associated risk factors for women and girls and embed a life course approach in policy and practice

Evidence supports initiatives raising awareness of chronic conditions and advocating primary prevention in women. However, most lack a gender lens and integration into policy and practice.

Key aligned activities

Gender-specific approaches to chronic condition awareness building and primary prevention in women and girls:

There is growing recognition that women experience chronic conditions differently from men. They tend to have different risk factors and may develop these conditions earlier. In large part, these differences are often still overlooked in policy and practice. However, there is evidence of successful initiatives that aim to raise awareness and educate about gender-specific approaches to primary prevention and managing risk factors in chronic conditions. Some of these initiatives include:

- Jean Hailes for Women's Health and the Heart Foundation have collaborated to provide heart health information tailored for women, emphasising the importance of regular heart checks and healthy habits to lower cardiovascular risk.[1]
- In 2023, the Heart Foundation partnered with CoastTrek, organising fundraising walks to raise awareness about women's heart health and fitness.[2] These walks encourage outdoor exercise and facilitate conversations about the specific cardiovascular risks faced by women.
- Her Heart also focuses on raising awareness of cardiovascular disease in women, aiming to educate them about risk factors, prevention, and advocacy. Initiatives include #KnowYourRisk and #HerHeartMatters campaigns.[3]
- Red-Dust Strong Women's Program delivers gendered specific messages to First Nations women in Alice Springs and remote NT communities.[4] The program addresses the link between lifestyle choices and wellbeing over a life course and specifically raises awareness for risk factors, with an emphasis on alcohol and fetal alcohol spectrum disorder.
- In 2023, the Australian Government also invested in improving access to drug and alcohol treatment services in the community, including $3.5 million allocated to the Glen for Women (Central Coast, NSW) to provide culturally appropriate services to First Nations women.[5]

Primary prevention of risk factors of women who are pregnant

- The Australian Government created 'Baby Steps' to help women with gestational diabetes make healthy lifestyle choices and reduce their risk of type 2 diabetes. A 2023 study showed that 60% of users found the app helpful. Women expressed a need for more support in achieving and maintaining a healthy birth weight after gestational diabetes.[6]
- In 2022, the NSW Government issued a policy directive requiring NSW Health services and clinical staff to offer evidence-based smoking and vaping cessation support to pregnant women.[7] Clinicians must possess skills in managing smoking and vaping, including offering carbon monoxide monitoring and assisting with quitting.

Areas for attention

- Efforts to raise awareness and prevent chronic diseases often target the general population rather than specifically focusing on women. Stakeholders have emphasised the need for both government and NGOs to prioritise a gender-based approach to primary prevention, aligning with the *National Preventive Health Strategy 2021-2030*.
- Chronic pain, especially during mid-life, is often overlooked and requires greater awareness of its impact on women throughout their lives. Additionally, chronic pelvic pain (excluding Endometriosis), anaemia, and osteoporosis need more attention in terms of activities and resources. It is important to improve integrated, coordinated care across the health care system to address these issues that intersect multiple areas for women.
- Currently, there is limited evidence of a comprehensive map of risk factors and intervention points for chronic conditions throughout women's lifespan. Health professionals have consulted and referenced an online mapping tool provided by AIHW to improve local services. However, there is no widespread implementation of this tool at the local level.
- Priority populations, including women with disabilities, older adults, LGBTIQA+ communities, individuals with low socioeconomic status, and those in rural/remote areas, have limited access to safe, affordable, and inclusive spaces for physical activity. Additionally, there is minimal evidence of progress in improving health providers' knowledge about exercise and physical literacy, particularly in relation to women.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 3.2 | Invest in targeted prevention, timely detection and intervention of chronic conditions affecting women and girls

Some evidence suggests that initiatives targeting chronic disease risk factors like cardiovascular disease and timely cancer detection (through national screening campaigns) for women and girls have improved, but challenges exist with culturally and linguistically targeted programs, with structural barriers hindering nationwide implementation.

Key aligned activities

Investment into early detection of cardiovascular health

- The Australian Government has allocated $8.7 million over 6 years from 2019-20 to implement the Heart Disease and Stroke Action Plan (including promoting Heart Health Checks).[1]
- The Global Cardiovascular Research Funders Forum targets under-representation of women in research, and disparities in outcomes.[2]

Support development of healthy habits in schools

- NSW's Live Life Well @School program encourages healthy habits like exercise and nutritious eating in students.[3]

Initiatives to increase uptake of cancer screening, immunisation programs and preventive health in priority populations

- The National Bowel Cancer Screening Program (NBCSP) has launched a nationwide campaign to increase participation in screening and raise awareness in CALD and First Nations communities. From 1 July 2024, eligible people aged 45–49 are able to request a NBCSP kit from the National Cancer Screening Register or a doctor.[4]
- Australian Government Investments in education for health providers in ACCHOs aims to reinforce and enhance knowledge about cervical screening and clinical pathways in First Nations women. The course was expanded in July 2022.[5]
- Progress in HPV vaccination accessibility includes the Department of Health, Disability and Ageing providing translated resources. NSW and WA have translated materials into 26 and 15 languages, respectively.[6]
- In 2023, Cancer Institute NSW funded 20 cancer control programs in CALD communities, with immediate progress marked of the highest ever monthly participation rate in total and amongst First Nations and CALD women.[7]
- In March 2022, the Australian Government committed $10.6 million to support the Enhanced Communications Campaign for CALD Communities - Prevention and Management of Chronic Conditions Campaign.[8]
- In November 2023, the Australian Government announced the National Strategy for the Elimination of Cervical Cancer in Australia by 2035. The Australian Government provided $48.2 million towards eliminating cervical cancer as part of the National Strategy for the Elimination of Cervical Cancer in Australia, aiming to improve screening access and develop management guidelines for the disease. Since 1 July 2022, all women and people with a cervix aged 25– 74 years now have two options for having a Cervical Screening Test. One option is to have a health care provider collect your sample, the other option is to collect their own sample. A national Self Collection Campaign will launch later this year partnering with NACCHO, FECCA and ACON. The campaign will focus on empowerment and choice in cervical screening for priority populations.[9]

Investment to promote early detection of cancer and access to treatment

- New and amended items continue to be listed on the PBS for conditions affecting women. Recent listings include Enhertu® for metastatic HER2-positive breast cancer*; Verzenio® for a type of high risk early breast cancer*; and Zejula® for ovarian cancer.[10]
- In 2022, the Australian Government invested $2.2 million over four years to offer more cervical screening options. New MBS items were introduced to allow women aged 25-74 to collect their own vaginal samples to make screening easier.[11]
- $20 million to support ovarian cancer research from the Medical Research Future Fund, focusing on risk factors and early detection strategies to improve prognosis of ovarian cancer.[12]
- The Australian Government provided $16.8 million for a new MBS item for the EndoPredict® gene test. It assessed the risk of recurrent breast cancer in 18,000 patients over 4 years, starting from November 2023.[13]

Areas for attention

- Gaps in cervical, mammogram, breast and bowel screening exist, particularly among First Nations women, with limited data availability. Cancer screenings for First Nations women, including cervical and breast cancer screenings, have not improved in 20 years and are significantly lower than for other Australians. Barriers for First Nations women include lack of culturally relevant education, shame, fear, and shortage of culturally sensitive health care providers.
- The role of GPs in bowel and breast cancer screening could be enhanced to raise awareness and improve uptake in screening. Activities could include better integration of screening data with GP medical software and My Health Record; and increased engagement and communication with GPs. Resources tailored for people with low literacy could also be considered to improve equity of access.
- Due to gendered differences in the presentation of cardiovascular disease, women are slower to seek medical attention than men when faced with symptoms of cardiovascular disease and receive delayed access to care. Stakeholders highlighted that more research grants are needed to promote timely detection of female-specific risk factors such as gestational diabetes and pre-eclampsia, along with greater awareness campaigns.
- The *National Strategic Action Plan for Heart Disease and Stroke* emphasises the need for a campaign targeting women and heart disease. However, there is no evidence of a national campaign for cardiovascular disease in women, indicating ongoing focus is required.
- Studies also suggest that there are fewer women undergoing Heart Health Checks than in previous years, suggesting that current Medicare rebates may be inadequate compared to rebate health checks for other chronic diseases such as diabetes.[14]
- Obesity is a key risk factor for cardiovascular diseases, particularly heart failure – and has become a leading cause for hospital admissions for women aged over 65 years (more so than for men). Addressing obesity across the lifespan with targeted prevention efforts would therefore have a significant impact.[15]
- There is significant omission of initiatives relating to chronic pain, with stakeholders emphasising the need for gender-specific efforts to improve access and destigmatise chronic pain in women. The *Inquiry into Women's Pain* in Victoria will provide recommendations to inform improved models of care and service delivery for Victorian women and girls in December 2024.[16]
- GPs need greater access to social workers and other social prescribers to raise awareness and ensure targeted prevention and timely intervention of chronic conditions.
- There is still further progress needed to improve data collection to better monitor changes in women's health outcomes over time, as current gaps limit assessment.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 3.3 | Tailor health services to meet the needs of all women and girls

There has been limited progress in delivering comprehensive and widespread tailoring of health services to meet the needs of all women and girls. NGOs have been driving progress in tailoring programs to suit different priority populations needs to increase health literacy, but sustainable funding is often scarce and inconsistent.

Key aligned activities

Applying a gendered approach to tailoring services to women and girls

There are various established health services designed specifically for women, providing a range of offerings such as preventive health measures, empowerment initiatives, and educational resources. While certain stakeholders advocate for further enhancements, notable examples of tailored services to accommodate the needs of women and girls include:

- Jean Hailes for Women's Health provides female specific services for women at two clinic sites, addressing issues such as menopause endometriosis, cardiovascular health, osteoporosis, eating disorders, and offering allied health support including dietetics, naturopathy, and psychology.[1]
- In 2024, Queensland Government allocated $46 million to fund four nurse-led walk-in clinics, enhancing primary and preventive health care for women and girls.[2] A 2022 survey revealed that 62% of primary health care nurses skip women's health checks. These clinics, part of the upcoming *Queensland Women and Girls' Health Strategy 2032*, will offer free, accessible care by experienced nurse practitioners, prioritising timely prevention measures.[3]
- Commonwealth funded endometriosis and pelvic pain clinics (see page 53).

Development of services and programs that promote navigation of the health system and health literacy

- Since March 2022, the Australian Government has provided $13.2 million to the Multicultural Centre for Women's Health (MCWH) to implement the National Bicultural Health Educator Program, Health in My Language (HIML). The HIML program uses a gendered approach to deliver COVID-19 vaccination information and education to migrant and refugee communities.[4]
- Jean Hailes for Women's Health develops educational presentations to health professionals, educators, social workers and community leaders to help deliver health information to women and girls across Australia.

Developing workforce capacity building to enable provision of targeted and tailored care for women

- The Obesity Collective, working alongside NSW Health, is training health care professionals to conduct inclusive and respectful discussions with women about their health. They are tailoring health services and training for professionals to engage in person-centred conversations about weight and health.[5]
- The Nursing in Primary Health Care Program (2018-19 to 2025-26) continues to train nurses in primary health care settings to enhance health outcomes. The program delivers a transition to practice program for newly graduated and experienced nurses, capacity-building clinics that promotes nurse-led care, and online chronic disease management and healthy ageing education for nurses.[6]
- The Australian Government funds CRANAplus to deliver the Training and Professional Support for the Remote Health Workforce program, including a 24-hour helpline that provides support services and referral services to the remote health workforce and their families.

Gender-based research to bridge the chronic condition gender gap and inform tailored health services.

- The recently launched Centre for Sex and Gender Equity in Health and Medicine at UNSW Sydney aims to challenge the male-centric approach to medical care, through research and advocacy striving for improved health outcomes by advocating for sex- and gender-sensitive perspectives in health care protocols.[7]

Areas for attention

- Stakeholders have observed a lack of gender consideration in health services for chronic conditions, which tend to focus on socio-demographic and cultural groups.
- Conducting local area needs assessments is suggested to identify service gaps and prioritise prevention and services for chronic conditions.
- Many organisations prioritise whole-of-population approaches, neglecting gender-specific needs, and funding for women's health programs is uneven and unsustainable. Additionally, limited evidence exists of health policy developments addressing the needs of priority populations like women and girls. Holistic policy interventions are needed to address these issues, including improving social determinants of health for culturally diverse populations.

Box 3.3.1 Health in my language - Multicultural Centre for Women's Health

'Health in my Language' program is a national education program for migrant and refugee communities to address various health barriers and empowers women by addressing health literacy in CALD populations. The program delivers education sessions in every jurisdiction. The program works with partner organisation to deploy a team of 44 bilingual educators to deliver health education in over 20 languages, reaching over 2,000 individuals across Australia. The program has been funded until June 2024 and has been further extended.[4]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 3.4 | Reduce the prevalence and impact of endometriosis and associated chronic pelvic pain

Significant progress has been made in addressing endometriosis, including substantial Commonwealth investment into research, awareness, education and clinical management and care. However, evidence of progress towards other chronic pelvic pain and causes is limited.

Key aligned activities

Since the development of the National Action Plan for Endometriosis in July 2018, substantial funding has been allocated towards initiatives aimed at mitigating the prevalence and impact of endometriosis, including a $58.3 million allocation announced in the 2022-23 Federal Budget.[1] As part of the 2024-25 Federal Budget, the Government has announced a further $49.1 million investment which means that from 1 July 2025, two new items will be added to the Medicare Benefits Schedule (MBS) enabling extended consultation times and increased rebates for Australian women suffering endometriosis and other complex gynaecological conditions like chronic pelvic pain and polycystic ovary syndrome (PCOS).[2]

Educating health care professionals and patients about the impacts of endometriosis to raise awareness.

- The Australian Government invested $1.4 million over 3 years from 2022-23 for the launch of EndoZone, a digital platform delivering evidence-based information on endometriosis, serving both patients and clinicians. Developed in collaboration with individuals affected by endometriosis, the platform received support from the Australian Government and Jean Hailes for Women's Health, involving various health care professionals and researchers in its creation.[3]
- A total of $2 million over 3 years from 2023-24 has been provided by the Australian Government to activities to raise awareness of endometriosis amongst priority populations - Australian Coalition for Endometriosis and Endometriosis Australia are receiving $0.25 million each for peak body funding, Endometriosis Australia is also receiving $0.8 million for a Workplace Assistance Program and $0.3 million for the Targeting Priority Populations and QENDO Inc is receiving $0.4 million for the Endometriosis Mentor Program.[4]
- The Australian Government allocated $5 million to a national expansion of the PPEP-Talk program, educating high school students on abnormal menstruation symptoms and seeking help.[5]
- $0.8 million was allocated in the 2022-23 Federal Budget to the development, promotion and dissemination of living clinical guidelines based on 'The Australian Clinical Practice Guideline of the Diagnosis and Management of Endometriosis'[6]
- Starting in 2020, Endometriosis Australia's Awareness Month effectively raised awareness of endometriosis in the mainstream. Through campaigns and events, it brought attention to the condition's symptoms and impact.[7]

Investment into promoting access to services, treatment and diagnosis

- 22 Endometriosis and Pelvic Pain GP clinics were established nationwide as well as the development of an endometriosis management plan for primary care patients.[8]
- The 2022-23 Federal Budget allocated $5.1 million over 4 years from 2022-23 for the creation of an endometriosis management plan for primary care patients.[9]
- Reducing financial barriers to treatment by the inclusion of MBS item 35631, 63563 and TGA approval of Ryeqo as the first treatment of endometriosis in 13 years.[10] Ryeqo was then listed on the PBS in March 2024 for treatment of moderate and severe pain associated with endometriosis.[11]

Strengthened research agenda

Stakeholders also highlighted increased investment to strength the research agenda for endometriosis and chronic pain, including national funding allocated through The National Endometriosis Clinical and Scientific Trials (NECST) Network. There are over a dozen nationally funded studies currently underway, including the NESCT registry, which has more than 1,200 registered participants to date.[12]

Areas for attention

- Endometriosis has received substantive funding and attention over the past few years, but it is only one of several causes for chronic pelvic pain. Other causes, including interstitial cystitis and Asherman's syndrome, require more investment. There is a lack of focus and investment in chronic pain more broadly.
- Despite strong research efforts, there has been minimal translation of research to directly reducing the prevalence and impact of the condition. More is needed to improve treatment and accessibility, including access to multidisciplinary teams and specialists (e.g., women's health physios).

Box 3.4.1

PPEP Talk ® Program

The PPEP Talk® Program, funded by the Australian Government Department of Health, Disability and Ageing and supported by state and territory governments, provides early support for girls with pain through trained educators and take-home resources, aiming to reduce the impact of pain and missed school. The program has expanded to include programs tailored for transgender and gender diverse teens nationwide.

QENDO

QENDO supports those affected by endometriosis and pelvic health conditions, offering tools, advocacy, and global peer support programs. The app is supported by government funding and helps over 20,000 users track and manage symptoms.[13]

Progress rating

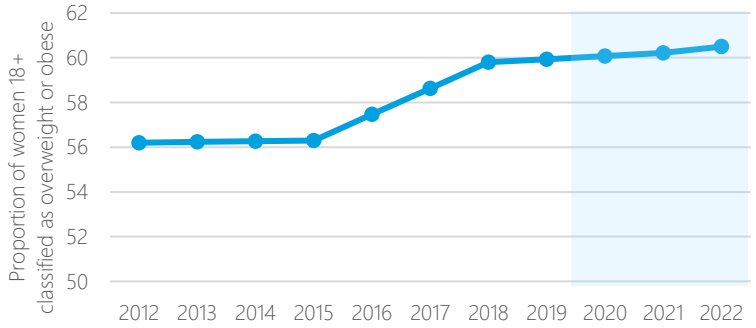
Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION OUTCOMES

Measure 3.1 | – Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women (1 of 2)

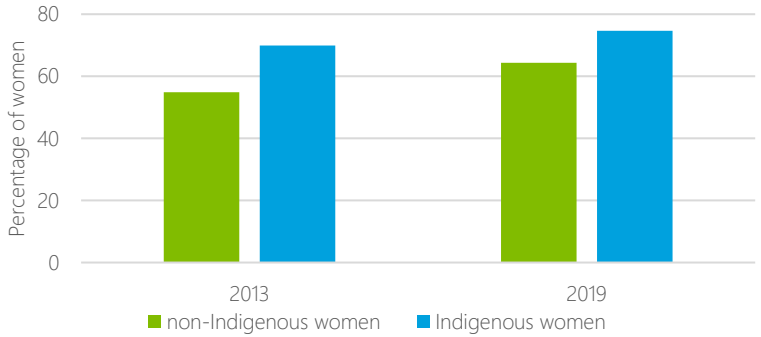
INDICATOR 3.1.1: Percentage of adult women (18+) who are living with overweight or obesity

Figure 3.1.1.A: **Percentage of adult women living with overweight or obesity**



Source: AIHW Overweight and Obesity data tables (2018)[1], ABS National Health Surveys 2011-2022[2], 2018, 2022 for All women. Midpoints between all other values were extrapolated and calculated.

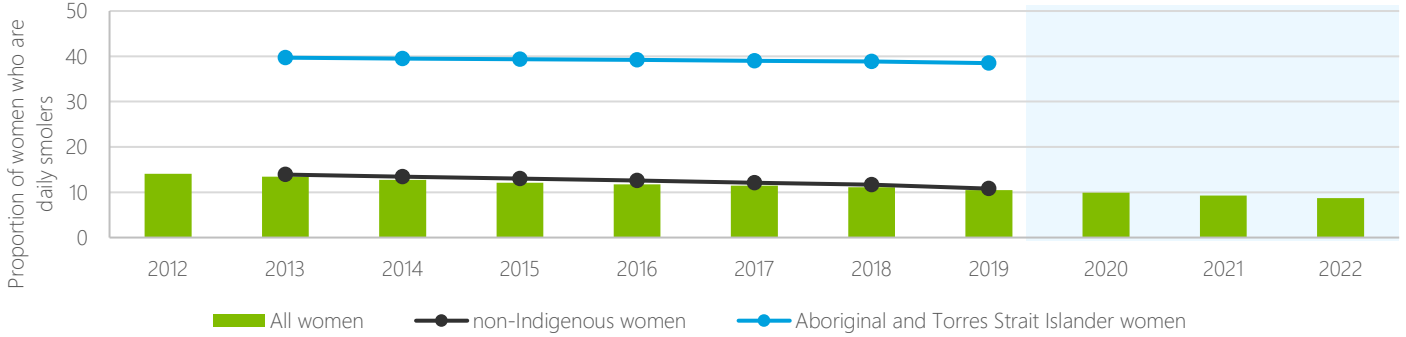
Figure 3.1.1.B: **Percentage of adult women living with overweight or obesity, indigenous status**



Source: ABS Aboriginal and Torres Strait Islander Health Surveys 2012-2019[3] Note: Updated data is likely to become available through the upcoming survey release (26/11/2024).

INDICATOR 3.1.2: Percentage of adult women (18+) who are daily smokers

Figure 3.1.2.A: **Percentage of adult women who are daily smokers**



Source: ABS National Health Surveys 2011-2022[2], ABS Aboriginal and Torres Strait Islander Health Surveys 2012-2019[3], AIHW National Drug Strategy Household Survey 2022–2023[4], Using 2012 and 2019 data for Aboriginal and Torres Strait Islander/non-Indigenous women and 2012, 2015, 2018, 2022 for all women. Midpoints between all other values were extrapolated and calculated.

Note: The proportions for Aboriginal and Torres Strait Islander and non-Indigenous women in Figure 3.1 and 3.2 have been age-standardised to the 2001 Australian Standard Population (and are directly comparable), however the "All women" proportions have not been age-standardised and are not directly comparable to these.

Key takeaways

- The age-standardised proportion of women living with overweight or obesity is significantly higher for Aboriginal and Torres Strait Islander women than non-Indigenous women (Figure 3.1.1.A).
- A recent study of 7,000 women aged 18-39 also revealed that nearly half were overweight or obese.[5]
- Between 2013 and 2019, the rate of non-indigenous women living with overweight or obesity has seen a steeper increase compared to Aboriginal and Torres Strait Islander women, despite an overall rise in obesity among adult women.
- The proportion of adult women who are daily smokers has decreased between 2012 and 2021, however persistence in higher smoking rates can be seen for the Aboriginal and Torres Strait Islander population (Figure 3.1.2.A).

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Moderate publication frequency and lag*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

ACTION OUTCOMES

Measure 3.1 | – Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women (2 of 2)

INDICATOR 3.1.3: Percentage of women who drink at levels that may increase the risk of harm

Figure 3.1.3.A: Percentage of women (14+) who drink at levels that may increase the risk of harm (based on NHMRC 2020 guidelines)

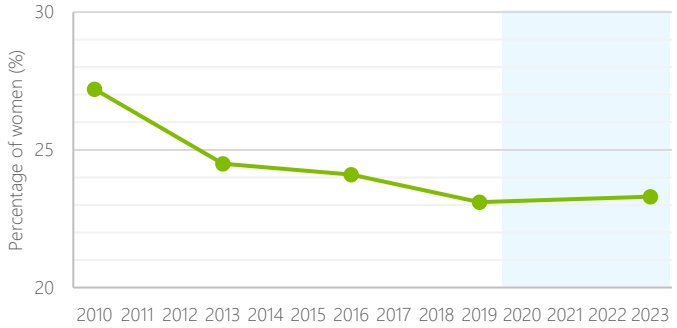
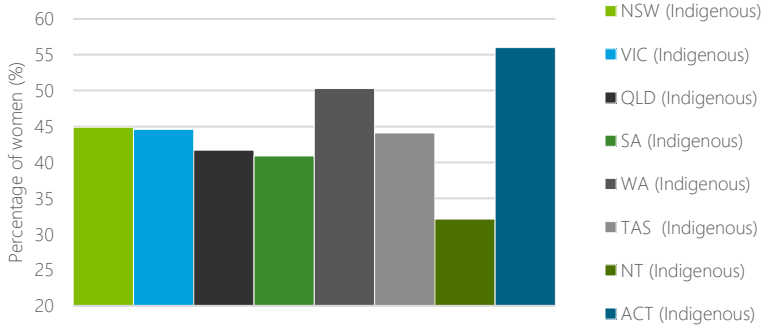


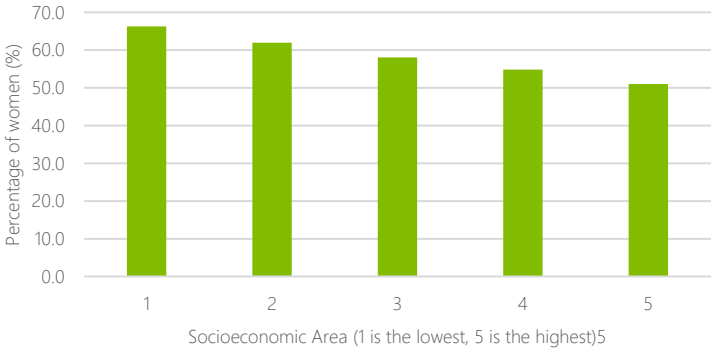
Figure 3.1.3.B: Percentage of Indigenous women (18+) that exceeded the single occasion risk guidelines in 2019 (based on NHMRC 2009 guidelines)



Source: National Drug Strategy Household Survey 2010-2022-23[4], ABS Aboriginal and Torres Strait Islander Health Surveys 2018-19[3]

INDICATOR 3.1.4: Percentage of women who meet the criteria for insufficient physical activity (AIHW)

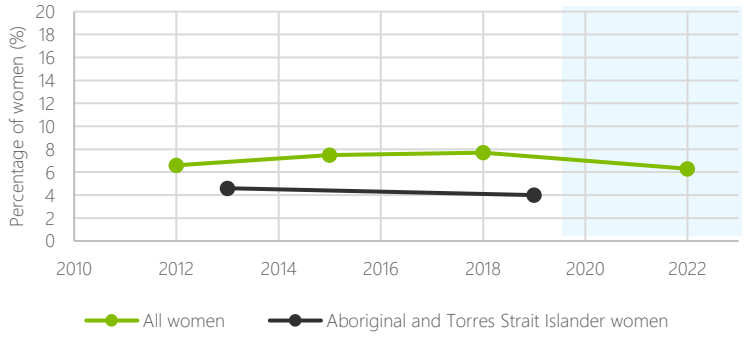
Figure 3.1.4.A: Percentage of women (18+) who meet the criteria for insufficient physical activity (AIHW) in 2018



Source: AIHW Physical Activity Data Tables (2023)[6]

INDICATOR 3.1.5: Percentage of women that meet both the fruit and vegetable intake guidelines (2013 NHMRC Guidelines)

Figure 3.1.5.A: Percentage of women that meet both the fruit and vegetable intake guidelines (NHMRC 2013)



Source: ABS Aboriginal and Torres Strait Islander Health Surveys 2012-2019[3], ABS National Health Surveys 2011-2022[2]

Key takeaways

- The proportion of women exceeding the NHMRC guidelines to reduce health risks from drinking alcohol (more than 10 drinks a week) decreased between 2010 and 2019 by 15 percentage points, however little change was observed between 2019 and 2022 (Figure 3.1.3.A).
- 40% of Indigenous women nationally drink at levels that may increase the risk of harm, but this differs across jurisdictions, with a significantly higher proportion observed in ACT (56%) than in NT (32.1%) for example (Figure 3.1.3.B).
- In 2018, the percentage of women who did not meet the sufficient activity criteria was considerably higher for those in lower socioeconomic areas compared to those in higher socioeconomic areas (Figure 3.1.4.A).
- The proportion of women meeting both NHMRC fruit and vegetable intake guidelines rose slightly between 2021 and 2018 but was lower in 2022 (6.3%) than in 2012 (6.6%) (Figure 3.1.5.A). The proportion of Aboriginal and Torres Strait Islander women meeting guidelines is lower than for the general population, decreasing from 4.6% in 2012-13 to 4.0% in 2018-19.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Moderate publication frequency and lag*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome	No observable change	Negative trend in outcome	Insufficient data available

Measure 3.2 | Lower incidence of cancer

INDCIATOR 3.2.1: Age standardised incidence rate of cancer per 100,000 women

Figure 3.2.1.A: Age standardised incidence rate of cancer per 100,000 women between 2010 and 2023.

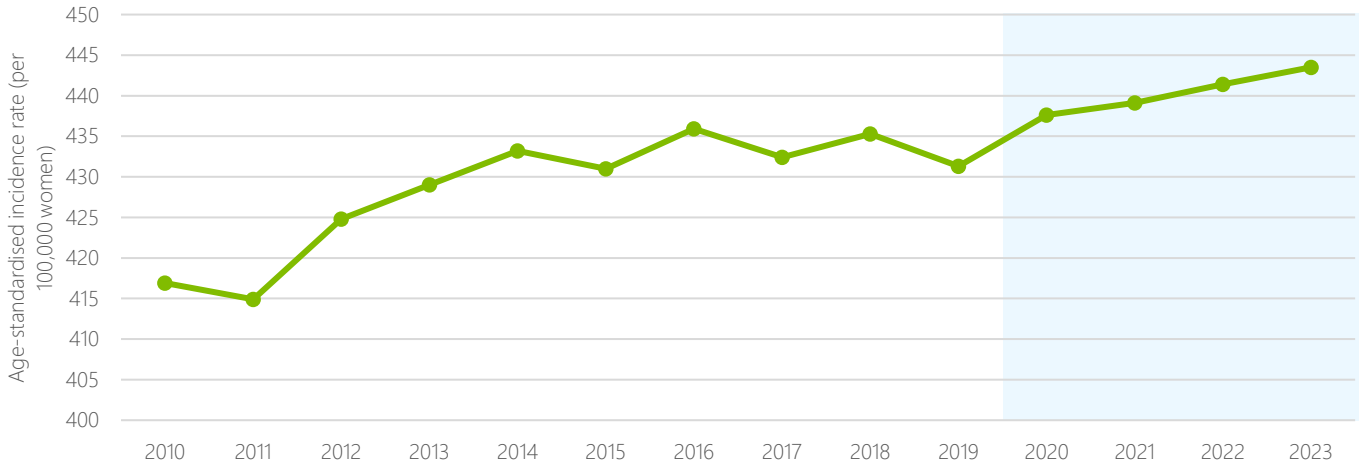
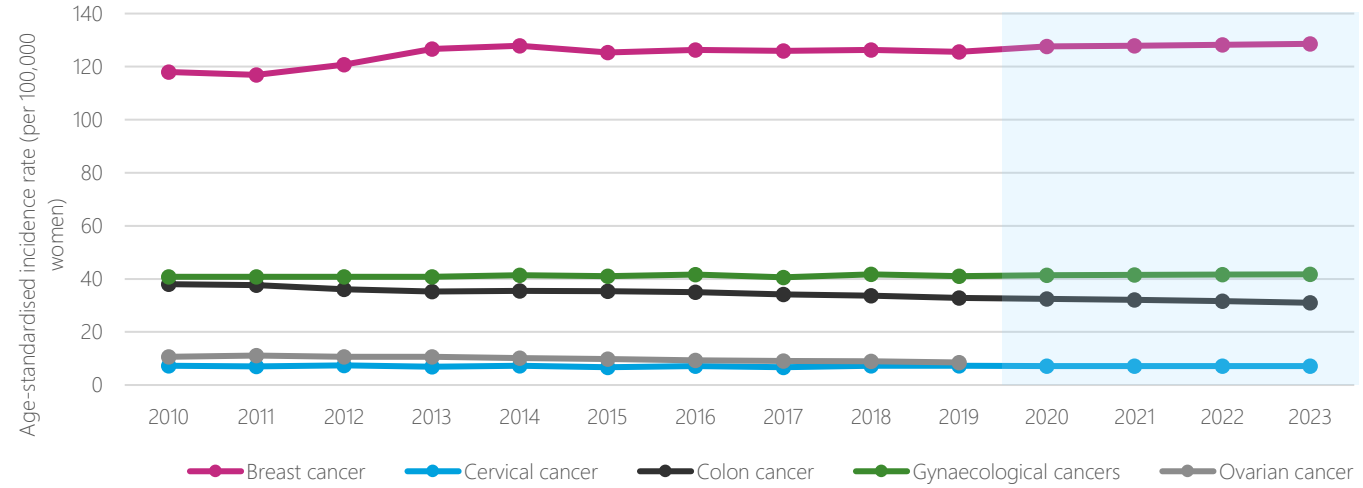


Figure 3.2.1.B: Age-standardised incidence rate of cancer per 100,000 women, by cancer type



Source: Australian Institute of Health and Welfare – National Cancer Database (2023)[1]
Note: Data for 2020-23 are projections based on the National Cancer Database.

Key takeaways

- Since 2010, there has been a steady increase in age-standardised incidence of all cancers for women (Figure 3.2.1.A).
- By cancer type, breast cancer remains the highest proportion of overall cancer incidence for cancers affecting women (Figure 3.2.1.B). In 2023, there was approximately 130 cases per 100,000 women, a 10% increase in incidence since 2010.
- The increase in breast cancer incidence since 2011 coincided with an expansion of the breast cancer screening program in 2013 to include women aged 70-74 years. Distinct trends in cancer incidence, beyond a significant jump in breast cancer in 2013, are harder to establish.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

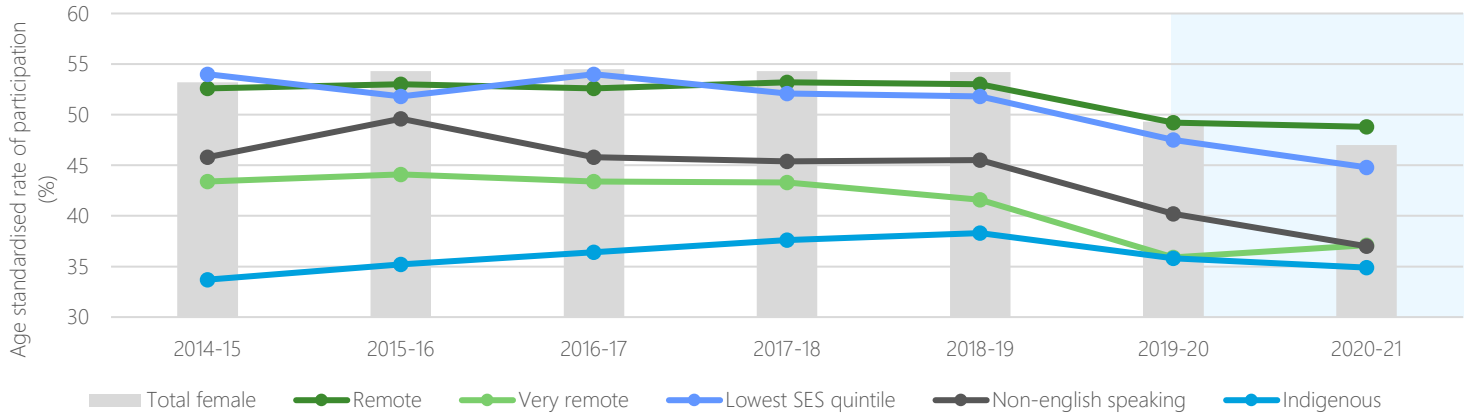
Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 3.3 | Improved rates of breast, cervical and bowel cancer screening for under-screened populations (1/2)

INDICATOR 3.3.1: Proportion of eligible female population who participated in BreastScreen program

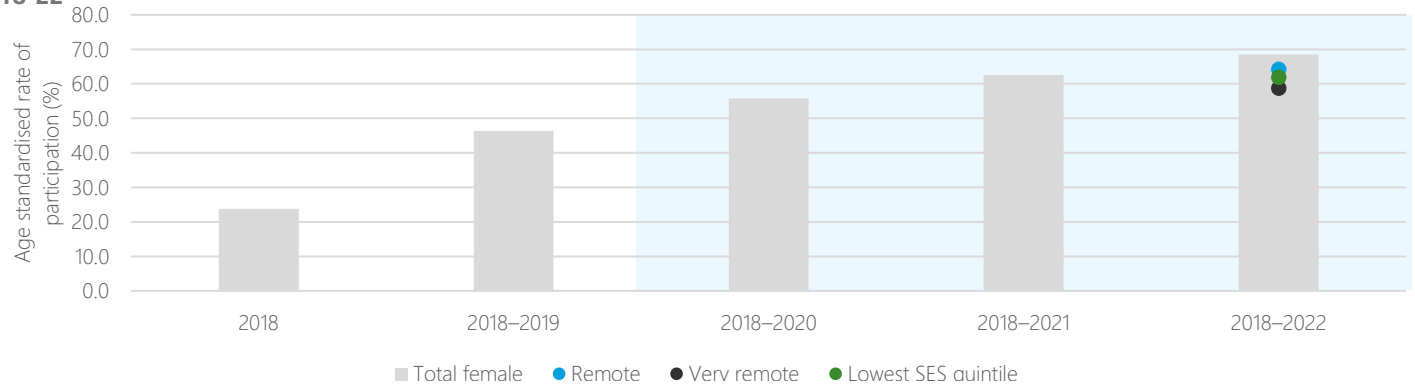
Figure 3.3.1.A: Age-standardised rate of participation in BreastScreen for women aged 50-74 years of age between 2014-15 and 2020-21, by priority populations



Source: AIHW Breastscreen Program Monitoring Report 2018-23[1]

INDICATOR 3.3.2: Proportion of eligible female population who participated in National Cervical Screening Program

Figure 3.3.2.A: Age-standardised rate of participation of NCSP for women aged 25-74 years over a 5-year progression between 2018-22



Source: AIHW National Cervical Screening Program Monitoring Report 2023[2]
Table S1.5a: Progression to 5-year participation 2018–2022, by age, 2018, 2018–2019, 2018–2020, 2018–2021, and 2018–2022

Key takeaways – BreastScreen

- Overall, BreastScreen has had a decrease in participation rates of eligible women aged 50-74 years since 2014-15. It is noted that 2019-21 are likely to be affected by the COVID-19 pandemic (Figure 3.3.1.A).
- First Nations women, very remote women and non-English speaking women have lower participation rates than the general female population (Figure 3.3.2.A).

Key takeaways – Cervical Screening

- Evidence shows an increase in the age-standardised rate of participation across a 5-year period for all women (Figure 3.3.2.A).
- Data for priority groups (2018-22) reveals lower participation rates for remote and very remote women and those with the lowest socioeconomic status.
- The National Cervical Screening Program (NCSP) does not have specific policy recommendations for Aboriginal and Torres Strait Islander or CALD populations. However, targeted communications, activities, resources and initiatives for the priority populations under the Elimination Strategy are all aimed at increasing participation for these population groups.
- Self-collection now accounts for 27% of all cervical screenings, a significant jump from the 1% share of screenings that were self-collected before screening test options were expanded in July 2022. This more private and discreet option has been especially beneficial for individuals who have never been screened or are overdue for screening.[3]

Trend Rating

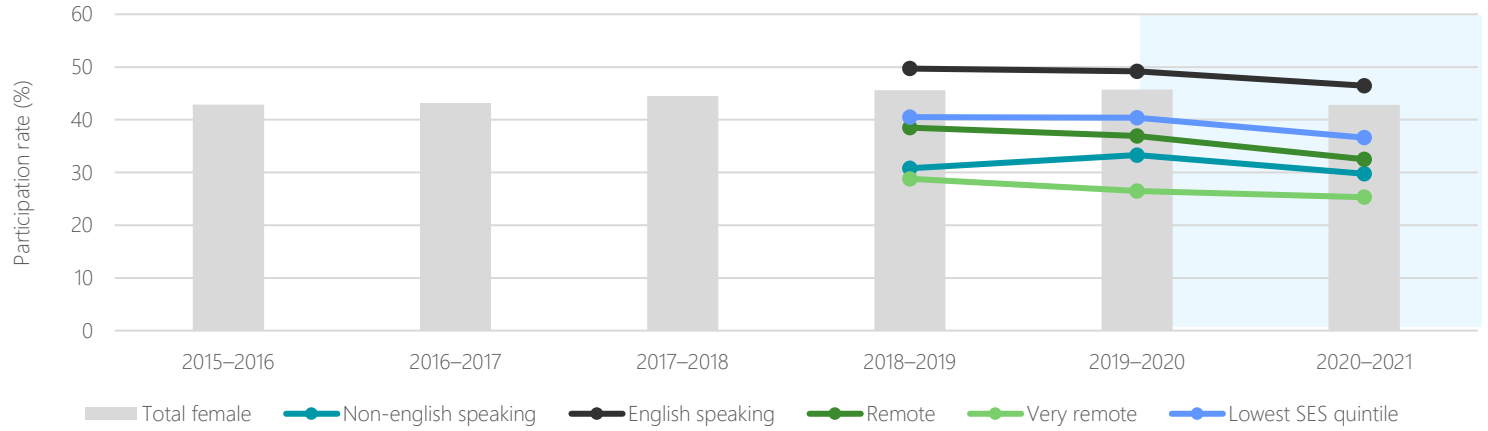
Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 3.3 | Improved rates of breast, cervical and bowel cancer screening for under-screened populations (2/2)

INDICATOR 3.3.3: Proportion of eligible female population who participated in National Bowel Cancer Screening Program

Figure 3.3.3.A: Participation rate of national bowel cancer screening for eligible population aged 50-74, between 2015-21



Source: AIHW National Bowel Cancer Screening Program monitoring report (2020, 2021, 2022, 2023)[4]
Note: Remote, Very Remote and Lowest SES Quintile are not disaggregated on a gender level – presented as combination of male and female. English and non-English speaking participation rates were presented as a range, the midpoint was calculated and presented in this graph

Key takeaways – Bowel Cancer Screening

- Since 2015-16, there has been little change in the proportion of eligible female population who participated in the NBCSP.
- In 2020-21, the participation rate for women is approximately 43%.
- Participation rates are significantly lower for remote and non-English speaking (CALD) women as well as women in the lowest SES quintile.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

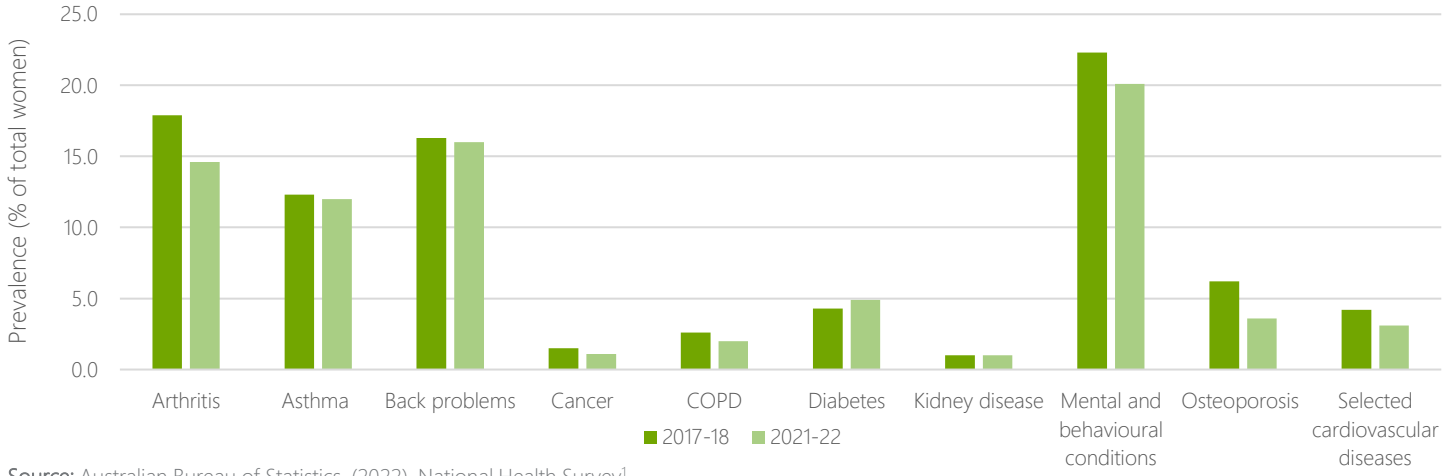
Trend Rating

Legend: Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 3.4 | Decrease in prevalence of chronic conditions in women

INDICATOR 3.4.1: Prevalence of chronic conditions, across top 10 chronic conditions

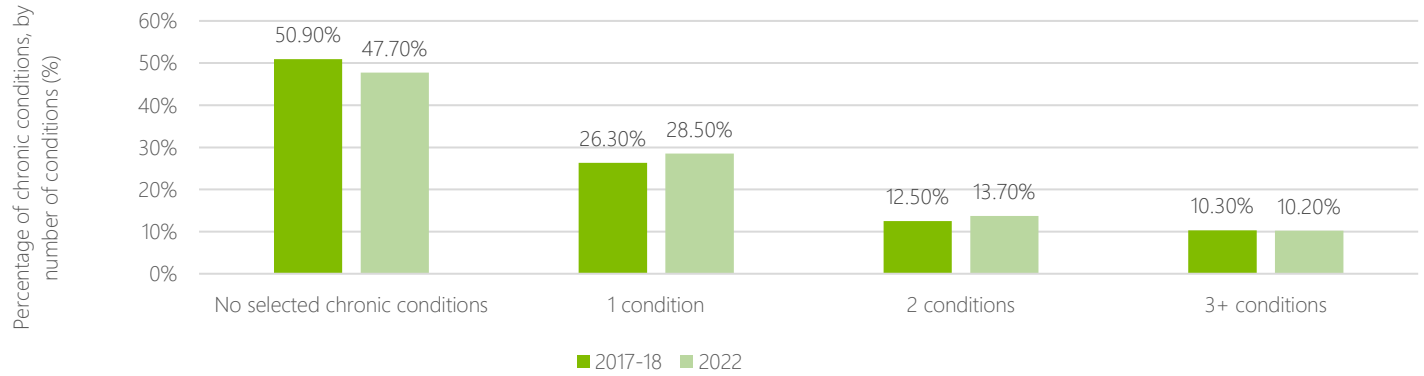
Figure 3.4.1.A: Change in prevalence of self-reported chronic conditions by top 10 chronic conditions reported in 2017-18 and 2021-22



Source: Australian Bureau of Statistics. (2022). National Health Survey[1]

INDICTOR 3.4.2: Proportion of women living with a chronic condition, by number of selected conditions

Figure 3.4.2.A: Percentage distribution of chronic conditions in women by number of conditions, 2017-2022



Source: Australian Bureau of Statistics. (2017-18). National Health Survey[2]

Key takeaways

- There has been an overall decrease in all but one (Diabetes) of the top 10 chronic conditions between 2017-18 and 2021-22 (Figure 3.4.1.A).
- Osteoporosis saw the largest decrease (72%) followed by cardiovascular disease (36%) (Figure 3.4.1.A).
- However, there has been an increase in the prevalence of multimorbidity of chronic conditions among women. The prevalence of having one or more chronic condition rose between 2017-18 and 2022 (Figure 3.4.2.A).

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

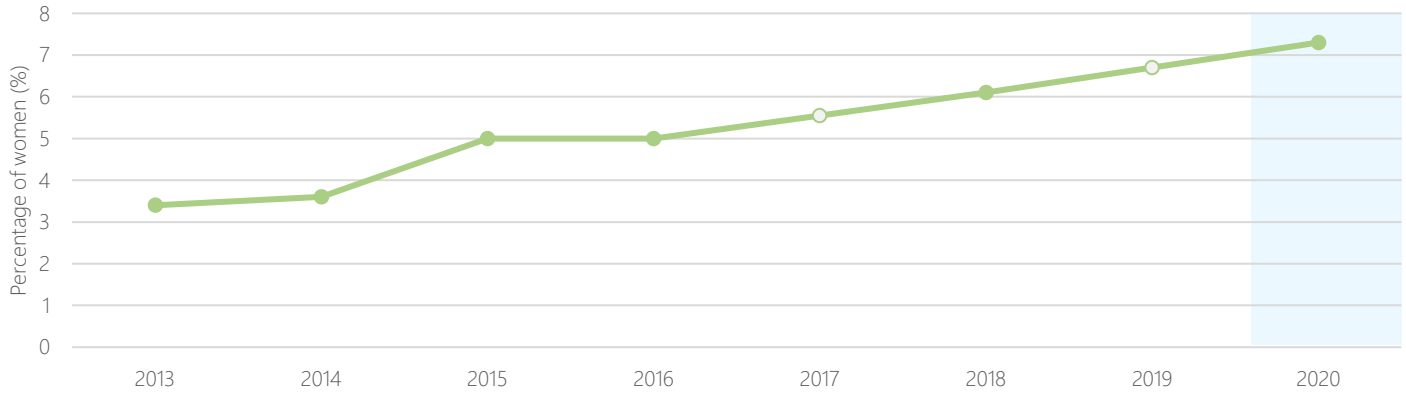
Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

ACTION OUTCOMES

Measure 3.5 | Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and managing these conditions (1/2)

INDICATOR 3.5.1: Percentage of women who have experienced (and been diagnosed with) endometriosis at some point during their lifetime

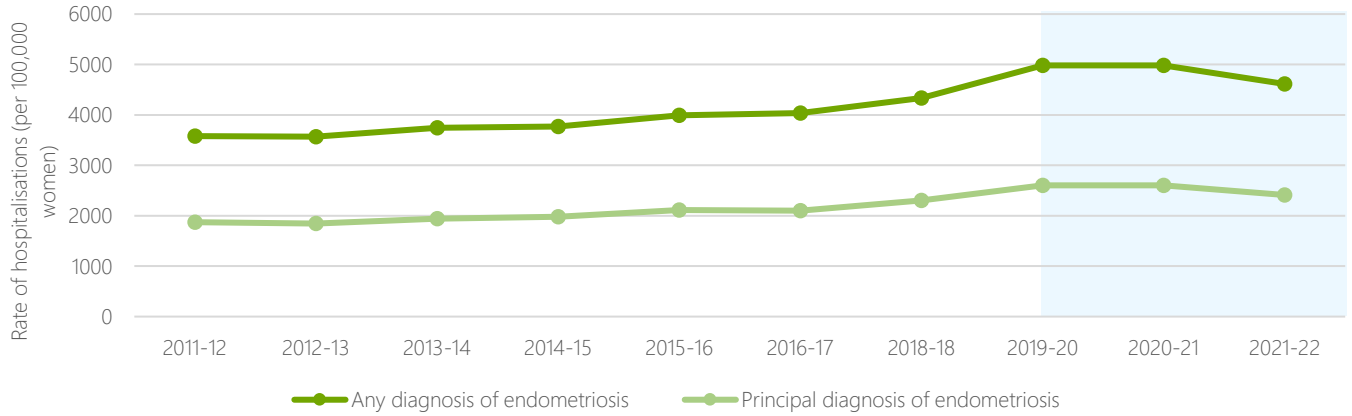
Figure 3.5.1.A: Percentage of women (born between 1989-95) who have ever had endometriosis or been diagnosed / treated for endometriosis in their lifetime



Source: ALSWH – cohort 1989-95, survey 1-6[1]
Note: data points for years for 2017 and 2019 have been extrapolated from the midpoint of data

INDICATOR 3.5.2: Age-standardised rate of hospitalisations per 100,000 women with a diagnosis of endometriosis

Figure 3.5.2.A: Age standardised rate of hospitalisation per 100,000 women with a diagnosis of endometriosis 2011-22



Source: AIHW – Endometriosis in Australia: Prevalence and Hospitalisations (2023)[2]

Key takeaways

- The proportion of women who have experienced or been diagnosed with endometriosis has risen from 3.4% in 2014 to 7.3% in 2020 (Figure 3.5.1.A).
- It is unclear whether this increase is due to improved detection methods or a higher prevalence of the condition.
- The rate of hospitalisation per 100,000 women (Figure 3.5.2.A) has shown an upward trend since 2011-12, with a slight decline observed between 2019-20 and 2021-22.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome	No observable change	Negative trend in outcome	Insufficient data available

Measure 3.5 | Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and managing these conditions (2/2)

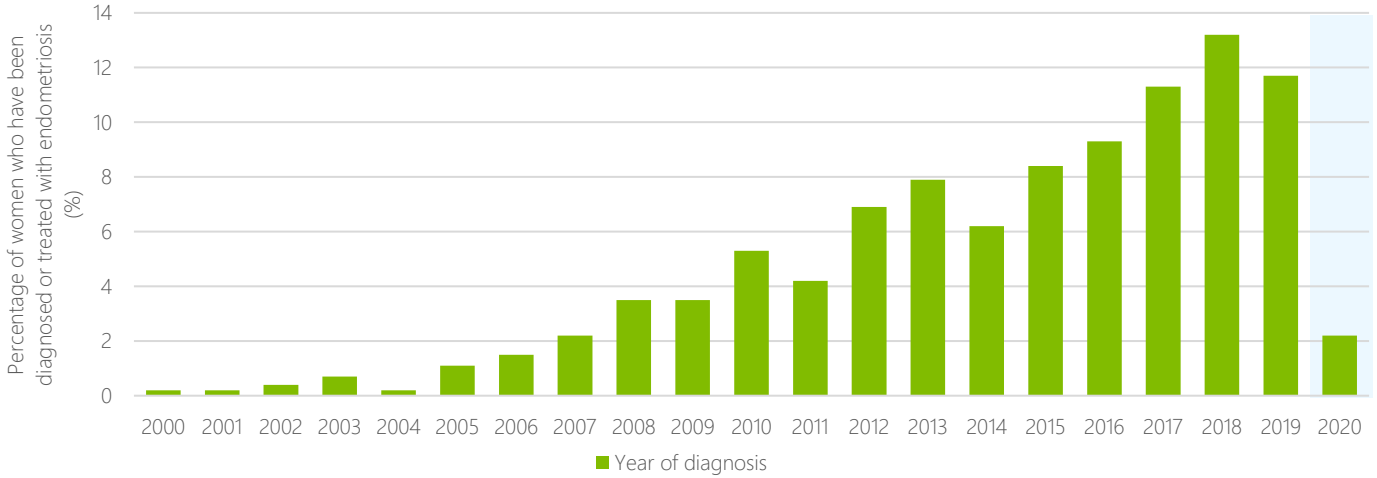
INDICATOR 3.5.3: Change in time from onset of symptoms to diagnosis and year of first presentation and diagnosis of endometriosis

Average time (years)	Endometriosis	Chronic pelvic pain
Between symptoms onset to diagnosis	7.8	NA
Between symptom onset and first doctor's visit	2.9	1.8
Between doctors visit and diagnosis	4.9	NA
Between year of first presentation and diagnosis (years)		
First sought medical attention before 2005	9.9	NA
First sought medical attention between 2005–2012	4.8	NA
First sought medical attention after 2013	1.5	NA

Source: Armour (2020)[3]

INDICATOR 3.5.4: Proportion of women who have been diagnosed or treated with endometriosis, by year first diagnosed

Figure 3.5.4.A: Percentage distribution of date of first diagnosis or treatment of endometriosis in ALSWH cohort, 2000-20



Source: ALSWH – cohort 1989-95, survey 6 (2020) [1]

Key takeaways

- Typically, there is a significant delay in diagnosing endometriosis, taking an average of 7.8 years from the onset of symptoms to receiving a diagnosis (Indicator 3.5.3).
- The average time between year of first presentation and year of diagnosis of endometriosis has decreased between 2005 and 2013 from 9.9 years to 1.5 years respectively (Indicator 3.5.3). Data is currently not available for 2013 onwards.
- As a further indication of better identification and detection of endometriosis, the proportion of women who have been diagnosed or treated with endometriosis by year has been increasing. With diagnosis rates rising in the population born in 1989-95 between 2015 and 2019 (Figure 3.5.4.A).
- There is no data available for other associated chronic pelvic pain.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Regular and timely publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Priority 4 – Mental Health

Summary insights | Mental Health

Implementation progress

Sub-priority	Summary	Progress Rating		
		Requires stronger focus	Some progress	Meaningful progress
Enhance gender-specific mental health education, awareness and primary prevention	Initiatives promoting mental health education, awareness, and primary prevention exist, but there's a notable absence of gender-specific focus in mental health. Currently in Australia, there is insufficient funding, services, treatment and education of women's specific health needs.	●	○	○
Focus on early intervention, diagnosis, integration and access to mental health care services	Efforts have been made to improve access to mental health services, with a particular focus on early intervention and diagnosis. Some of these investments have been specifically directed towards women. However, there is still a need for better integration of these services and improved support for priority populations.	○	●	○
Invest in service delivery for priority populations	While some initiatives target specific populations like perinatal women and CALD/First Nations women, stakeholders stressed the need for increased investment in mental health services accessible to diverse groups facing barriers, such as LGBTIQA+ individuals and rural/remote women.	○	●	○
Adopt a multi-faceted approach to support women and girls with eating disorders	Efforts to support women and girls with eating disorders include increased investment in facilities and programs promoting healthy body images, as well as workforce support in identifying and treating eating disorders. While evidence is mostly non-gendered, there is a particular focus on young women and girls due to their higher risk.	○	○	●
Raise awareness and embed practices to reduce stigma and discrimination associated with mental ill-health	Although this priority is hard to measure, stakeholders highlighted that there is more open discourse to stigma associated with womens mental ill health than ever before. This includes education and programs that promote and positive mental health messageing to combat stigma, misinformation and discrimination affecting women and girls.	○	●	○

Trend in outcomes in past five years

Measure of success	Summary	Trend
Lower incidents of mental health reporting, self-harm and suicide	There is minimal evidence to suggest that incidents of self-harm and suicide rates have decreased over the past five years. Rates of mental health self-reporting as proxied from rates of ambulance attendances has also remained stable, with no significant decreases.	No observable change
A reduction in mental health related illness	A sustained increase in the percentage of women who reported ever having a long-term mental health illness was seen, with no indication of this increase slowing down over time. Anxiety disorders were the most prevalent amongst women who reported having a mental health condition.	Negative upward trend
Increase in the number of mental health services and ability for priority populations to access	Data availability on mental health service number and uptake for priority populations is limited, however uptake for all women showed improvement as the rate of MBS health services per 1000,000 women grew steadily from 2007 to 2022. Rate of crisis support showed minimal evidence of improvement with regular fluctuations. Noting limited data, the current trend does appear to be positive overall.	Positive upward trend
Greater integration of mental and physical health care	There is no available data to gain insight on this measure.	Insufficient data

ACTION OUTCOMES

Priority 4.1 | Enhance gender-specific mental health education, awareness and primary prevention

Initiatives promoting mental health education, awareness, and primary prevention exist, but there's a notable absence of gender-specific focus in mental health. Currently in Australia, there is insufficient funding, services, treatment and education of women's specific health needs.

Key aligned activities

Activities in early learning institutions and schools to educate students, parents and teachers:

- Beyond Blue's Be You program, a commonly referenced service for students and teachers, adopts a comprehensive approach to mental health education. The program is not specifically gender-focused but covers a vast array of culturally appropriate resources co-designed with First Nations community members, as well as resources supporting teachers to promote gender inclusivity within their classrooms. A 2022 evaluation of the project outlined that educators using Be You were 13% more likely to feel that that they can support children and young people with a mental health condition and 14% more confident talking to a patient or carer about a student's mental health.[1.]
- Learning institutions and schools allocate substantial resources to raise awareness and prevent eating disorders. The Butterfly Foundation offers tailored programs (such as Be BodyKind) and resources for primary and secondary schools, targeting school professionals, young individuals, parents, and caregivers.[2]
- Through its National Workforce Centre for Child Mental Health initiative, Emerging Minds builds the capacity of professionals and organisations working with children and families to identify, assess and support children at risk of mental health conditions through access to free, evidence-based online professional learning, resources, and support. Though not a tailored initiative, it includes resources to support professionals working with gender diverse populations.[3]

Media and community awareness materials to support the promotion of gender specific mental health issues

- Jean Hailes for Women's Health refers to websites on mental health and emotional wellbeing for women seeking information on comorbidities.[4]
- Liptember is an awareness-raising campaign for gender-specific mental health causes (see right).[5]

National strategies that promote and mobilise investment and awareness in women's mental health

There is evidence of development and implementation of protective health strategies aimed at reducing mental health issues. The following Strategies have been developed and delivered to address mental ill health:

- *The National Mental Health and Suicide Prevention Agreement, The National Mental Health Strategy for 2022-2032 (2022), The National Mental Health and Wellbeing Pandemic Response Plan (2020).* All states and territories also have mental health strategies.[6]

Increased recognition of mental health issues that have been traditionally underdiagnosed in women

Stakeholders noted that there has been an increase in attention and awareness towards the presentation of neurodivergence (especially ADHD and Autism) in women and girls. This targeted awareness is important for a cohort that has been traditionally underdiagnosed.

The Australian Government's National Perinatal Mental Health Check and Universal Perinatal Mental Health Screening initiative provides public health services with access to iCOPE digital screening tools, supporting states and territories in meeting their commitments to the National Mental Health and Suicide Prevention Agreement. This helps ensure early intervention and support for expectant and new mothers.[7]

Awareness and beauty standards in women

- There are several education programs that promote media literacy and prevention by addressing unrealistic beauty standards. These evidence-based programs aim to enhance understanding of the media's influence on society's perception of beauty, health, and appearance. Examples include Body Project Australia, Dove Self-Esteem Project, and Flinders University Media Smart.[8]

Areas for attention

- Despite evidence of some progress, there is still a significant gap in gender-tailored initiatives in education, awareness, and primary prevention of mental health. The majority of identified efforts were implemented before the release of the strategy in 2020, underscoring the need for further enhanced efforts to tailor service delivery and educational programs for women and girls. This is particularly important for conditions that disproportionately affect women and girls, such as depression, anxiety and eating disorders, or mental health issues related to preconception and perinatal health.
- Stakeholders highlighted that although there is progress in education and awareness campaigns in schools, more should be done to increase young people's access to mental health services and improve mental health screening and supports in schools.
- Concerns were raised in consultations about the lack of focus on preventive mental health care, poor access to specialist mental health services (including psychiatrists), the fragmentation of care across providers and a lack of integration with other health care services.
- There is insufficient awareness, funding, and resources for peer support programs tailored to women's experiences.
- Stakeholders also noted that there is poor education and primary prevention services catered towards trans/intersex people with mental health issues.

Box 4.1.1: Liptember

Liptember raises awareness and funds for gender-specific mental health causes. Since its establishment in 2010, this campaign has generated over $14 million in funding for a wide range of women's mental health initiatives. Liptember organises an annual month-long campaign in September, encouraging individuals to wear lipstick to spark conversations about women's health, raise funding and awareness.[5]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION OUTCOMES

Priority 4.2 | Focus on early intervention, diagnosis, integration and access to mental health care services

Efforts have been made to improve access to mental health services, with a particular focus on early intervention and diagnosis. Some of these investments have been specifically directed towards women. However, there is still a need for better integration of these services and improved support for priority populations.

Key aligned activities

Investments aimed to increasing access mental health services

- The Australian Government delivers *Head to Health* centres across the country. The establishment of *Head to Health* centres was highlighted by stakeholders as improving access to free assessment and referral services.[1]
- Headspace, the Australian Government's program for youth mental health, provides services to young people aged 12-25 years with mild to moderate mental illness. As of March 2022, 145 Headspace services were across 164 locations have been established, including 77 in regional areas.[2] In 2020-21, nearly 65% of young people accessing Headspace centre were female and 67% of those accessing the services were identified as gender diverse.[3] The independent evaluation also showed that LGBTIQA+ young people had poorer clinical outcomes than cisgender, heterosexual people.[3]
- The Commonwealth *Better Access* initiative provides Medicare rebates to eligible people so they can access the mental health supports they need[2]. As of November 2022, 16 new MBS items for group therapies have been included. A 2022 evaluation found that 70% of psychiatrists agree that Better Access has improved outcomes for consumers.[4.]
- The Australian Government has invested $91.3 million to support the mental health workforce - 500 psychology postgraduate positions.[5.]
- The Australian Government funds initiatives to support the mental health of expectant and new parents, including establishing 12 perinatal mental health centres operated by Gidget Foundation Australia.[6]
- Primary Health Networks are funded to plan and commission regionally appropriate mental health and suicide prevention services within a person-centred stepped care approach, so that a range of service types are available to suit local population needs. This included prioritising the needs of priority population groups.

Investments aimed at providing women specific mental health care

- In 2023, Victoria launched Australia's first Women's Mental Health Service, known as Women's Recovery Network (WREN), in Melbourne and Shepparton. It offers tailored care to over 750 women annually, co-designed with women with mental health experiences.[7]

Services that provide early intervention

- Beyond Blue provides various low-intensity, early intervention supports like peer forums. They also recently rolled out the *New Access Mental Health Coaching* program that involves six guided mental health sessions to anyone feeling stressed or overwhelmed about everyday life issues, free of charge with no referral required.[8]
- The Australian Government is working in partnership with all states and territories through the National Mental Health and Suicide Prevention Agreement to create a national network of Head to Health Kids Hubs (children's mental health and wellbeing centres) for 0-12 years olds and their families.[9]

Investment to alleviate financial and access barriers to mental health services

- New MBS item codes introduced for extended primary care consultations, mainly for women (60% of consultations), to support patients with complex needs and benefit female GPs managing complex cases compared to male GPs.
- The introduction of new MBS item codes for telehealth has spurred innovation in mental health service delivery, with 4 MBS psychological therapy items available for clinical psychologists and 20 psychological items offered via telehealth, addressing geographical and access barriers.

Areas for attention

- Programs that specifically cater to the mental health care needs of women and girls, particularly during significant life stages like pregnancy, motherhood, and menopause, still have room for improvement.
- There are still challenges in meeting the needs of priority populations, especially the needs of transgender people and non-binary individuals in accessing mental health services.
- There is a need to upskill health professionals, for example through inclusive training programs, to enhance the sensitivity and competence of mental health professionals in addressing women's mental health needs.
- Research inadequately investigates how ADHD/autism presents in women and girls, leading to underdiagnosis.
- Stakeholders have emphasised the insufficient integration of physical and mental health support across various sectors like aged care and workplaces.
- There needs to be greater integration across sectors, including justice, education, alcohol and drug services and housing, to support those experiencing mental health conditions.
- CALD women face barriers to health care access, including a lack of culturally competent care, shortage of female doctors, and challenges in tracking health outcomes due to a lack of data. Focus is on addressing these obstacles.

Box 4.2.1: Women's Mental Health Services – Women's Recovery Network

In 2023, the Victorian Government invested $100 million in Australia's first Women's Mental Health Service. The service, located in Melbourne and Shepparton, provides tailored mental health care for over 750 women annually, including 35 beds in Melbourne and five beds in Shepparton.[7]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 4.3 | Invest in service delivery for priority populations

While some initiatives target specific populations like perinatal women and CALD/First Nations women, stakeholders stressed the need for increased investment in mental health services accessible to diverse groups facing barriers, such as LGBTIQA+ individuals and rural/remote women.

Key aligned activities

Tailored services that promote access to services for various women from various priority populations:

- The *Embrace Multicultural Mental Health* project run by Multicultural Mental Health Australia works to upskill organisations to deliver culturally safe services and commissions specialist services for different language groups.[1]
- The *Red Dust Strong Women* Program in Alice Springs and remote areas of the NT delivers culturally appropriate mental health care in remote First Nations communities (see below).[2]
- The Primary Health Network for Hunter New England and Central Coast (HNECC) has commissioned mental health services targeting priority populations in the region, offering up to 12 service contacts per year to eligible individuals, with over 25,000 services commissioned overall to ensure access.[3] However, this service is non-gendered.
- The Perinatal and Infant Mental Health Services (PIMHS) in NSW offers free mental health support to pregnant women and parents of children under two. The primary focus of PIMHS is to provide support to mums, dads, parents, and families, including those from LGBTIQA+ backgrounds, who are dealing with diagnosed, severe, or complex perinatal mental health disorders.[4]
- The Department of Veteran Affairs provides various services for women veterans, including non-liability health care. This fully funded mental health treatment is available to eligible veterans without the need to prove that their condition was service-related.[5]
- For LGBTIQA+ women and gender diverse people seeking support, headspace National received funding of $6.8m through the 2023-24 Federal Budget to support eheadspace, which includes qheadspace - a digital platform where gender and sexually diverse young people can connect with others and seek support within a peer moderated online community.[6]
- The Government has also provided $14.1 million over 4 years from 2021-22 to 2024-25 to LGBTQ+ Health Australia to deliver QLife telephone and webchat support, an Australia-wide, anonymous LGBTIQA+ peer support and referral service.[7]

Services access for low prevalence high impact conditions

- EPPIC (Early Psychosis Prevention & Intervention Centre), working with young people with psychotic disorders.[8]
- Turning Point offers the COPE program, the concurrent treatment of PTSD and Substance Use Disorders. The COPE program is available to women aged 25 or older with current PTSD symptoms and problematic substance use.[9]

Box 4.3.1: Red Dust Strong Women's Program

The *Red Dust Strong Women* Program is funded to support the delivery of culturally appropriate mental health care in remote First Nations communities in the NT and border communities. The program is targeted to young women aged 13 years and above and is led by First Nations women. The program employs role models, educators, health workers and local facilitators to deliver remote women's camps, yarning circles, cultural activities and remote bush camping programs.[2]

Areas for attention

- Certain mental health disorders, like depression, anxiety disorders, and eating disorders, are more common in women than men, with some conditions only affecting women. Priority populations also are affected differently. It is important that services and programs provide tailored and gender-specific services to address these intersectionalities.
- Stakeholders highlighted that there has been insufficient investment in expanding service delivery to support women with lower prevalence high impact conditions.
- There is limited progress identified for regional and remote areas and First Nations women (for example, in WA due to geographical reasons).
- Further consideration is needed to ensure that initiatives adequately address the unique needs of priority populations like LGBTIQA+ individuals, particularly trans women; for example, incorporating their needs and experiences into training and education for mental health professionals to provide early intervention services.
- There is no evidence of specific strategies to target and reduce mental ill health among priority populations. The National Mental Health Commission's *National Mental Health Research Strategy 2022* outlines that there should be strengthened inclusion of diverse populations as partners in research.[10]
- The National Mental Health Workforce Strategy 2022–2032 aims to build a sustainable workforce for mental health services but does not target priority populations.[11]
- Research has found that women aged 21-26 without reported baseline depression were at significantly higher risk of developing depression over an average 10.9 year follow up period in association with greater air pollution.[12] Further prospective incidence studies should be undertaken to better understand the gendered impacts on mental health due to air pollution.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION OUTCOMES

Priority 4.4 | Adopt a multi-faceted approach to support women and girls with eating disorders

Efforts to support women and girls with eating disorders include increased investment in facilities and programs promoting healthy body images, as well as workforce support in identifying and treating eating disorders.

Overview of progress to date

Providing a consistent national approach to eating disorders

The National Eating Disorder Collaboration (NEDC) is administered by the Butterfly Foundation and is viewed as one of the leading bodies in eating disorder awareness, service delivery and education in Australia. The NEDC also guides a national approach, leading to the publication of the National Eating Disorders Strategy 2023-33.[1] This strategy includes a call to action and roadmap for improving Australia's response to eating disorders.

Access to services for women with eating disorders

- The Wandi Nerida residential recovery centre is an example of an eating disorder residential facility (see right).[2]
- The Butterfly Foundation via 1800EDHope provide free phone, email and web support and referrals for individuals experiencing eating disorder.[3]
- The Australian Government invested $26.9 million in coordinated care providers to enhance treatment services for people with eating disorders and their families.[4]
- The Australian Government invested $58.5 million to establish six community-based residential eating disorder treatment centres through the Community Health and Hospital Program.
- Through the 2022-23 Federal Budget, the Government committed to $20 million to implement new community-based treatment services. These services will focus on local needs, using innovative and evidence-based models of care that are free to those who access them.[5]

Access to services for young women and girls in schools

- The Butterfly Foundation's *Butterfly Body Bright* program promotes healthy attitudes towards body image, eating, and exercise in schools. A 2022 evaluation found that more than half (54%) of participants reported an immediate increase in how happy they felt about their body shape and how they look.[6]
- The Commonwealth also allocated $6.2 million to support children in developing a positive body image and reducing appearance pressures.[7]

Initiatives that support workforce in identifying and treating eating disorders

- In February 2024, the Australian and New Zealand Academy for Eating Disorders expanded the Credential to include GPs. The Credential for GPs improves care for eating disorders in Australia by focusing on early identification, assessment, diagnosis, and referral to appropriate treatment providers.[8]
- The Australian Government allocated $1.1 million to the Butterfly Foundation in the 2022-23 Federal Budget for the development of the eating disorder peer workforce and advice to state governments.[5] The Eating Disorders Peer Workforce Guidelines was released by the Butterfly Foundation in early 2024.[9]
- The InsideOut Institute received $1.8 million from the Australian Government to upskill staff at Head to Health and headspace Centres build their capacity to identify and treat eating disorders.[10]

Research to coordinate and conduct research into eating disorders

- The University of Sydney was granted $13 million by the Australian Government in 2022 to establish the Australian Eating Disorders Research and Translation Centre, a four-year initiative focused on eating disorder research.[11]

Areas for attention

- Stakeholders noted that there is still minimal focus on gender-specific initiatives to address eating disorders.
- There is a need for greater investment in the prevention and early intervention of eating disorders (e.g., regulations around social media). Eating disorders were noted to receive a disproportionately lower allocation of mental health research funding grants despites having a higher mortality rate. When adjusted for inflation, this equated to $2.05 per affected individual, compared to $19.56 for depression and $32.11 for autism.[12]
- Stakeholders also noted that further consideration is needed to support people of all ages with eating disorders, not just young people, as eating disorders can develop at any life stage.
- Stakeholders highlighted the need for increased funding for treatment, Medicare subsidies and national research to better address the complexities of eating disorders.
- The majority of research in eating disorders focuses on cisgendered and white women. The National Eating Disorder Strategy 2023-33 calls for greater research into other demographic groups including Aboriginal and Torres Strait Islander people, LGBTIQA+ people and neurodivergent people.

2x more likely to develop an eating disorder than men in Australia[13]

LGBTIQA+ people are at greater risk of an eating disorder[14]

27% higher incidence of eating disorders in First Nations people[15]

Wandi Nerida Residential Recovery Centre

In a recently completed clinical evaluation of Wandi Nerida, 88.% per cent of participants surveyed were female. The evaluation showed that there were meaningful and measurable improvements in eating disorder and other psychological symptoms and in mental health related quality of life as well as physical health status.[2]

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 4.5 | Raise awareness and embed practices to reduce stigma and discrimination associated with mental ill-health

Stakeholders highlighted a trend of more open discourse around mental ill health for women and girls. This has been supported by education and programs that promote positive mental health messaging to combat stigma, misinformation and discrimination.

Key aligned activities

A study by Morgan et al (2021) reviewed all Australian initiatives aimed at reducing stigma towards individuals with complex mental illness. The study identified 61 programs in Australia, including face-to-face interventions, online resources, awareness campaigns, and advocacy projects.[1]

National strategies, conferences and advocacy efforts

The *National Stigma and Discrimination Reduction Strategy* developed by the Australian National Mental Health Commission is due to be published in 2024 after rounds of review and feedback.[2] The strategy was developed collaboratively with input from individuals with lived experience, families, carers, experts, and the wider community. It aims to reduce self-stigma among those with mental health issues and their supporters, diminish public stigma, and address structural stigma. It was outlined by stakeholders to be ambitious and only effective with long-term funding and monitoring. While not gender-focused, it is viewed as a crucial first step in raising awareness and reducing stigma of mental health.

Awareness raising of stigma and discrimination associated with mental ill health has been the focus of several public facing forums and interactions including:

- World Mental Health Day (Mental Health Australia)
- National Mental Health Commission
- National Stigma and Discrimination Strategy

Continual promotion of guidelines and support messaging through media channels

- The *Mindframe National Communication Charter* program, funded under the National Suicide Prevention Leadership and Support Program since 2017, is a set of guidelines for the media aimed at ensuring consistent messaging around suicide, mental illness and alcohol and other drugs. The program has recently been expanded. It now operates with 31 organisations undertaking 40 projects over three years (2022-25).[3]
- The *Life in Mind* knowledge exchange portal translates research on suicide prevention into interventions (see right).[4]

Areas for attention

- There is limited implementation of best-practice programs that focus on reducing stigma and discrimination associated with mental ill health for individuals from priority populations, especially CALD, First Nations and LGBTIQA+ people.[1]
- Reducing stigma and implementing practices to combat stigma will empower individuals to seek help for their mental health, with a particular need for increased focus on reducing stigma in youth mental health and increasing service utilisation.
- Stigma and discrimination also extend to workplaces, employment, and income. Stakeholders have emphasised the importance of incorporating mental health leave into the workplace, requiring additional support to ensure that individuals feel comfortable taking it without facing stigma or discrimination.

Box 4.5.1: Life in Mind

Life in Mind is a knowledge exchange portal that provides translated evidence, policy and resources in suicide prevention. Between January and June 2023, *Life in Mind* has:

- Supported suicide campaigns (for example: RUOK, World Pride LGBTIQA+)
- Reach 20,888 people through social media with 97,196 page views
- Established and continued collaborative relationships with 24 PHNs
- Partnered with AIHW to translate and host data presented in the Suicide and Self-harm monitoring system.

Progress rating

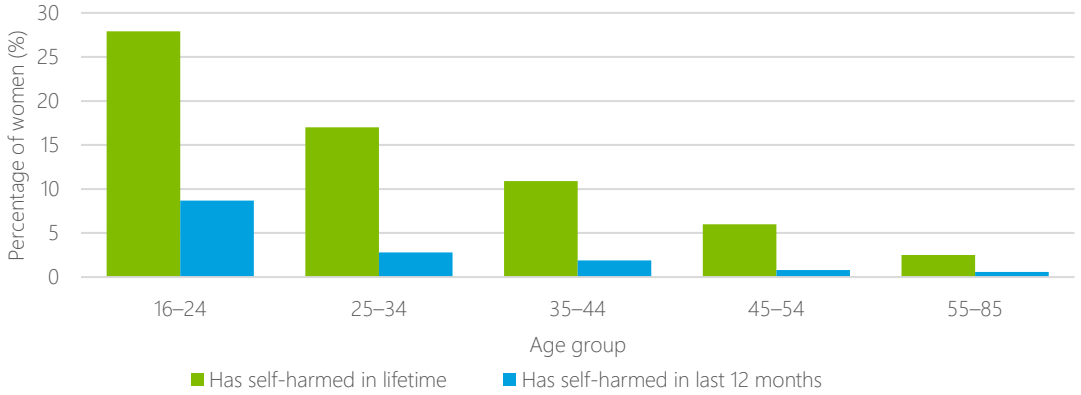
Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

ACTION OUTCOMES

Measure 4.1 | Lower incidents of mental health reporting, self-harm and suicide (1/2)

INDICATOR 4.1.1: Percentage of women who have ever self-harmed

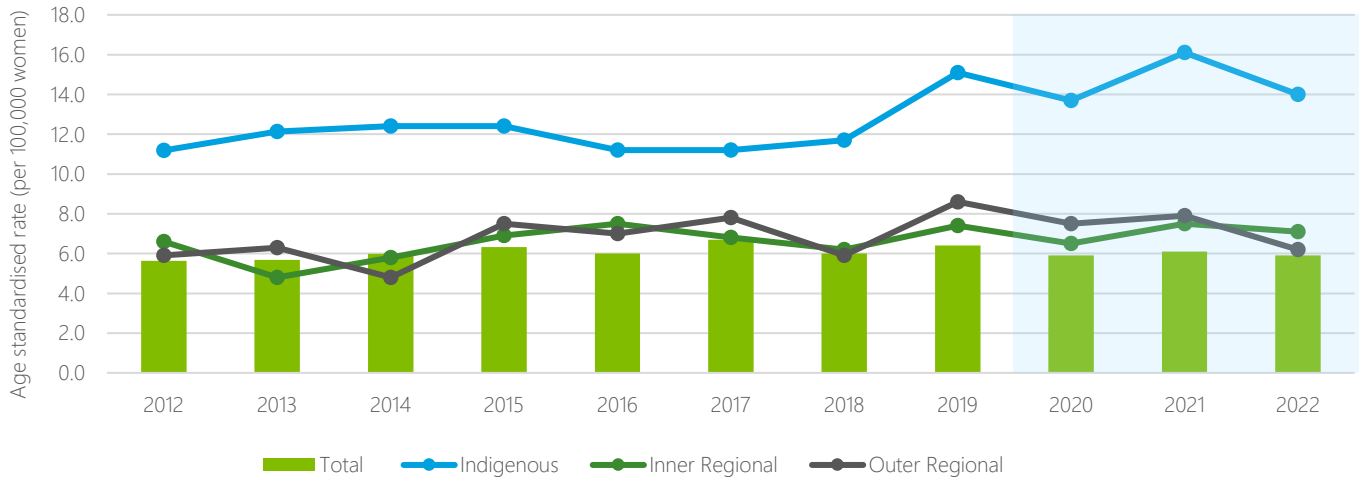
Figure 4.1.1.A: Percentage of women who have self -harmed in lifetime and in last 12 months for period of 2020-22



Source: Australian Bureau of Statistics, National Study of Mental Health and Wellbeing: Summary Results, 2020-22[1]

INDICATOR 4.1.2: Suicide rate per 100,000 women

Figure 4.1.2.A: Age-standardised rate of suicide per 100,000 women between 2012-22, by priority population



Source: Australian Bureau of Statistics, National Study of Mental Health and Wellbeing: Summary Results, 2020-22[1]

Key takeaways

- The National Study of Mental Health and Wellbeing found that approximately 30% of women aged 16-24 years have engaged in self-harm during their lifetime. The rate is lower among those aged 25-34 years, at 16% (Figure 4.1.1.A).
- The suicide rate among women has remained relatively stable, ranging from 5 to 7 per 100,000 women, between 2012 and 2022. However, there are notably higher rates among Indigenous women (14 per 100,000) and women residing in inner and outer regional areas compared to the general female population (Figure 4.1.2.A).

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*All relevant priority groups disaggregated*

Trend Rating

Legend

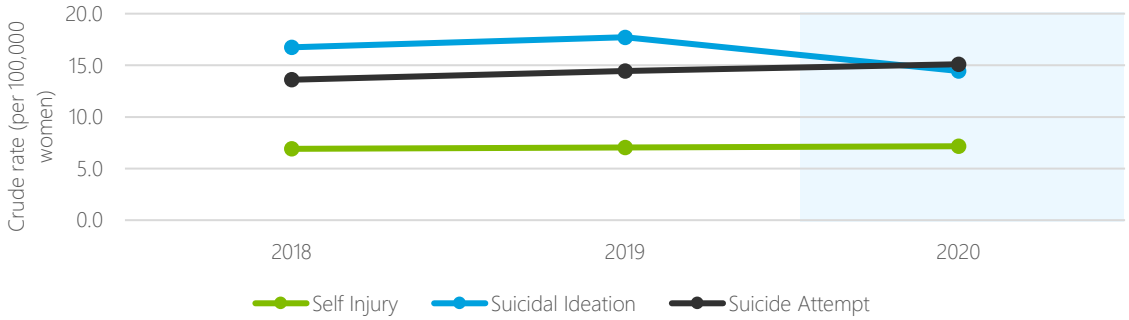
Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

ACTION OUTCOMES

Measure 4.1 | Lower incidents of mental health reporting, self-harm and suicide (2/2)

INDICATOR 4.1.1: Rate of ambulance attendances due to suicidal ideation, suicidal and self-harming behaviours per 100,000 women

Figure 4.1.1.A: Rate of ambulance attendances due to suicidal ideation, suicidal and self-harming behaviour per 100,000 women between 2018 and 2020



Source: AIHW – Suicide & self-harm monitoring data: Ambulance attendances[2]
Note: Data collated is averaged across quarterly data and based off 4 jurisdictions, NSW, TAS, ACT and VIC

Key takeaways

- Rates per 100,000 women of self-injury, suicidal ideation and suicide attempt between 2018 and 2020 stayed relatively constant from 2018 to 2020 (Figure 4.1.1.A).
- From Figure 4.1.1.A evidence of a slight decrease in the rate of suicidal ideation for women between 2018 (16.8) and 2020 (15.1) can also be seen.
- A 2021 study, which surveyed 10,500 Australian women aged 18-79, identified concerningly high prevalence of moderate to severe depressive symptoms among young Australian women. For example, prevalence was identified for 35% of women aged 18-24 years, 28% for women aged 25-29 years, and 24% for women aged 30-34 years.[3]

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*All relevant priority groups disaggregated*

Trend Rating

Legend: Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

ACTION OUTCOMES

Measure 4.2 | A reduction in mental health related illness

INDICATOR 4.2.1: Percentage of woman diagnosed with a mental health condition, *including: Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Affective disorders, Depressive Episode, Dysthymia, Bipolar Affective Disorder, Substance Use disorders, Alcohol Harmful Use, Alcohol Dependence and Drug Use Disorders*

Figure 4.2.1.A: Percentage of women who self-reported / diagnosed with a mental health condition in the last 12 months, by condition 2020-22

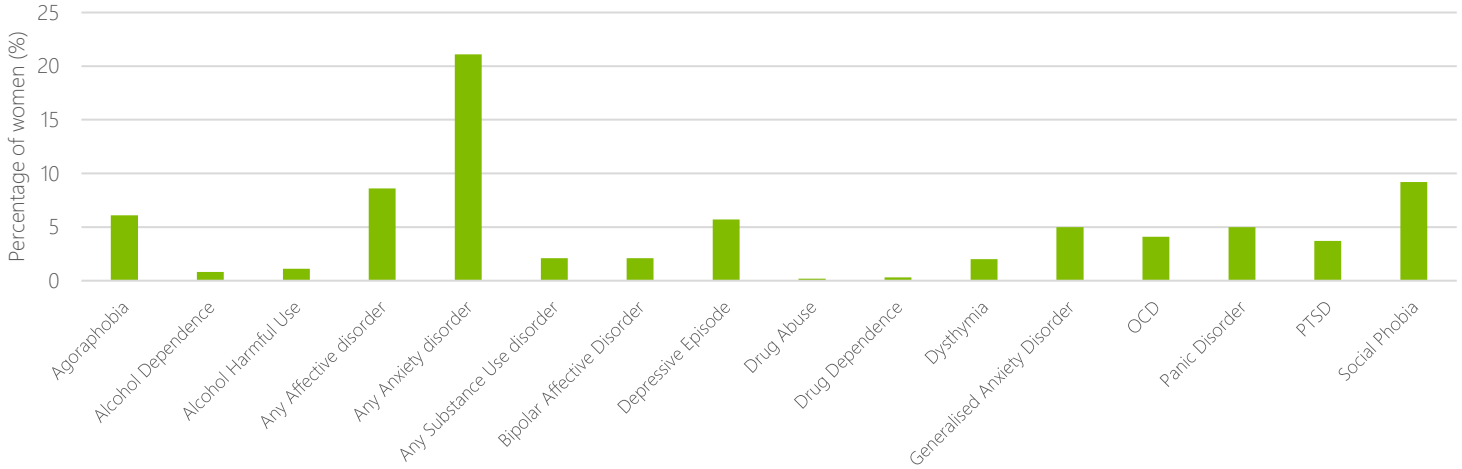
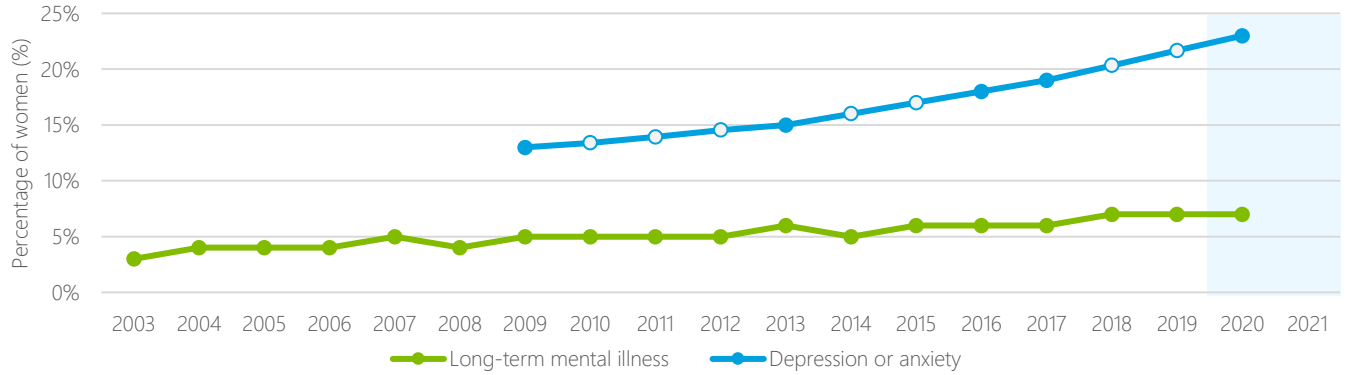


Figure 4.2.1.B: Percentage of women who have reported ever having a long-term mental health illness



Source: AIHW analysis of Household, Income and Labour Dynamics in Australia (HILDA) Survey (Wave 21) data from University of Melbourne (2021) 'Household, Income and Labour Dynamics in Australia Survey', University of Melbourne.[1] National Study of Mental Health and Wellbeing 2020–2022;[2] For Figure 4.2.1.B, years 2014-2016 and 2018-19 for depression and anxiety were extrapolated using midpoints of 2014 and 2020 surveys

Key takeaways

- From 2020 to 2022, approximately 21% of women reported experiencing anxiety disorders, while 9% reported incidents of any affective disorder (Figure 4.2.1.A).
- The percentage of women who have ever reported a mental health illness has been steadily increasing since 2013, with a 4% rise between 2003 and 2021 (Figure 4.2.1.B).
- This upward trend is consistent for depression or anxiety (Figure 4.2.1.B).
- According to an ongoing study by the Black Dog Institute, rates of female, gender diverse, sexuality diverse, or Aboriginal and/or Torres Strait Islander adolescents identifying as presenting with clinically significant symptoms of mental health conditions were significantly higher than the overall cohort.[3] There is also a stark gender difference in rates of anxiety and depression in early teenage years. Future iterations of the monitoring and reporting of the strategy should look to incorporate this data as it is released.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*Some priority groups disaggregated*

Trend Rating

Legend

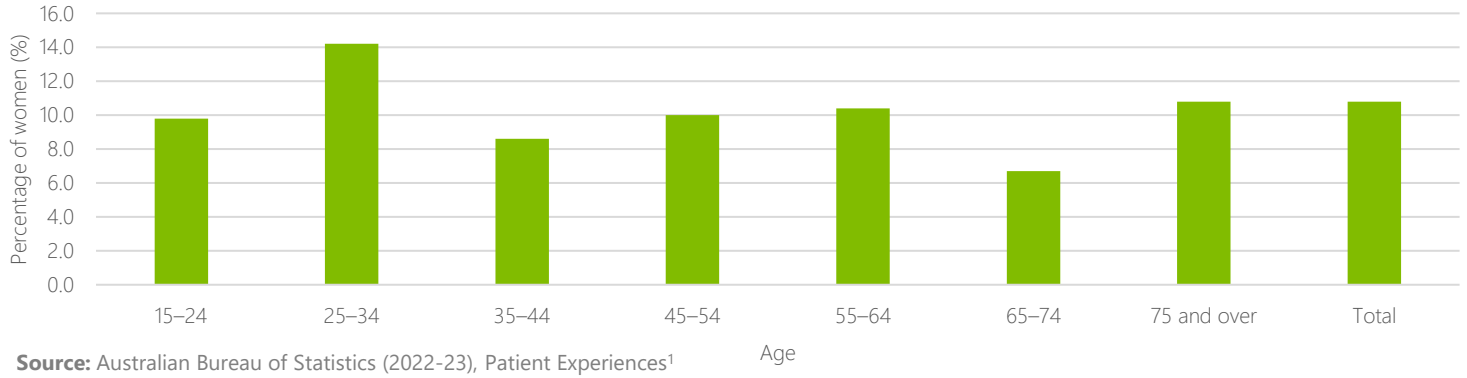
Positive trend in outcome	No observable change	Negative trend in outcome	Insufficient data available

ACTION OUTCOMES

Measure 4.3 | Increase in the number of mental health services and ability for priority populations to access (1/2)

INDICATOR 4.3.1: Percentage of women aged 15 or above who did not see any mental health care providers but needed to in the last 12 months

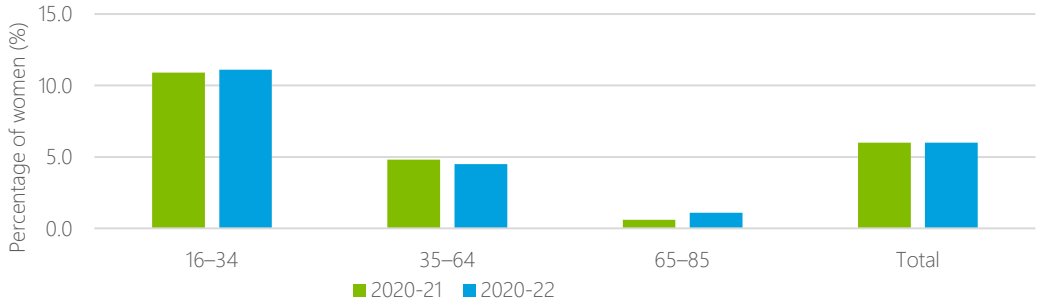
Figure 4.3.1.A: Percentage of women aged 15 and over that needed to but did not see a mental health professional at all (All types of mental health professionals) in 2022-23



Source: Australian Bureau of Statistics (2022-23), Patient Experiences[1]

INDICATOR 4.3.2: Percentage of women who have accessed mental health services via digital technologies*

Figure 4.3.2.A: Percentage of women who have accessed at least one mental health service via digital technologies by age between 2020-22



Source: Australian Bureau of Statistics, National Study of Mental Health and Wellbeing 2020-2022[2]. Table 9.3 Persons 16–85 years, Other services for mental health accessed via digital technologies(a) by age

Key takeaways

- Data availability for the number of mental health services accessible to (and taken up by) priority populations is severely lacking, particularly for women.
- The percentage of women aged 15 and over that did not see a mental health professional at all despite needing to (between 2022-23) varied significantly by age group, with 25–34-year-olds being the highest (14.2%) and 65-74-year-olds being the lowest (6.7%) (Figure 4.3.1.A).
- The percentage of women who have accessed at least one mental health service via digital technologies (Figure 4.3.2.A) is much higher for those aged 16-34 compared to older age groups. An increase in uptake from 2021 to 2022 was noted for those aged 16-34 and 65-85, while converse results were seen for those aged 35-64.

Data quality assessment

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*No relevant priority groups disaggregated*

Trend Rating

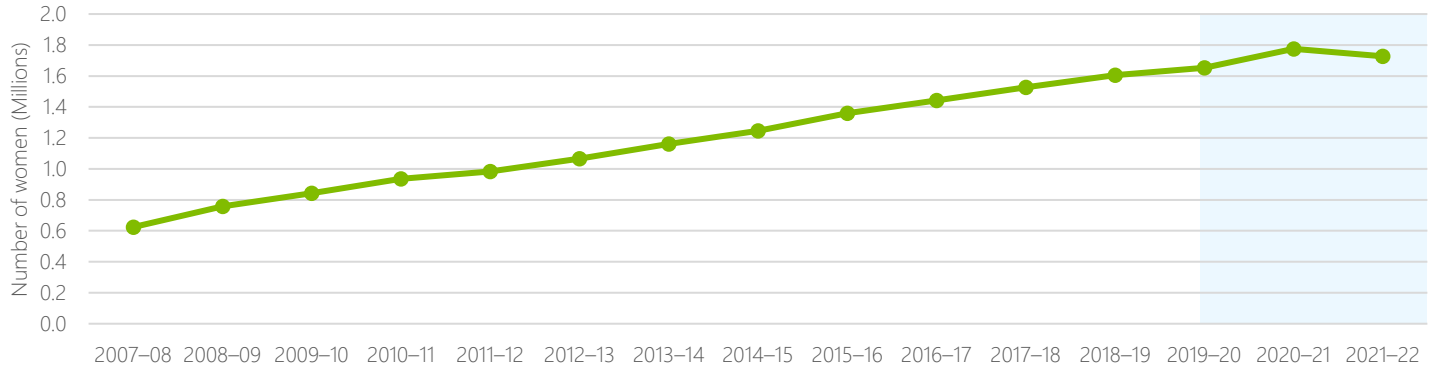
Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 4.3 | Increase in the number of mental health services and ability for priority populations to access (2/2)

INDICATOR 4.3.3: Rate of MBS mental health services per 100,000 women

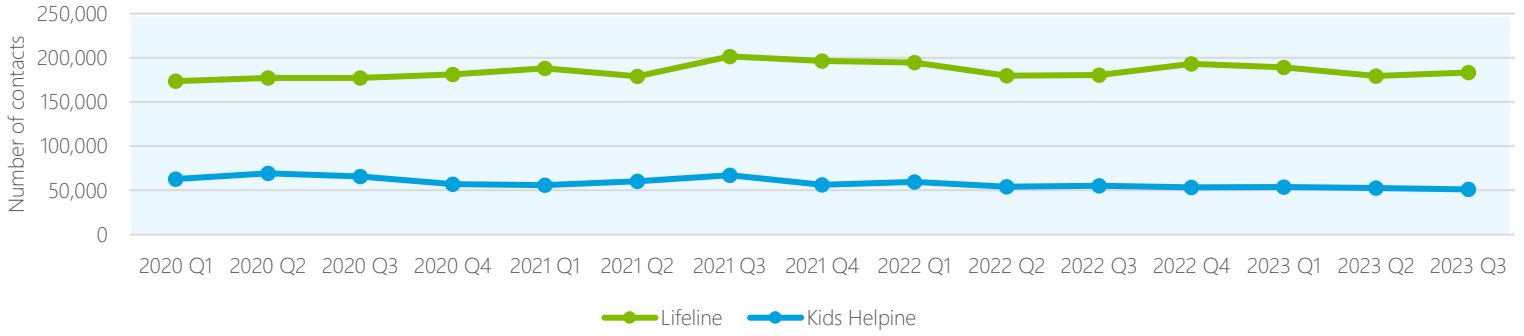
Figure 4.3.3.A: Number of women receiving Medicare subsidised mental health specific services,



Source: AIHW – Mental health services activity monitoring: quarterly data[3]

INDICATOR 4.3.4: Rate of crisis support – aggregate lifeline and kids helpline contacts*

Figure 4.3.4.A: Number of Contacts by women each quarter to crisis support services



Source: AIHW – Mental health services activity monitoring: quarterly data[1] and Watson et al. (2006)[4]

*Estimated 67.84% of callers to Lifeline were female

Key takeaways

- The rate of MBS mental health service uptake has steadily increased between 2007-08 and 2021-22, increasing by 176.8% (Figure 4.3.3.A).
- Since 2020, the rate of crisis support for women on the Lifeline helpline has fluctuated significantly. The rate of support for girls on the Lifeline Kids helpline has decreased slightly (Figure 4.3.4.A).

Data quality assessment

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*No relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Priority 5 – Health impacts of violence against women

Summary insights | Health impacts of family violence

Implementation progress

Sub-priority	Summary	Progress Rating		
		Requires stronger focus	Some progress	Meaningful progress
Raise awareness of the health impacts of violence against women and girls	While there is evidence of increasing investment in the primary prevention of violence against women and girls, there has been limited focus on the health impacts of this violence.	●	○	○
Address health and related impacts of family and sexual violence	While some initiatives aimed at upskilling the health care workforce have been implemented, stakeholders identified that many practitioners lack the capability and confidence to recognise domestic, family and sexual violence (DFSV) as a cause of poor health and respond effectively to these health impacts.	○	●	○
Co-design and deliver safe and accessible services for women experiencing family, intimate partner and/or sexual violence	There is evidence of investment in the co-design and delivery of services for women experiencing DFSV. However, most of this investment is still targeted at immediate crisis support rather than prevention or long-term recovery.	○	●	○

Trend in outcomes in past five years

Measure of success	Summary	Trend
Increase in number of services available, and women accessing these services	A lack of data availability across years limited the insights that could be made on this measure. The most common sources of support or advice for female victims of sexual assault, physical assault and physical threats were family or friends, underscoring the importance of these networks of support.	No observable change
Decrease in deaths from physical violence on women	The number of deaths attributed to intimate partner violence (per 100,000 women) dropped substantially from 2004-2021. Recent data by the Australian Institute of Criminology National Homicide Monitoring Program has found 34 women were killed by an intimate partner in 2022-23, an increase of 28 per cent on the previous year.	No observable change
Reduction in the proportion of women who have experienced abuse or trauma in their life	Most indicators show improvements in trend as percentage of women experiencing intimate partner violence, cohabiting partner violence and sexual harassment decreased from 2005 to 2022. However, the rate of sexual violence against women increased from 2012 to 2022.	No observable change
Reduction in the rate of reproductive coercion	A trend for the rate of reproductive coercion cannot be determined due to limited data availability on this measure.	Insufficient data
Reduction in the gap in mental and physical health trajectories between women who have and have not experienced violence	Across the indicators, there is limited evidence of mental and physical health trajectories converging between women who have and have not experienced violence. This is consistent across the range of indicators here.	No observable change

Priority 5.1 | Raise awareness of the health impacts of violence against women and girls

While there is evidence of increasing investment in the primary prevention of violence against women and girls, there has been limited focus on the health impacts of this violence and raising awareness for these impacts.

Key aligned activities

Under the *National Plan to End Violence Against Women and Children* 2022-2032 (National Plan), Commonwealth and state governments, health bodies and not-for-profits have acted in response to violence against women and girls.[1] Notable examples include NSW Health's *Prevention and Response to Violence Abuse and Neglect* (PARVAN) Unit in NSW Health, Respect Victoria and Our Watch. The National Plan acknowledges the physical and health impacts of violence, including depressive and anxiety disorders, early pregnancy loss and alcohol use disorders. This section of the strategy supplements the *National Plan* by providing further detail on the actions required in response to these health impacts.

To date, most awareness raising initiatives targeting violence against women and girls are focused on recognising the signs of abusive behaviour, rather than raising awareness of health impacts. For information on the primary prevention of violence see Box 5.1.1.

Awareness of the health effects of violence

- Stakeholders recognised the work of the Monash Gender and Family Violence Prevention Centre in collecting data and informing policy on the health impacts of domestic, family and sexual violence (DFSV) for women and girls – for example, the Centre published research titled *the provision of emergency healthcare for women who experience intimate partner violence: part 2* in 2020.[2] Similarly, Australia's National Research Organisation for Women's Safety (ANROWS) has raised awareness of the health impacts of violence through its research and advocacy work. In 2020, ANROWS released an article titled *Violence against women and mental health*.[3] Stakeholders also noted the importance of the work done by Kelsey Hegarty, joint chair in the prevention of family violence (Royal Women's Hospital and the University of Melbourne).
- Not-for-profit organisations, like 1800RESPECT and Full Stop, have conducted social media marketing campaigns and provided digital resources aimed at raising awareness of the health impacts of violence and where to access help. For example, 1800RESPECT developed the *Daisy* app, which provides localised information on potential pathways to support services, including key health services.[4]
- State and territory governments have also conducted awareness campaigns on violence against women and girls. Some of these campaigns – including the annual *16 Days in WA* – have explored the health impacts of DFSV through collaborations with local health services (e.g., the South West Women's Health and Information Centre, Joondalup hospital).[5]
- Victoria's Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit aims to assist health care professionals with identifying and responding to family violence signs and symptoms experienced by patients.[6]

Box 5.1.1: Peer education on the impacts of violence

- In 2022, education ministers from around the country unanimously agreed to implement a holistic and age-appropriate consent curriculum from 2023.[7] As a result, all Australian schools (including independent schools) will be required to explicitly teach respectful relationships education (RRE) and consent from foundation to year 10. This education addresses the drivers of gendered violence, outlines the warning signs and health impacts of abusive behaviour and provides methods of seeking help.
- States have also taken action to upskill teachers in RRE – for example, Queensland has introduced the *Respect* program, which provides teachers with detailed learning resources aligned to the Australian Curriculum, and *Teacher Relief Scheme* funding, which allows Queensland state schools to release teachers for professional development in RRE. Similarly, Victoria has established 'lead' RRE schools, which receive funding for two years to model a whole-of-school approach to RRE to neighbouring schools.
- Not-for-profits play a large role in primary prevention of violence against women and girls. For example, over 10,000 students participate annually in *Love Bites* – a RRE education program run by NAPCAN – in NSW alone.[8]

Areas for attention

- Stakeholders identified that historically there has been insufficient investment in prevention and addressing the underlying drivers of gendered violence. Instead, the focus has been targeted at responding to health impacts of violence that has already occurred. Recent efforts to correct for this will need to be expanded upon and sustained over the long-term to result in meaningful change.
- While peer education is increasingly targeting primary prevention, there is limited focus on the health impacts of violence against women and girls. For example, the RRE curriculum aims to build positive gender-related attitudes and does not explicitly cover the health impacts of violence.
- The delivery of RRE is inconsistent across the country and rarely explores the health impacts of violence against women and girls. For many schools, the delivery of RRE is siloed in health and physical education rather than embedded in a whole school approach. While some schools are educating students about preventive behaviours, others are not yet delivering comprehensive RRE.
- There is an ongoing need to raise awareness of the physical and mental health manifestations of violence among the broader health workforce. A lack of awareness of the types of DFSV, such as emotional abuse and sexual violence, and how their health impacts differ is preventing some GPs and allied health workers from playing an important role in identifying and responding to this violence.
- Some stakeholders noted that there is low awareness of how the health impacts of violence differ for women based on their identities. In particular, the experiences of women with disabilities, who have a significantly higher risk of being exposed to violence, are often overlooked.
- It was noted that refugee women face significant levels of domestic violence, emphasising the need to address the specific needs of this population.
- There is limited data available on the prevalence of sexual violence, leading to an overreliance on the Personal Safety Survey. This survey is not conducted annually and, according to stakeholders, cannot capture the full picture of DFSV.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 5.2 | Address health and related impacts of family and sexual violence

While some initiatives aimed at upskilling the health care workforce have been implemented, stakeholders identified that many practitioners lack the capability and confidence to recognise DFSV as a cause of poor health and respond effectively to these health impacts.

Key aligned activities

Education of broader health workforce

- The *National Plan to End Violence Against Women and Children 2022-2032 (National Plan)* acknowledges the need to raise awareness among health professionals of the health impacts of DFSV.[1] For example, it aims to 'build the capacity of maternal health professionals to understand and identify the signs and risks of violence against pregnant women.'
- The Australian Government has funded training programs and resources to upskill primary care in responding to DFSV.
    - The University of Melbourne's Safer Families Consortium (consisting of the RACGP, Blue Knot Foundation and Phoenix Australia) was funded from 2019-20 to develop and deliver a national training program (the *Readiness Program)* for primary health care providers to better identify and respond to DFSV. The *Readiness Program* was delivered through to the end of June 2024 and includes face-to-face workshops, an online community of practice network and web-based, practice-specific engagement.[2]
    - In 2019-20, six PHNs were funded to build the capacity and capability of primary care in supporting victims of DFSV and pilot locally integrated models of DFSV identification, response and referral. The funding covered professional development sessions and the creation of informative resources on how to treat the health impacts of DFSV. The pilot was extended in 2022-23 to cover 12 PHN regions.[3]
- Since 2007, Lifeline Australia has delivered *DV-alert,* a nationally recognised training program that aims to build the knowledge and capability of frontline workers to reduce and prevent family and sexual violence. Ongoing investment in *DV-alert* is a key component of the *National Plan.*
- The Australian Government is funding the Multicultural Centre for Women's Health to support health professionals to address the health impacts of female genital mutilation and/or cutting. Funded initiatives include mapping the current workforce supporting survivors of female genital mutilation and/or cutting, establishing a National Community of Practice and delivering a training package for health professionals.
- The Council of Remote Area Nurses of Australia (CRANA) supports rural and remote health professionals in responding to family and sexual violence by offering professional development, educational resources and referrals (e.g., to the Education Centre Against Violence).
- As noted in Section 5.1, Victoria's Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit aims to educate health care professionals to identify signs and symptoms of family violence in patients.[4]

Innovative models to address health impacts of violence

- From 2022-23, $67.2 million in Federal funding was invested into the *Supporting Recovery* pilot program led by the Department of Health, Disability and Ageing. The pilot is delivered in six PHN regions across Australia and trials a new model of trauma-informed mental health care for women and children who have experienced DFSV. It aims to promote longer-term recovery by providing victim-survivors with access to trauma-informed mental health care. The model of care used to shape the delivery of this pilot was developed in consultation with the Mental Health and Family, Domestic and Sexual Violence Expert Reference Group, which includes representation of victim-survivors with a lived experience of DFSV.
- In March 2023, the Australian Government invested $31.6 million in expanding the *Escaping Violence Payment* (EVP) place-based trial.[5] A further two new sites in Darwin and Broome will provide individualised financial assistance packages of up to $5,000 and confidential support (including health service referrals) to First Nations peoples experiencing DFSV. However, advocates caution that only 43% of people who apply for the EVP receive it, raising questions over whether the scheme is meeting the needs of victim-survivors.
- In the 2023-24 Federal Budget, the Australian Government committed $23.2 million to the delivery of seven place-based trauma-aware and culturally responsive health programs aimed at early intervention and supporting First Nations families impacted by violence.[6]

Areas for attention

- Stakeholders shared the view that health care providers need more training to recognise, refer and respond to DFSV. There is a lack of workforce capability in this area, particularly in using trauma-informed care models. Further, there is little understanding that the various types of DFSV have differing health impacts. As such, health care providers need to be upskilled in identifying the various types of DFSV and tailoring their service delivery to each type.
- Some stakeholders suggested that training on recognising and responding to DFSV should be incorporated into mainstream health professional qualifications (e.g., GPs). This would ensure all health care professionals have the capability and confidence to address DFSV, rather than just those with a specific interest in the space.
- It was suggested that more investment is needed to upskill those who deliver primary prevention programs (e.g., schoolteachers, allied health services) in the drivers of gendered violence, respectful relationships and how to recognise violence.
- Stakeholders revealed that the general health workforce is not attuned to the needs of women with a disability, who are at a higher risk of experiencing violence. There are not enough supports available with specialist knowledge in disability – for example, the ability to recognise signs of carer abuse.
- There is a lack of high-quality national data on the health impacts of DFSV, reducing the ability of health practitioners to address these impacts. The mental health impacts of DFSV (e.g., depression, suicidality and self-harm) are often not recorded in the health system as linked to DFSV. This limits the ability of the health system to understand the magnitude and prevalence of these impacts and respond effectively.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Priority 5.3 | Co-design and deliver safe and accessible services for women experiencing family, intimate partner and/or sexual violence

There is evidence of investment in the co-design and delivery of services for women experiencing DFSV. However, most of this investment is still targeted at immediate crisis support rather than prevention or long-term recovery.

Key aligned activities

Improvements to the delivery of services to address violence against women are primarily being driven by the *National Plan*. The strategy supplements the *National Plan* from a health perspective. The activities listed below are aligned to the sub-priorities of Priority 5.3, which have a specific focus on the mental and physical impacts of DFSV.

Choice of pathways to recovery for women who have experienced violence

- There has been an increased focus on trauma-informed recovery programs, as opposed to just immediate crisis support. The aim of these programs is to achieve long-term improvements to health and wellbeing. In 2022-23, the Department of Health and Aged Care commenced the development of the *Supporting Recovery* pilot program across six PHNs.[1] Under the expansion, PHNs will contract new services to provide access to free, long-term trauma-informed mental health care for those who have experienced DFSV. The program's design was informed by a reference group composed of subject matter experts in mental health, family, domestic and sexual violence, including individuals with lived experience.
- Wattle Place assists residents in NSW who experienced sexual abuse in an institutional setting as children and are considering applying to the *National Redress Scheme*.[2] The service provides trauma-informed support and information for free.

Accessible services for women who have experienced violence

- There have also been initiatives aimed at connecting social services to one another to improve the access of women experiencing violence to wraparound supports. In 2023, the WA Government piloted the integration of legal services with women's health services in Kalgoorlie and Northbridge.[3] This will assist clinicians in identifying and responding to women experiencing DFSV and make specialist legal service more accessible.
- $6 million was announced in the 2024-25 Federal Budget to trial a trauma-informed model of outreach health care in women's crisis and temporary accommodation and services to support women and children experiencing family, domestic and sexual violence and homelessness. This pilot will operate in up to 6 PHN regions for two years and includes an independent evaluation on the impact of this support service. The place-based model of care will be located in a range of regions including metropolitan, regional and rural locations.[4]

Digital information and 24-hour phonelines

- There has been ongoing investment in digital information sources and applications, as well as 24-hour phone lines like 1800RESPECT, the Victorian Sexual Assault Crisis Line, and Full Stop. 1800RESPECT is Australia's national DFSV counselling service. Via telephone and web chat, 1800RESPECT provided almost 270,000 responses to people experiencing family, domestic or sexual violence in the 2022-23 financial year.[5]
- 1800RESPECT's *Daisy* app provides information about local support services. In alignment with the strategy, it has a range of safety features including allowing users to search discreetly in their browser (without it showing on browser history).[6]
- In 2023, 1800RESPECT launched a new SMS service, which allows people experiencing family and sexual violence to text to receive counselling information and support. The expanded service aims to reach more people in rural and remote communities, especially those with limited access to landlines and internet.[7]
- In 2024, 1800RESPECT introduced on-demand video counselling to provide people needing support with the option of connecting face-to-face. This is expected to increase the reach of the service to include those who may have a communication difficulty using phone or text.

Areas for attention

- Australia has a legacy of ad hoc and inadequate funding of health services for women experiencing DFSV. Significant improvements in the rates of DFSV and service quality will depend on large and sustained investments by governments and community organisations.
- Stakeholders noted that there is a focus on front end service delivery. While many women still face delays in accessing immediate crisis support, these services are far more developed than primary prevention services and longer-term supports (e.g., redress services). Currently, the delivery of prevention and long-term supports is ad hoc across the country.
- It is difficult to measure changes in the usage of DFSV-specific health services due to a lack of timely data. Anecdotally, many services report that demand has increased, and they are operating over-capacity, reducing the quality of their service delivery.
- Services for women in long-term recovery, particularly from childhood sexual violence, face long waitlists. For example, there are strong delays in accessing Full Stop Australia's face-to-face support services for sexual violence across NSW health centres. Despite extremely limited capacity, the program has not been expanded since its inception. In another example, a stakeholder noted that calls to the Victorian Sexual Assault Crisis Line go unanswered as the line is underfunded.
- There is a lack of services co-designed with and tailored to the needs of the priority groups.
    - Despite facing significantly higher rates of DFSV, people with a disability (particularly those with an intellectual disability) face limited options for support.
    - There is a shortage of language interpreters and culturally appropriate services for First Nations and CALD women. A lack of safe housing and men's behaviour change programs are also contributing to high rates of DFSV for these groups. Stakeholders noted that interpreters needed further specialised education and support for dealing with women experiencing violence.
    - Workforce shortages, high-turnover of health practitioners due to a lack of ongoing positions and secure funding, and a lack of specialist knowledge are preventing access to care for people in regional and rural areas.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

Measure 5.1 | Increase in number of services available, and women accessing these services (1/2)

INDICATOR 5.1.1: Percentage of women who sought help after most recent incident of family and domestic violence

Figure 5.1.1.A: **Female victims who sought advice or support after most recent incident of family and domestic violence, 2016**

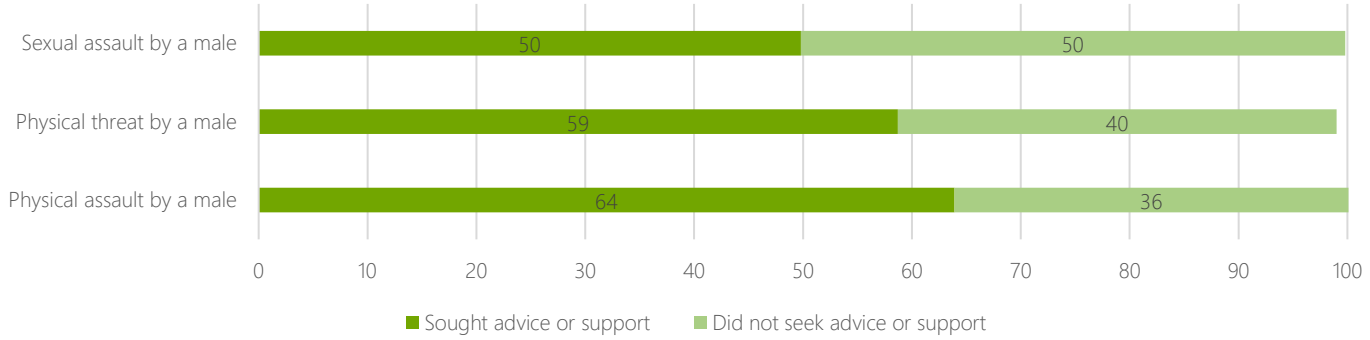


Figure 5.1.1.B: **Sources of advice or support received by female victims (given advice or support was sought) after the most recent incident of family and domestic violence**

Source: Australia Bureau of Statistics (ABS) (2017) Personal Safety, Australia, 2016,[1] AIHW analysis *of Whether sought advice or support after most recent incident* by Violence MRI Index.

Key takeaways

- In 2016, a significant proportion of women who were sexually assaulted by a male chose not to seek advice or support. Women are more likely to seek support after a physical threat or assault, compared to sexual assault (Figure 5.1.1.A)
- Friends and family members were the major sources of support for women after physical threats or assault by a male, while other common sources of support included the police, health professionals, counsellors, support workers and telephone helplines (Figure 5.1.1.B). GPs are the second most common source of support after physical assault, underscoring the importance of GPs having the capability to respond appropriately to patients experiencing DSFV.
- The rate of engagement with police was lower when women were physically assaulted by a male compared to when physical threats were made (Figure 5.1.1.B).
- The ABS' Personal Safety Survey is the main data source used in Australia to understand prevalence of, and use of services related to, DSFV. However, as noted earlier, the survey is limited as it is not conducted annually (the last survey was undertaken in 2017) and, according to stakeholders, cannot capture the full picture of DFSV.

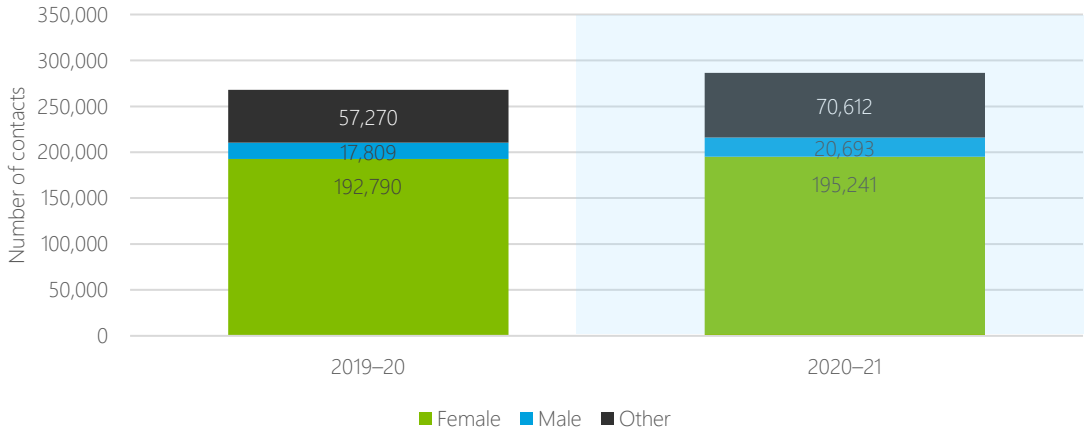
Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Irregular publication of data*	*Some relevant priority groups disaggregated*

Measure 5.1 | Increase in number of services available, and women accessing these services (2/2)

INDICATOR 5.1.2: Number of women who called a family violence hotline by gender between 2019-20 and 2020-21

Figure 5.1.3.A: Number of women who called 1800RESPECT between 2019-20 and 2020-21 by gender



Source: AIHW (2022) - Family, domestic and sexual violence data in Australia[1]
Note: Numbers include every contact to the service, including hand-ups, pranks and wrong numbers.
Comparisons between years should be undertaken with caution. An increase could be due to a number of different factors (such as, an actual increase in the number of women experiencing family violence, an increase in women experiencing family violence who are willing to call the hotline, and an increase in awareness of the hotline among women experiencing family violence).

Key takeaways

- 1800RESPECT is a nationwide helpline and online assistance service in Australia, offering counselling and support to individuals impacted by family, domestic, and sexual violence, as well as their loved ones and frontline workers.
- The majority of calls to 1800RESPECT in 2019-20 and 2020-21 were made by women (Figure 5.1.3.A).
- Between 2019-20 and 2020-21 there was an approximate 1% increase in the number of women calling 1800RESPECT (Figure 5.1.3.A).

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data available	*Irregular publication of data*	*Some relevant priority groups disaggregated*

Trend Rating

Legend: Positive trend in outcome | No observable change | Negative trend in outcome

Measure 5.2 | Decrease in deaths from physical violence on women

INDICATOR 5.2.1: Number of deaths attributed to intimate partner homicide per 100,000 women

Figure 5.2.1.A: Numbers of deaths per 100,000 women aged 16 years or older attributed to intimate partner homicide between 2004-21

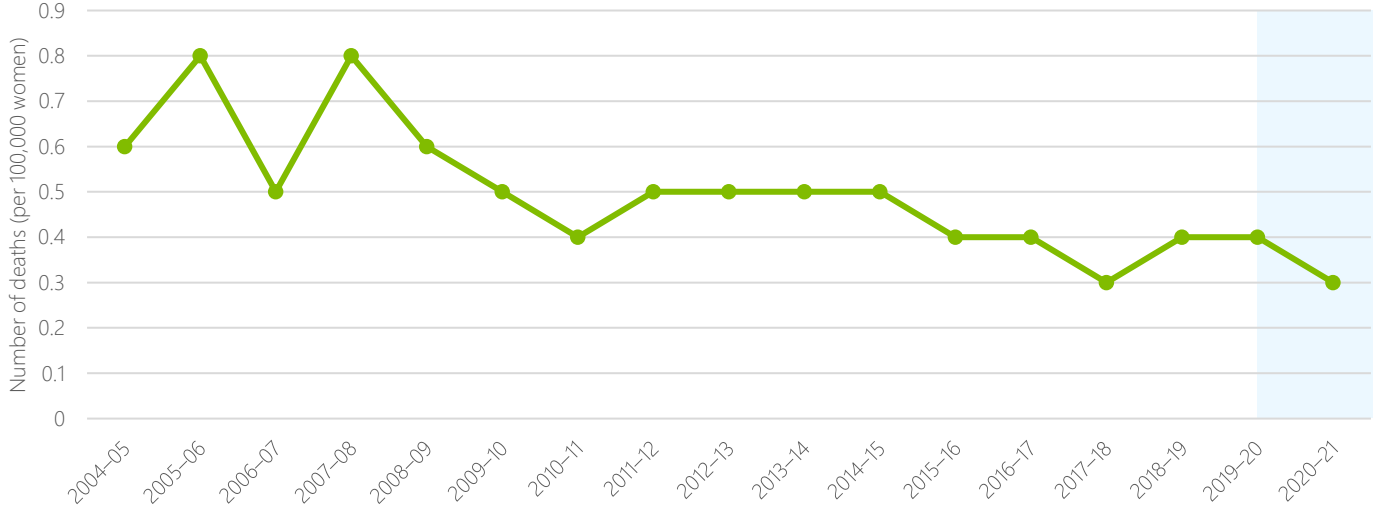
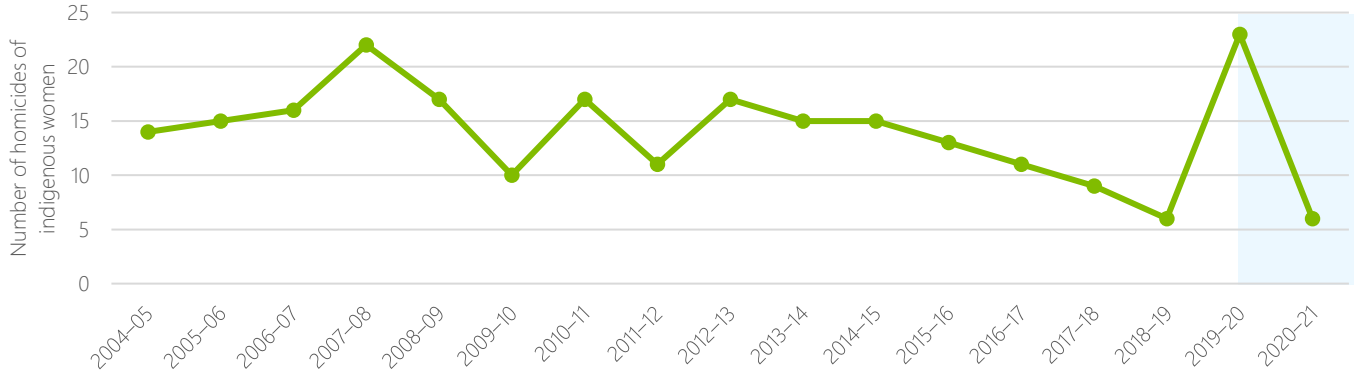


Figure 5.2.1.B: Total number of homicides of Indigenous women aged 16 years or older from 2004-21



Source: Australian Institute of Criminology National Homicide Monitoring Program[1]

Key takeaways

- Rates of intimate partner homicide of women have declined between 2004-05 and 2020-21, with fluctuations year on year. The rate has dropped by more than half during this period (Figure 5.2.1.A).
- Recent data by the Australian Institute of Criminology National Homicide Monitoring Program has found 34 women were killed by an intimate partner in 2022-23, an increase of 28 per cent on the previous year.[1]
- The total number of homicides of Indigenous women has fluctuated over the same period, with regular fluctuations and a spike in 2019-20 (Figure 5.2.1.B). Importantly, this refers to homicide incidents in general, as opposed to intimate partner homicides. Regular data on the rate of intimate partner homicide of Indigenous women is not available.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Regular and timely publication of data*	*All relevant priority groups disaggregated*

Trend Rating

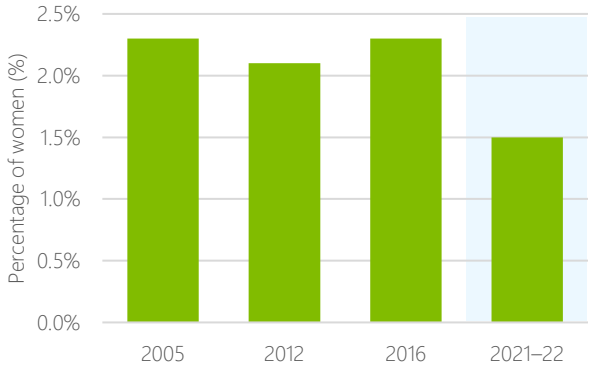
Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 5.3 | Reduction in the proportion of women who have experienced abuse or trauma in their life

INDICATOR 5.3.1: Proportion of women who experienced intimate partner violence in last 12 months

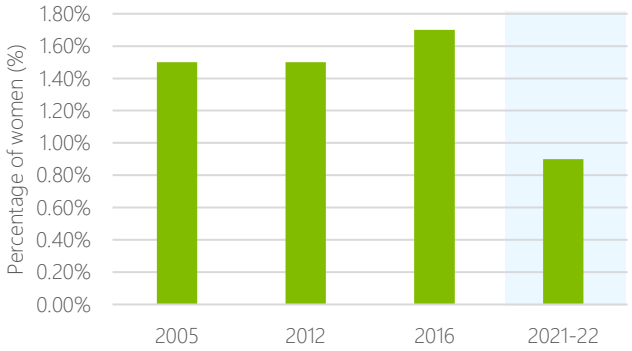
Figure 5.3.1.A: Percentage of women over the age of 18 who have experienced intimate partner violence in the last year, 2005 to 2022



Source: ABS, Personal Safety, Australia 2021–22[1]

INDICATOR 5.3.2: Proportion of women who experienced cohabitating partner violence in last 12 months

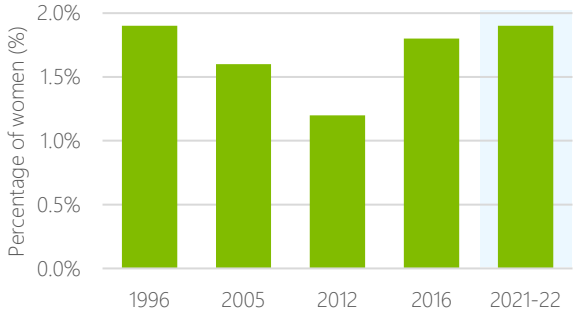
Figure 5.3.2.A: Percentage of women over the age of 18 who have experienced cohabiting partner violence in the last year, 2005 to 2022



Source: ABS, Personal Safety, Australia 2021–22[1]

INDICATOR 5.3.3: Proportion of women who experienced sexual violence in last 12 months

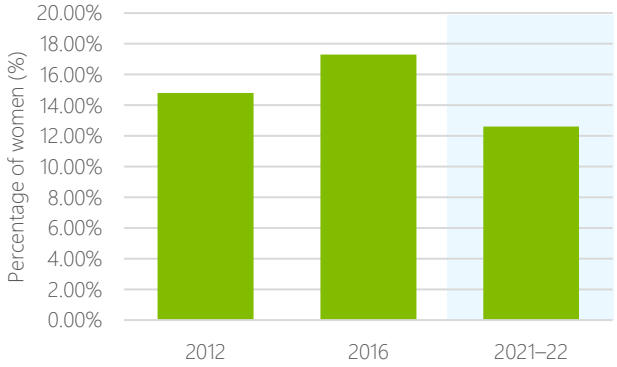
Figure 5.3.3.A: Percentage of women over the age of 18 who have experienced sexual violence in the last year, 1996 to 2022



Source: ABS, Personal Safety, Australia 2021–22 . 1996 data are from the ABS, Women's Safety Survey 1996[1]

INDICATOR 5.3.4: Proportion of women who experienced sexual harassment in last 12 months

Figure 5.3.4.A: Percentage of women over the age of 18 who have experienced sexual harassment in the last year, 2012 to 2022



Source: ABS, Personal Safety, Australia 2021–22[1]

Key takeaways

- The proportion of women who experienced intimate partner violence in the last 12 months remained relatively constant between surveys undertaken in 2005, 2012 and 2016; however a marked decrease is observed between 2016 and 2021-22 (Figure 5.3.1.A).
- The proportion of women who experienced sexual violence in the last 12 months decreased between surveys undertaken in 1996 and 2012, but rose in 2016 and again in 2021-22 (Figure 5.3.3.A).
- Conversely, the proportion of women who experienced sexual harassment in the last 12 months increased between 2012 and 2016 but subsequently decreased in 2021-22 (Figure 5.3.4.A).

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Infrequent publication frequency and lag*	*Some relevant priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 5.4 | Reduction in the rate of reproductive coercion

INDICATOR 5.4.1: Proxy measurements to the rate of reproductive coercion experienced by women and girls

Box 5.4.1: Estimates of reproductive coercion experienced by women

32% of counselling clients were living in a coercive context, with the rate disproportionately higher for First Nations clients (up to 50%)[1]

24% of women experienced one incident of being forced or frightened into doing something sexual in lifetime (Australian Study of Health and Relationships)[3]

36.0% **(in 2008) and** **36.8%** **(in 2018)** of surveyed female students reported receiving unwanted sex[2]

"my partner thought I should"

was the most commonly cited reason (52% of participants who reported experiencing unwanted sex)[2]

Source: De Visser, R.O. et, al. (2014). Experiences of sexual coercion in a representative sample of adults: The Second Australian Study of Health and Relationships. pp. 472–480), Fisher, C. M. et al. (2019). National Survey of Secondary Students and Sexual Health 2018: Results of the 6th National Survey of Australian Secondary Students and Sexual Health. p. 39data .

Box 5.4.2: What is reproductive coercion?

Reproductive Coercion and Abuse, encompasses a variety of actions aimed at controlling a person's reproductive decisions and undermining their autonomy. These actions can include applying pressure, manipulating, emotionally blackmailing, using trickery, making threats, and engaging in different forms of abuse.[4]

Key takeaways

- There is limited data available on rates of reproductive coercion in Australia.
- Our Watch's *Progress on Prevention* paper uses several measures to proxy for reproductive coercion (Indicator 5.4.1).
- Stakeholders highlighted that this should be an area of concerted focus for research.
- The Australian Government has allocated grant funding to the SPHERE Centre of Excellence to conduct future research on reproductive coercion.
- Many women experiencing reproductive coercion first present to a GP or a maternal and child health nurse. More supports are needed to upskill these workers and assist them in helping women experiencing reproductive abuse.

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Partial data is available	*No publication frequency and lag*	*No priority groups disaggregated*

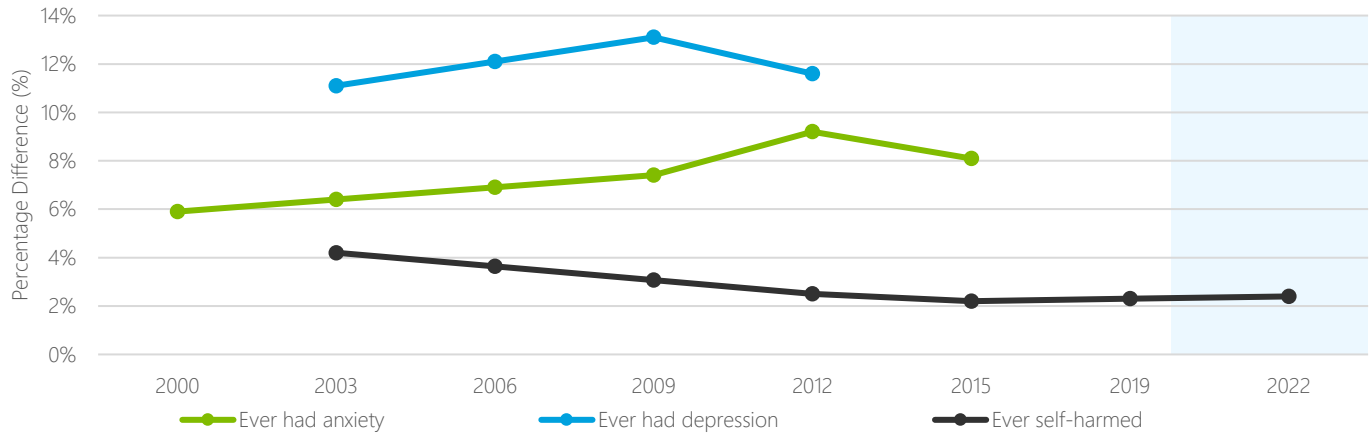
Trend Rating

Legend: Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Measure 5.5 | Reduction in the gap in mental and physical health trajectories between women who have and have not experienced violence (1/3)

INDICATOR 5.5.1: Difference in percentage of women (born between 1973-78) who have and have not experienced violence by mental health behaviours:

Figure 5.5.1.A: Difference in percentage points between women who have and have not experienced violence in mental health



Key takeaways

- When comparing women who have encountered violence with those who have not, a significantly higher percentage of women who have experienced violence also report symptoms of anxiety, depression, or self-harm (Figures 5.5.1.A – 5.5.1.D). For example, in 2015, 16.7% of women who had experienced violence had been diagnosed with anxiety, compared to 8.6% of women who had not experienced violence – a difference of 8 percentage points.
- Since 2000, there has been no reduction in the difference in anxiety and depression rates between women who have and have not experienced violence. However, there is some evidence that women who experience violence have fewer incidents of self-harm, narrowing the gap with women who have not experienced violence (Figures 5.5.1.A – 5.5.1.D).

Figure 5.5.1.B: Percentage of women who have been diagnosed with anxiety in women who have and have not experienced violence

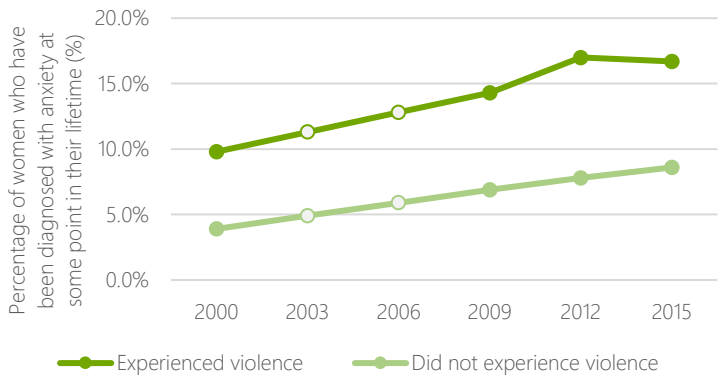


Figure 5.5.1.C: Percentage of women who have been diagnosed with depression in women who have and have not experienced violence

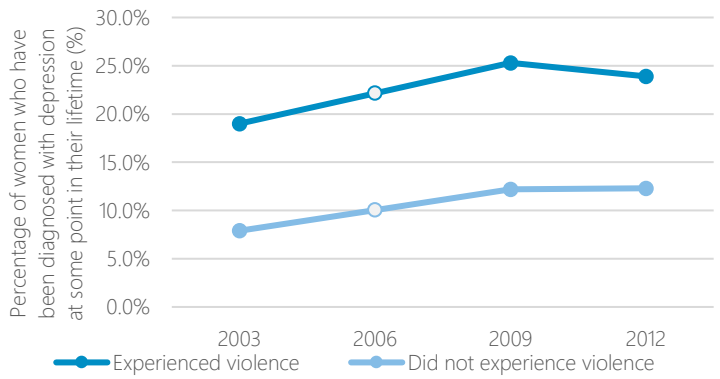
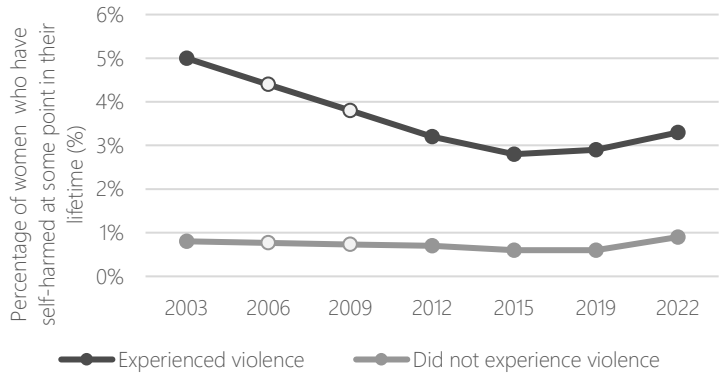


Figure 5.5.1.D: Percentage of women who re have self-harmed in women who have and have not experienced violence

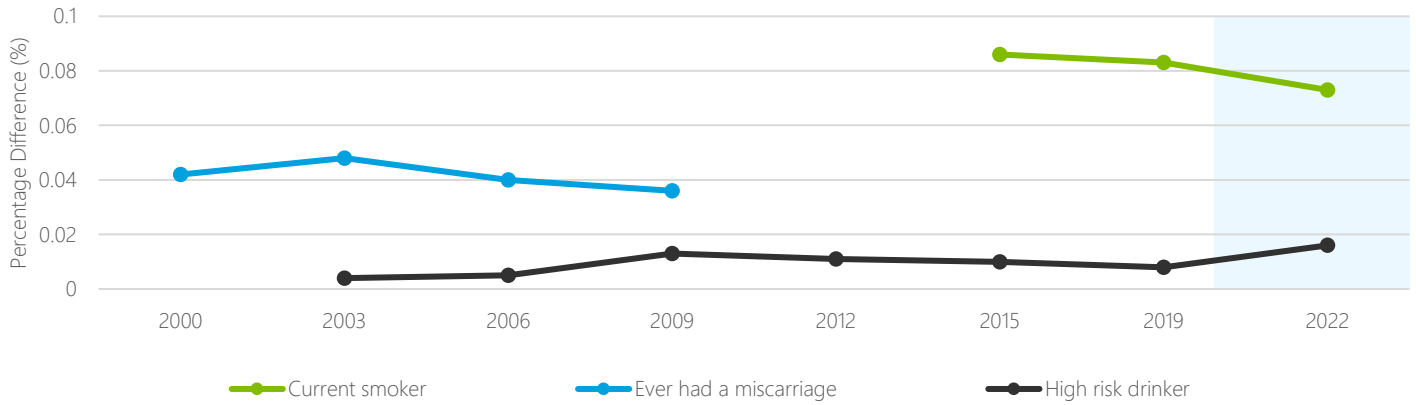


Source: ALSWH– Cohort 1973-78, survey 1-9[1]
Note: Grey data points were extrapolated using the midpoints of data

Measure 5.5 | Reduction in the gap in mental and physical health trajectories between women who have and have not experienced violence (2/3)

INDICATOR 5.5.2: Difference in percentage of women (born between 1973-78) who have and have not experienced violence by physical health behaviours

Figure 5.5.2.A: Difference in percentage points between women who have and have not experienced violence in physical health



Key takeaways

- When comparing women who have encountered violence with those who have not, a significantly higher percentage of women who have experienced violence also report engaging in behaviours of high-risk drinking and smoking and have experienced a miscarriage in their lifetime (Figures 5.5.2.A – 5.5.2.D).

Figure 5.5.2.B: Percentage of women who are have experienced one miscarriage sometime in their lifetime in women who have and have not experienced violence

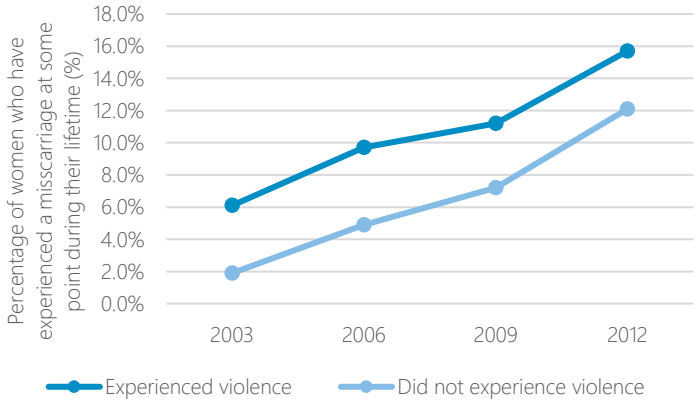


Figure 5.5.2.C: Percentage of women who are classified as high-risk drinkers in women who have and have not experienced violence

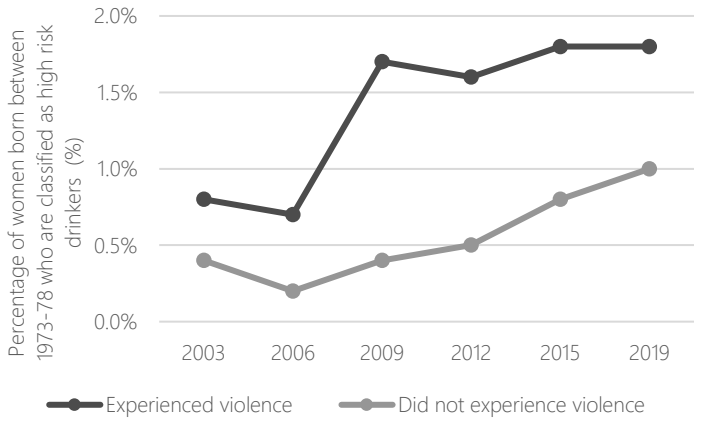


Figure 5.5.2.D: Percentage of women who are classified as current smokers in women who have and have not experienced violence

Source: ALSWH– Cohort 1973-78, survey 1-9[1].

Measure 5.5 | Reduction in the gap in mental and physical health trajectories between women who have and have not experienced violence (3/3)

INDICATOR 5.5.3: Percentage of women who have and have not experienced child maltreatment and mental and physical health risk behaviours throughout life

Children who have experienced child maltreatment are....

- 1.3x more likely to binge drink at least weekly
- 1.9x more likely to be a current smoker
- 1.2x more likely to have obesity
- 4.6x more likely to have attempted suicide in the past 12 months
- 3.9x more likely to have self-harmed in past 12 months
- 6.2x more likely to be cannabis dependent

Source: Australian Child Maltreatment Study (2023). Note: this data is not gender specific (and includes young people aged 16-24 years of age)[2]

Key takeaways

- The Australian Child Maltreatment Study published in 2023, records the associations between experiences of child maltreatment on physical and mental health behaviours.
- Across listed physical and mental health behaviours, there is a significant increase in rates of these behaviours on children that have experienced maltreatment (Indicator 5.5.3).

Data quality

Data availability	Data frequency/ timeliness	Priority group disaggregation
Ideal data available	*Slightly irregular and timely publication of data*	*No priority groups disaggregated*

Trend Rating

Legend

Positive trend in outcome | No observable change | Negative trend in outcome | Insufficient data available

Investing in Research

Summary insights | Investing in Research

Implementation progress				
Sub-priority	**Summary**	**Progress Rating**		
		Requires stronger focus	**Some progress**	**Meaningful progress**
Strengthen and diversify research and data collection across identified health priorities for women and girls	There is evidence that data collection across identified health priorities for women and girls has increased, though gaps remain. However, there is a lack of investment in the analysis of existing datasets, resulting in underutilised resources and duplication.	○	●	○
Strengthen and diversify research and data collection across identified health priorities for women and girls	There is evidence of investment in building research capability in women's health, particularly by the Australian Government. However, working conditions for academics continue to limit the participation of women, especially First Nations women, in research.	○	○	●

1 | Strengthen and diversify research and data collection across identified health priorities for women and girls

There is evidence that data collection across identified health priorities for women and girls has increased, though gaps remain. However, there is a lack of investment in the analysis of existing datasets, resulting in underutilised resources and duplication.

Key aligned activities

Addressing research gaps

- The *Australian Longitudinal Study on Women's Health* (ALSWH), established in 1996, is funded to collect data across women's health priorities.[1] In recent years, it has focused on addressing key research gaps relating to menopause, polycystic ovary syndrome, dementia and endometriosis. Australia was the first country to have national prevalence figures for endometriosis.
- In 2024, the Victorian Government announced an *Inquiry into Women's Pain*, the first of its kind in Australia, to collate information about the pain experienced by women and how that pain is treated by the health system.[2]
- Beyond Blue conducted population-level surveys through the *Australian Wellbeing Check* that examined the higher prevalence of anxiety and depression among women.
- Jean Hailes conducts an annual *Nation Women's Health Survey*, which covers the health, health care experiences, health information needs and health behaviours of women living in Australia. The findings from this study is used to investigate key data gaps. For example, in 2023, Jean Hailes produced a report that investigated *Pelvic Pain in Australian Women*.[3]
- In 2022, the ALSWH recruited additional survey participants to increase the diversity of the sample and align with migration. Stakeholders reflected that the Government is aiming to reflect the diversity of the Australian community in datasets.
- The Australian Government has committed $53.6 million over four years from 2024–25 for research into health priorities such as women's health including menopause, pregnancy loss and infertility. The Australian Government has also committed $5.5 million to develop a data set on sexual and reproductive health which will assist in identifying sexual and reproductive health needs across the lifecourse (including during menopause), explore equity in care and identify priority population groups and service use.
- The Victorian Government has committed to the creation of a Women's Health Research Institute to link with other national and international institutes and researchers, and cover common health issues and diseases for women.

Analysis by sex and gender

- The Australian Government has also increasingly incorporated analysis by sex, gender and sexual orientation into medical research. The *Statement on Sex, Gender, Variation of Sex Characteristics and Sexual Orientation in Health and Medical Research*, a joint initiative of National Health and Medical Research Council (NHMRC) and the Department of Health, Disability and Ageing, was released in July 2024. It provides guidance on the consideration of sex, gender, variations of sex characteristics and sexual orientation throughout the design, conduct, analysis, reporting, translation and implementation of all research to ensure that health and medical research produces an evidence-base that is relevant to all people in Australia.[4]
- Most of the research conducted across the identified health priorities is not targeted specifically at women. Despite this, such research can provide important insights into the health of Australian women provided the data is disaggregated by sex and gender. For instance, the *National Study of Mental Health and Wellbeing 2020-2022* provides detailed information about the prevalence of mental disorders, use of services and lived experience of self-harm and splits this data by sex.

Areas for attention

- Historically, women's health has been under-researched (e.g., women were excluded from clinical trials and conditions that primarily affect them were not studied). It will take sustained investment in women's health over time to correct for this historical prejudice.
- Stakeholders revealed that a lack of available data limited their ability to assess health outcomes for women. Specific gaps include sexual and reproductive health outcomes (e.g., contraception and abortion), the productivity impacts of menopause, chronic fatigue, incontinence, breastfeeding rates, cancer staging and recurrence, eating disorders, neurodiversity, and irritable bowel syndrome.
- While significant amounts are spent on collecting linked data, there is low awareness of existing datasets and insufficient investment in their analysis. This results in underutilised resources and instances of duplication. Stakeholders suggested that needs to be an implementation plan for research into women's health.
- Many datasets are not disaggregated by priority group (e.g., women with a disability and/or First Nations women). As such, it is difficult track progress for these groups.
- There is a lack of detailed data available on primary care. Current MBS billing codes lack the specificity required to understand the conditions that are driving service use.
- There is no national dataset on domestic, family and sexual violence. As a result, reporting is fragmented across different systems (e.g., courts, housing, police) and there is an over-reliance on the Personal Safety Survey.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

2 | Build research capacity and capability in women's health

There is evidence of investment in building research capability in women's health, particularly by the Australian Government. However, working conditions for academics continue to limit the participation of women, especially First Nations women, in research.

Key aligned activities

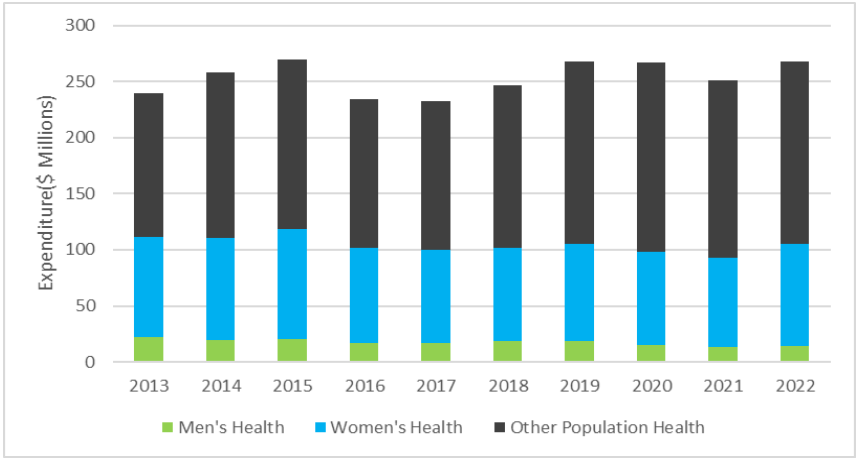
Research-focused clinicians and social scientists working in women's health

- At a Commonwealth level, there has been ongoing investment in research capacity and capability in women's health, primarily through the Australian Government's medical research body – NHMRC – and the Medical Research Future Fund (MRFF). As part of the 2024-2025 Federal Budget, further funding will be made available from the MRFF for women's health priorities including menopause, pregnancy loss and infertility. Much of this investment has been occurring over the past decade, with an average of $88.1 million per year invested in research relevant to women by NHMRC (compared to $17.5 million in men's research).[1] The percentage of total investment by NHMRC directed towards women's research declined from 38% in 2013 to 32% in 2019-2021, before reaching 34% in 2022.[1] These funds have supported research into conditions that primarily affect women (e.g., breast cancer), as well as conditions that differ for women compared to men (e.g., onset of a heart attack).
- From 2023, NHMRC implemented new gender equity targets for Investigator Grants, which led to near equal numbers of grants being awarded to women and men at Leadership Level and equal rates at the Emerging Leadership Level. Overall, it has led to women receiving $8 million more in funding than men (compared to receiving on average $73 million less each year in the first 4 years of the scheme).[2] This, in turn, should advance the number of researchers working to solve health problems specific to women and girls as female researchers are more likely to target women's health.
- State and territory governments have also been expanding research capability in women's health. For example, the Victorian Government established a *Women's Health Advisory Council* in 2022, with a mandate to enhance research into women's health.[3] Victoria is also currently developing a business case for a Women's Research Institute.

Support for First Nations researchers

- NHMRC has built research capability in First Nations health through allocating at least 5 percent of the Medical Research Endowment Account to Aboriginal and Torres Strait Islander health. In 2021, NHMRC exceeded their target by 2 percentage points, funding $58 million across 206 grants.[4]
- The Australian Government has increased support for First Nations researchers through funding the establishment of the *National First Nations Research Network*.[5]The *Network* brings together 91 investigators, the largest cohort of First Nations researchers assembled, to grow the next generation of research leaders.
- The Lowitja institute has provided grant funding to First Nations community-controlled organisations, such as Aboriginal Health and Medical Research Council of NSW and Danila Dilba Health Service, to increase First Nations led research that strengthens the health of First Nations peoples.[6] It is important to note that the aims of the Lowitja Institute are not gender-specific.

Figure 6.2.A: NHMRC expenditure for research relevant to population health related research 2013-2022



Source: NHMRC (2023)[1]

Areas for attention

- The working conditions for academics are challenging, with many young female researchers employed on low-paid, casual, short-term contracts. These working conditions do not support rigorous long-term investment in women's health.
- Long-term longitudinal studies and data collections into women's health require greater collaboration among government agencies tasked with data collection (e.g., AIHW, ABS).
- Despite some investment, First Nations women and/or women with a disability are still underrepresented as researchers.

Progress rating

Requires stronger focus | Some evidence of progress | Evidence of meaningful progress

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Priority 1

Executive Summary

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Appendix: List of stakeholders consulted

Stakeholders consulted | Government

Semi-structured interviews or focus groups were conducted with representatives from four key stakeholder groups: State and Territory Health Departments, Commonwealth Department of Health, Disability and Ageing, Other Commonwealth Departments and Non-Government Organisations.

The list of stakeholders consulted is shown in Appendix Table 1 (Government) and Appendix Table 2 (Non-Government)

Appendix Table 1. Stakeholders consulted from Government

Stakeholder group	Stakeholder name
Commonwealth Department of Health, Disability and Ageing	• Department of Health, Disability and Ageing – Primary and Community Care • Department of Health, Disability and Ageing – Population Health • Department of Health, Disability and Ageing –Cancer, Hearing and Chronic Conditions • Department of Health, Disability and Ageing – First Nations Health • Department of Health, Disability and Ageing – Mental Health and Suicide Prevention • Department of Health, Disability and Ageing – Office for Health Protection • Department of Health, Disability and Ageing – Health Workforce
Other Commonwealth Departments	• Department of Prime Minister and Cabinet – Office for Women • Department of Social Services – Women's Safety Group
State and Territory Health Departments	• ACT Health • NT Health • NSW Ministry of Health • QLD Department of Health • SA Health • TAS Department of Health • Victorian Department of Heath • WA Department of Health

Stakeholders consulted | Non-Government

Appendix Table 2 Stakeholders consulted from Non-government organisations

Stakeholder group	Stakeholder name		
Non-Government Organisations (Public Health Organisations, Research Institutes etc.)	• 1800RESPECT • Australia's National Research Organisation for Women's Safety • Australian Breastfeeding Association • Australian Cervical Cancer Foundation • Australian College of Midwives • Australian College of Rural and Remote Medicine • Australian Longitudinal Study of Women's Health • Australian Menopause Society • Australian Nursing and Midwifery Federation • Australian Women's Health Alliance • Black Dog Institute • Bowel Cancer Australia • Breast Cancer Network Australia • Butterfly Foundation • Cancer Council Australia • Carers Australia • Centre for Aboriginal Health • Centre for Perinatal Excellence • Consumers Health Forum • CRANAplus • Council of the Aged • Country South Australia Primary Health Network • Country Western Australia Primary Health Network • Dementia Australia • Diabetes Australia	• Endometriosis Australia • Family Planning Alliance Australia • Full Stop Australia • Harmony Alliance • Heart Foundation • Jean Hailes for Women's Health • Lowitja Institute • Mental Health Australia • Monash University • Monash Gender and Family Violence Prevention Centre • MSI Australia • Multicultural Aged Care (PICAC Alliance) • Multicultural Centre for Women's Health • NAACHO • National Aboriginal and Torres Strait Islander Women's Alliance • LGBTIQ+ Health Australia • National Mental Health Consumer and Carer Forum • National Rural Women's Coalition • National Seniors Australia • Northern Territory Primary Health Network • Our Watch • Ovarian Cancer Australia • Pain Australia • Pharmaceutical Society of Australia • RACGP	• RANZCOG • Research Australia • Royal Women's Hospital • Stillbirth Foundation of Australia • The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives • The George Institute for Global Health • The Obesity Collective • University of Melbourne • University of Technology Sydney, Public Health Association of Australia • Waminda • Women's Health Research, Translation and Impact Network.

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