Women's Community Health Network WA

Strengthen families, strengthen communities …

Invest in Women's Health

Increase funding for Western Australia's Women's community health services to:

Prevent and respond to high rates of mental illness amongst girls and women
Prevent and respond to violence against women and children
Promote good sexual and reproductive health outcomes amongst girls and women
Promote gender equity for good health outcomes

Clear disparities in health outcomes exist in Western Australia, with different groups experiencing wellbeing and illness in unequal ways. Women are one of those groups. While Western Australian women are more likely to live longer than Western Australian men, their higher prevalence and incidence of non-fatal health problems result in more years lived with ill health and disability.[1] For women aged 15 to 44 years, for instance, intimate partner violence is the leading contributor to disability and illness and, tragically, death.[2]

Evidence shows that gender-based inequities are both the underlying cause of poor health outcomes for Western Australian women *and* the barriers to achieving improvements in women's health (and thus Western Australia's health).[3] Women's socio-economic disadvantage relative to men exposes them to risks and vulnerabilities for poor health outcomes, with financial insecurity, housing insecurity, low social capital and poverty being among the most significant of predictors for ill health.[4]

Why do we need gendered and trauma-informed services?

While both genders may face multiple issues, women are much more likely to have experienced childhood and domestic abuse and trauma and to be the main carers of children. The evidence shows that trauma and abuse is a significant factor for many women and girls. Taking account of trauma is therefore vital to deliver

[1] Australian Bureau of Statistics. Australian Demographic Statistics, June 2013. Cat. no. 3101.0. Canberra: ABS; 2013.
[2] VicHealth. The health costs of violence: measuring the burden of disease caused by domestic violence, 2004.
[3] Ibid.
[4] Social Determinants of Health: The Solid Facts. Second Edition. Editors: Richard Wilkinson and Michael Marmot. International Centre for Health and Policy. 2003.

services that meet women's specific and often complex needs. A woman-centred approach also means supporting woman's access to services at a practical level – such as providing on-site child-care.

There is strong evidence that women-centred working can deliver solutions for women by integrating and tailoring services around women's needs. Principles in action:

- Safe, supportive, community-based accessible
- Holistic, tailored, multi-agency
- Empowerment, co-production
- Effective, outcomes focused, evidenced
- Preventative, cost-effective

Services are more effective when designed around the needs of users. A woman-centred approach builds upon this principle in a gendered way – and a growing body of research is testament to the tangible outcomes it can deliver. The long-term benefits are significant – for women, their children and families, for future generations and for whole communities.

Evidence suggests that services should include women-only spaces; be informed by the highly gendered factors (for example family and domestic violence and sexual assault) affecting women's outcomes; attend to clients' presentations in an integrated way; provide better social and community support; increase overall responsiveness to the person, not the illness; and offer better opportunities, among other initiatives.[5]

Barriers to treatment and support are compounded for women by the scarcity of women-only services or of services configured to meet the distinct and different needs of women. The findings of a recent survey of women's health information needs, undertaken by the Jean Hailes Foundation, show strong support for women's health services.[6]

Evidence shows that women achieve better health outcomes where strong and well-resourced women's health services exist.[7] It is in the interests of the next State Government to partner with Western Australian women's health services in the development of strategies and actions to improve the health, wellbeing and safety of Western Australian women. This will, in turn, improve the health of the Western Australian population and reduce the burden of ill health and disease across the state.

Women's mental health and wellbeing

Gender differences are evident in the onset, prevalence, diagnosis, trajectory, co-morbidity, treatment, prognosis and outcomes of mental health and depression. Women's mental health needs to be considered within multiple and interacting social, psychological and biological factors. Often lower levels of income, poor housing, social exclusion and a general feeling of having little control over one's life are common inequalities amongst high risk groups of women in the community, and this can impact on their mental health.[8]

Adverse mental health conditions are associated with higher rates of death, exposure to physical and sexual violence and increased exposure to risk factors such as smoking, drinking alcohol and using other drugs.[9] Mental ill-health represents the leading cause of disability and the highest burden of non-fatal illnesses for women in Western Australia.[10] Mental health conditions can start at a young age and continue across the life span.[11] Key statistics for

[5] Ibid.

[6] Jean Hailes for Women's Health 2015, What do women want to know? Women's health information needs in Australia survey 2015.

[7] Nicola Carroll and Carol Grant 2014. Women Centred Solutions. Women Centred Working.

[8] Maria Duggan 2016. Investing in Women's Mental Health: Strengthening the Foundations for Women, Families and the Australian Economy. Policy Issue Paper No. 2016-02. Australian Health Policy Collaboration.

[9] Tomlin S, Joyce, S, Patterson, C. Health and Wellbeing of Adults in Western Australia. Perth: Department of Health Western Australia Epidemiology Branch: 2012.

[10] Western Australian Women's Health Strategy 2013-2017. Department of Health, Perth, Western Australia.

[11] Ibid.

Western Australia and Australia include:

- Women are more likely to report a long-term mental health issue and higher levels of psychological distress than men.[12]
- Women in prisons are more likely to have a high level of psychological distress, history of mental illness or self harm than men in prisons.[13]
- Women from CALD backgrounds are particularly vulnerable to developing emotional distress or mental health disorders in the perinatal period and frequently do not receive the care they need.[14]
- Almost 60% of women with disabilities report experiencing at least one stressor in the past 12 months.[15]
- Young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24). Young women are more likely than young men to have (or report symptoms of) the following conditions: anxiety disorders; affective disorders; eating disorders; and deliberate self-harm.[16]
- Women are 1.6 times as likely as men to suffer coexisting mental and physical illness. These multi-morbidities are associated with increased severity of mental illness and increased disability.[17]
- Aboriginal women have much poorer physical and mental health than other Western Australians including:
    - much higher rates of mental health conditions and higher rates of morbidity and premature mortality associated with comorbid conditions, including diabetes and cervical and ovarian cancers
    - anxiety and depression are the foremost health problems reported by Aboriginal women
    - the suicide rate of Aboriginal women is highest within the 20-24 years old; which is more than five times higher than their corresponding non-Aboriginal counterparts.[18]

- Girls are at greater risk of most kinds of abuse, including severe maltreatment by a parent during childhood and child sexual abuse.[19] Compared with the sexual abuse of boys, the sexual abuse of girls is more likely to be perpetrated by family members, to begin at an earlier age and to occur repeatedly. The sexual abuse of boys is more likely to be perpetrated by non-family members, to occur later in childhood and to be a single incident.[20] The Australian Longitudinal Study on Women's Health cites evidence suggesting that 18% of Australian women report CSA experiences before they are 16 years old (Coles et al. 2015). Childhood sexual abuse (CSA), can have lifelong impacts on women's mental health.[21]
- Women who are refugees or from CALD backgrounds have substantially raised levels of mental illness, with higher incidence rates of all clinically relevant mental disorders across the whole life course (Rich et al. 2013).
- Lesbian, bisexual, transgender (LBT) women and intersex people have significantly higher levels of psychiatric illness than heterosexual women, as well as deliberate self-harm, and use of alcohol and other substances. LBTI people report that there are few services that are non-discriminatory and inclusive.[22] [23]A Western Australian study in 2006 found that almost one in five (19.3 percent) of women who

[12] Australian Bureau of Statistics. Mental Health in Australia: A Snapshot, 2004-05. Cat. no. 4824.0.55.001. Canberra: ABS; 2006

[13] Australian Institute of Health and Welfare 2013. The health of Australia's prisoners 2012. Cat. no. PHE 170. Canberra: AIHW

[14] Australian Bureau of Statistics. Reflecting a Nation: Stories from the 2011 Census, 2012–2013. Cat. No. 2071.0. Canberra: ABS; 2013

[15] Australian Bureau of Statistics. General Social Survey, Victoria, 2006. Table 4 Personal characteristics, By Age – Females. Canberra: ABS; 2007

[16] Maria Duggan 2016. Investing in Women's Mental Health: Strengthening the Foundations for Women, Families and the Australian Economy. Policy Issue Paper No. 2016-02. Australian Health Policy Collaboration.

[17] Ibid.

[18] Australian Bureau of Statistics. The health and wellbeing of Aboriginal and Torres Strait Islander women: A snapshot, 2004-05. Cat. No. 4722.0.55.001. Canberra: ABS; 2007

[19] McNeish, D & Scott, S 2014, Women and girls at risk: evidence from across the lifecourse, Lankelly Chase Foundation.

[20] Pereda, N, Guilera, G, Forns, M & Gómez-Benito, J 2009, The international epidemiology of child sexual abuse: a continuation of Finkelhor (1994), Child Abuse & Neglect, vol. 33, no. 6, pp. 331–342.

[21] Radford, L, Corral, S, Bradley, C, Fisher, H, Bassett, C, Howat, N & Collishaw, S 2011, Child abuse and neglect in the UK today, NSPCC, London, UK,

[22] Warner, J, McKeown, E, Griffin, M, Johnson, K, Ramsay, A, Cort, C, & King, M 2004, Rates and predictors of mental illness in gay men, lesbians and bisexual men and women, The British Journal of Psychiatry, vol. 185, no. 6, pp. 479–485.

[23] McNair, R, Szalacha, L & Hughes, T 2011, Health status, health service use and satisfaction according to sexual identity of young Australian women, Women's Health Issues, vol. 21, no. 1, pp. 40–47.

identified as lesbian or bisexual reported receiving treatment for a mental health condition.[24]

- The prevalence rate for clinically significant maternal perinatal mental health issues in Australia is around 15%. This figure does not include antenatal mental health problems, mental health problems other than postnatal depression (such as postpartum psychosis), or postpartum issues in the context of pre-existing mental illness.[25] [26]

Despite this evidence, sex and gender differences are not routinely considered in policy and service provision in Western Australia. Sexual violence, for example, is a gendered crime — that is, it has an unequal impact on women, and the perpetrators of this violence are mostly men. Sexual violence can have serious and long-term psychological, emotional, physical, social and interpersonal effects on a victim. These impacts can lead to lost quality of life and ongoing mental health issues. It is crucial that prevention and intervention be informed by this evidence-base.

Women seeking help at key transition points in the life course – when they may have to deal with overwhelming interactions between biological, social, emotional and economic risk factors that require integrated and holistic responses – often do not receive timely, appropriate and accessible services and supports.[27] Available services are often designed around women's mental health from an individual pathology perspective, whereas the women who need these services consistently ask for a more holistic view of their lives.[28]

For many women, their child-bearing years are a particularly challenging life stage.[29] Depression, anxiety disorder, suicide and self-harm are the top causes of disease burden for women during the childbearing years and this has a significant negative impact on women, their babies and their families if these problems go undetected or inadequately responded to.[30] Women's mental health directly impacts on their ability to care for and nurture their children and care for their own wellbeing. This is more problematic for some Aboriginal women due to the added trauma associated with past and present cultural experiences.[31]

Community based services and appropriate care pathways play a central role in promoting the emotional well-being of women, infants and their families and in ensuring that all women with mental health concerns get appropriate and timely care. Increased government investment will help services in Western Australia ensure more women, infants and their families receive the best care as outlined in the Perinatal and Infant Mental Health Model of Care.[32]

There are a range of society- level protective factors for mental health and wellbeing, many of which can be achieved by government intervention.

Implications for government action

[24] Hyde Z, Comfort, J, Brown, G, McManus, A, Howat, P. The Health and Wellbeing of Lesbian and Bisexual Women in Western Australia. Perth: WA Center for Health Promotion Research Curtin University of Technology; 2007.
[25] Beyond Blue. Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period: A guide for primary health care professionals. Melbourne; 2011
[26] Austin, MP & Kildea, S 2007, Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. Medical Journal of Australia, vol. 186, no. 7, pp. 364–367.
[27] Maria Duggan 2016. Investing in Women's Mental Health: Strengthening the Foundations for Women, Families and the Australian Economy. Policy Issue Paper No. 2016-02. Australian Health Policy Collaboration.
[28] Ibid.
[29] Priest S, Austin, MP, Buist, A. A Psychosocial risk assessment model (PRMA) for use with pregnant women and postpartum women in primary care settings 2008.
[30] Priest S, Austin, MP, Buist, A. A Psychosocial risk assessment model (PRMA) for use with pregnant women and postpartum women in primary care settings 2008.
[31] Department of Health Western Australia. Enhanced Aboriginal Child Health Schedule Rationale Document 2012 - Child and Adolescent Community Health Statewide Policy. Perth: Child and Community Health; 2012.
[32] Western Australian Department of Health. Perinatal and Infant Mental Health Model of Care - a framework. Perth: North Metropolitan Health Service, Western Australian Department of Health, Western Australia; 2016.

Based on the evidence above, there is a need for the next State Government to undertake a number of actions, including (but not limited to) the following:

1. Invest in women's health services that promote good mental health outcomes for women and their children by building capacity across core areas (health, safety, social connectedness, education, employment).
2. Fund women's health services to implement best practice programs with young women and girls to promote mental health and wellbeing, recognising that primary prevention and early intervention is key to lifelong mental health.
3. Build capacity in the community to provide evidence-based, best-practice perinatal and infant mental health services and care pathways to ensure that Western Australian women, infants and their families receive the best quality care as outlined in the Perinatal and Infant Mental Health Model of Care Framework 2016.

Violence against women

While violence against women is an under-reported crime and thus statistics are likely to be an underestimate, findings from the latest *Australian Personal Safety Survey* (2012) reveal the following figures.

- One in three Australian women has experienced physical violence and one in five has experienced sexual violence, in their lifetime. These statistics have not changed since 2005.
- Women are four times more likely than men to have experienced sexual violence since the age of 15 years.
- Women are more than three times more likely than men to have experienced violence by an intimate partner, since the age of 15 years.[33]

Violence against women is associated with a range of physical, mental and sexual and reproductive health problems, including:

- Brain injuries, disabilities, chronic diseases and physical injuries;[34]
- Depression, anxiety, traumatic and post-traumatic stress disorder, substance dependency (including tobacco and alcohol use, illicit and prescribed drug use), sleeping problems, self-harm tendencies and suicidal ideation;[35] and
- Unplanned pregnancies, sexually transmitted infections (including HIV), gynaecological problems and pregnancy complications.[36]

Violence against women is an entrenched social problem and a major public health crisis. Recently published research commissioned by Australia's National Research Organisation for Women's Safety (ANROWS) shows that intimate partner violence **is** prevalent–affecting one in three women since the age of 15.[37] Violence against women has serious impacts for women's health–contributing to a range of negative health outcomes, including poor mental health, problems during pregnancy and birth, alcohol and illicit drug use, suicide, injuries and homicide.[38] It contributes more to the disease burden of women than any other risk factor in women aged 18-44 years, more than well known risk factors like tobacco use, high cholesterol or use of

[33] Australian Bureau of Statistics, 2012, *The Personal Safety Survey, 2012*, Cat. No. 4906.0, Australian Bureau of Statistics, Canberra.
[34] Kramer, A, Lorenzon, D & Mueller, G, 2004, Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics, *Women's Health Issues*, 14, pp.19-29.
[35] The Royal Women's Hospital, 2012, *Family Violence – Information for Women*, The Royal Women's Hospital, Melbourne.
[36] Ibid.
[37] Examination of the burden of disease of intimate partner violence against women in 2011: Final report / Julie Ayre, Miriam Lum On, Kim Webster, Michelle Gourley, Lynelle Moon. Sydney : ANROWS, 2016.
[38] Ibid.

illicit drugs.[39]

Aboriginal and Torres Strait Islander women aged 18-44 years experience a health risk 6.3 times higher than non-Indigenous women due to intimate partner violence.[40] Three in five Aboriginal and Torres Strait Islander women have experienced intimate partner violence since the age of 15, contributing to 10.9% of their disease burden.[41] Reducing the burden of disease gap between Aboriginal and Torres Strait Islander women and non-Indigenous women is vital to Western Australia's future. This can only be achieved through policy and practitioner collaboration with Aboriginal communities.[42]

The health burden of intimate partner violence can be reduced by:

- supporting women and children's long-term recovery in the aftermath of violence;
- responding to violence to stop it occurring again;
- intervening when there are early warning signs of violence; and
- preventing violence from occurring in the first place by addressing known root causes.[43]

Because experiencing intimate partner violence increases the risk of health problems, to substantially reduce the health burden, it will be necessary to prevent new cases of violence. This will require a greater emphasis on early intervention and primary prevention to stop violence from occurring in the first place.[44]

Improving women's health will also strengthen the wellbeing of children, families and communities, representing a high social return on investment.

Implications for government action

Based on the evidence above, there is a need for government to undertake a number of actions, including (but not limited to) the following:

1. Commit to the prevention of violence against women as a priority in Western Australian health planning.
2. Provide further resources to ensure the provision of culturally competent and safe women's health and sexual assault services to women in the Kimberley region.
3. Improve the capacity of women's health services to better prevent and respond to violence against women and children; and to help women and their children who have experienced violence to recover and move forward.

Sexual and reproductive health

Sexual and reproductive health is a fundamental issue for all Western Australian women, affecting them at every life stage. Sexual and reproductive health is interlinked with many other aspects of health – particularly mental health – and contributes to the overall health and wellbeing of the individual.

A strong body of evidence indicates that sexual and reproductive health morbidity is to a large extent preventable.[45] Women and girls continue to experience the overwhelming burden of sexual and reproductive ill health when compared with their male counterparts.[46] Research shows:

- Chlamydia is the most commonly reported infection in Australia. Since 2003 the number of women

[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Ibid.
[45] World Health Organisation (2010) *Social Determinants of Sexual and Reproductive Health: Informing future research and programme implementation.*
[46] Ibid.

diagnosed with chlamydia has doubled.[47]

- Women in prison experience high rates of STIs, blood born viruses, gender-based violence and one in five have been paid for sex.[48]
- Same-sex attracted young women are more likely to be sexually active earlier and are at higher risk of STIs than their heterosexual peers. [49]
- Women with a disability continue to have their sexual and reproductive rights denied through forced sterilisation, inappropriate sexual and reproductive healthcare, poor access to assisted reproductive technologies and poorly managed pregnancy, birth and post natal care.[50]
- International and Australian research consistently shows an emphatic association between intimate partner violence and abortion.[51]
- 16.9% of Australian women have been diagnosed with a sexually transmitted infection or blood-borne virus at some stage of their life.[52]
- One in five Australian women has been coerced into unwanted sex. For young women in Years 10 and 12, experience of unwanted sex increased from 28.1% of sexually active female students in 2002 to 37.8% in 2008.[53]
- Over half of all women in Australia have experienced an unplanned pregnancy.[54]
- Predominantly, women bear the primary responsibility for contraception.[55]

Implications for government action

Based on the evidence above, there is a need for government to address the social determinants of sexual and reproductive health and with a focus on prevention, including (but not limited to) the following components.

1. Fund translation of research into practice in relation to women's sexual and reproductive health and disseminate findings.
2. Support women's right to health through the provision of safe, legal and accessible abortion services by way of:
    - the provision of accurate and timely information, counselling and referral to services that provide abortion;
    - publicly funded sexual and reproductive health services, including those that provide termination of pregnancy and contraception, to meet catchment need; and
    - funding education, training and professional development initiatives for health practitioners to support the provision of accessible surgical and early medication abortion.

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[47] Australian Government Department of Health (2012) *Notification rate of Chlamydial infection, Australia 2003 and 2013,* Australian Government Department of Health: Canberra.

[48] Indig, D., Topp, L., Ross, B., Mamoon, H., Border, B., Kuman, S. and McNamara, M. (2010) *2009 NSW Inmate Health Survey: Key findings report,* Justice Health: New South Wales.

[49] Hillier, L. Jones, T., Monagle, M. Overton, N., Gahan, L., Blackman, G and Mitchell, A. (2010) *Writing Themselves In 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people*, Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.

[50] Frohmader, C. (2010) *Women With disabilities and the Human Right to Health: A Policy Paper,* Women With Disabilities Australia: Australia.

[51] Taft, A. J., Watson, L. F. (2007) 'Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women', *Australian and New Zealand Journal of Public Health, 31(2)*, 135–42; World Health Organisation (2013) Intimate partner violence, abortion and unintended pregnancy: Results from the WHO multi-country study on women's health and domestic violence, *International Journal of Gynaecology and Obstetrics,* vol. 120, pp. 3–9.

[52] Australian Institute of Health and Welfare (2004). Australia's Health 2004 9th Biennial Report, Australian Government: Canberra

[53] De Visser R O, Smith A M, Rissel C E, Richters J & Grulich A E. Sex in Australia: Experiences of Sexual Coercion in a Representative Sample of Adults. Australian and New Zealand Journal of Public Health 2003; 27(2): 198-203.

[54] Australian Research Centre in Sex, Health and Society. (2009) Fourth National Survey of Australian Secondary Students and Sexual Health 2009. Available online at: http://www.latrobe.edu.au/arcshs/downloads/arcshs-research-publications/secondary-students-and-sexual-health-2008.pdf

[55] Marie Stopes International (2008) Real Choices: Women, contraception and unplanned pregnancy. Available online at: http://www.mariestopes.org.au/research/australia/australia-real-choices-key-findings.

3. Invest in health promotion programs that promote positive self-image, resilience and social and emotional competencies amongst girls and young women in a social environment that depicts sexuality and body image in ways that can be unhealthy for girls and women.

Gender Equality & Equity for Health Outcomes

A lack of equity in women's pay, single parenting, lower education levels and unemployment means that women are particularly susceptible to socioeconomic disadvantage and poverty.[56] Many health issues and diseases experienced by women are closely tied to disadvantage, with research showing that women from low socioeconomic background have a much higher exposure to risk factors for poor health.[57] The power relations and unequal status between men and women in society are a root cause for gender inequality, as they determine a person's ability to take control over their life, health and safety.[58] [59] A gender equity approach recognises that strategies and measures must be implemented to account for these disparities in order to ensure equal and equitable outcomes.

The National Women's Health Policy states that "gender can contribute to differences between and among women and men in financial security, paid and unpaid caring work and experiences of violence… resulting in different and sometimes inequitable patterns of exposure to health risk, in unequal access to and use of health information, care and services, different help-seeking behaviour and, ultimately, different health outcomes.[60]

Gender inequality negatively affects women throughout their life course, from their educational and training pathways to their employment opportunities and work life balance, positions of formal leadership, health and safety, economic security and social inclusion. These interrelated factors combine to place women at greater risk of poverty, disadvantage and social exclusion. Women are more likely to live in low economic resource households, be unable to raise $2,000 in an emergency, have little or no superannuation coverage or be financially secure in retirement.[61] Women have substantially lower labour force participation rates[62] and when they do engage in work it is more likely to be in lower paid, insecure work. Older women are particularly at risk of financial and housing insecurity due to a lifetime of inequality leaving them with limited savings in retirement.

Women from low socioeconomic backgrounds, Aboriginal and culturally and linguistically diverse backgrounds, those with disability and long-term health conditions, and those living in regional and rural Australia, may experience multiple and intersecting forms of discrimination and disadvantage, placing them at greater risk of poverty, family violence, poor health and wellbeing and exclusion from economic and social participation. Communities with greater gender equality have higher rates of wellbeing and lower depression among both men and women.[63]

There is a dual rationale for promoting gender equality. Firstly, equality between women and men is a matter of human rights and social justice. Secondly, greater equality between women and men is a precondition for (and an indicator of) equitable, prosperous and healthy communities. Gender is increasingly recognised as an important social determinant of health. Gender influences education, income, reproductive roles, and caring responsibilities, among other determinants.[64]

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[56] Department of Health and Ageing 2010, National Women's Health Policy 2010, Department of Health and Ageing
[57] Australian Women's Health Network 2013, Women's Health: Meaningful Measures for Population Health Planning, Australian Women's Health Network
[58] World Health Organisation (WHO) 2002, Gender and Mental Health, WHO.
[59] World Health Organisation (WHO) 2009, Women and Health: Today's Evidence, Tomorrow's Agenda, WHO.
[60] Department of Health and Ageing 2010, National Women's Health Policy 2010, Department of Health and Ageing.
[61] ABS, *Gender Indicators, Australia, Aug 2015*, Cat. No. 4125.0, 'earnings, income and economic situation', ABS, 2015.
[62] ABS, *Gender Indicators, Australia, Aug 2015*, Cat. No. 4125.0, 'earnings, income and economic situation', ABS, 2015.
[63] Science Nordic, *Gender equality gives men better lives*, Norway, 2015.
[64] (Greaves, Pederson and Poole (2014) Making it better: gender-transformative health promotion, p. 2.

Addressing gender inequality will also result in enormous cost savings. The most robust evidence for this is in relation to the impact of violence against women. In addition to the serious physical health, mental health and social impacts on the individual, violence against women gives rise to enormous preventable 'downstream' costs to the policing and justice systems, housing and homelessness services, health system and child protection services.[65] A recent study commissioned by Our Watch and VicHealth, and conducted by PriceWaterhouseCoopers, estimated that violence against women costs $21.7 billion a year, including $7.8 billion a year in direct costs to governments.[66]

Despite the profound impacts of gender inequality over the life course, government policy and programs have tended to take a 'gender-blind' approach, As a result, strategies, interventions and services across all portfolio areas have not been tailored for women, and opportunities to improve outcomes for women have been missed, reinforcing gender inequality.

Strong, coordinated government action is essential for effectively addressing gender inequality. The World Health Organisation's (WHO) framework for health in all policies provides important practice principles that could usefully be adopted to progress gender inequality. The approach recognises that coordinated action across the three tiers of government, and across government departments, is necessary to tackle gender inequality. The Western Australian Government's leadership in adopting this approach will provide the 'mandate, incentives, budgetary commitment and a sustainable mechanism that support government agencies to work collaboratively on integrated solutions'[67] to achieve equal outcomes for women and men.

Implications for government action

Practical steps towards achieving gender equality and equity should include:

1. A governance structure with inter-ministerial representation and the support of an inter-departmental committee (i.e. health and human services, education, justice); and financial resourcing and collaboration with sectors who have gender equity expertise (i.e. the women's sector) that can lead and support practical cross sector initiatives.
2. Continue to value, support and resource Western Australia's women's community health services and other specialist women's services so they can continue to advance gender equity and equality, share best practice, build the capacity of particularly disadvantaged women, and coordinate local gender equity initiatives.

Women in regional, rural and remote areas

Many women in rural and remote areas face multiple disadvantages that impact on their health and wellbeing. Compared to their urban counterparts, women in rural and remote Australia experience poorer health, lower life expectancy and greater difficulties accessing a range of health services.[68] [69] In addition, levels of alcohol consumption and rates of obesity and chronic disease are higher.[70] Remote and rural areas have disproportionately high rates of domestic and family violence, as well as fetal alcohol syndrome.[71] Women in these communities report fewer visits to GPs and specialists, and are more likely to be admitted to hospital for conditions which could potentially have been prevented through the provision of non-hospital health services and care.[72]

Women living in some rural and remote communities have limited access to services that are gender and trauma informed. As a result, some women living in such communities may not always seek health advice and treatment in sensitive areas such as the prevention of cervical and breast cancer, fertility control,

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[65] Our Watch, ANROWS and VicHealth (2015) Change the story: a shared framework for the primary prevention of violence against women.
[66] PricewaterhouseCoopers Australia (2015) A high price to pay: the economic case for preventing violence against women, p. 10.
[67] WHO, 2010, Adelaide Statement on Health in All Policies, Government of South Australia, Adelaide. P. 2.
[68] Dobson, A, Byles, J, Dolja-Gore, X, Fitzgerald, D, Hockey, R, Loxton, D, McLaughlin, D, Pachana, N, Powers, J, Rich, J, Sibbritt, D, Tooth, L, (2011). *Rural, remote and regional differences in women's health: Findings from the Australian Longitudinal Study on Women's Health.* Report prepared for the Australian Government Department of Health & Ageing.
[69] AIHW, (2008). *Australia's health 2008*. Cat. no. AUS 99. AIHW: Canberra.
[70] National Rural Women's Coalition [NRWC], (2005). *Healthy women – healthy communities.* Policy research paper prepared for NRWC.
[71] National Rural Women's Coalition [NRWC], (2005). *Healthy women – healthy communities.* Policy research paper prepared for NRWC.
[72] National Rural Women's Coalition [NRWC], (2005). *Healthy women – healthy communities.* Policy research paper prepared for NRWC.

menopause, and domestic violence.[73]

Implications for government action

The Women's Community Health Network supports a combination of actions and policy approaches to:

1. Improve the availability of health services in regional, rural and remote areas, including recruitment and retention incentives; supportive health funding models; improved health infrastructure; and medical specialist outreach assistance programs, for communities that lack such services. Investment in mental health and domestic and sexual violence services is vital to improve access to these services in rural and remote areas.
2. Improve understanding of women's health in regional, rural and remote areas; and to ensure appropriate and effective responses to the health disparities and access barriers that exist in these locations.

Next steps

Gendered differences in population health status means there remains significant scope in 2017 to improve the health of Western Australian women. The Women's Community Health Network encourages the next State Government to continue to partner with the women's community health sector to reduce the burden of ill health and disease for better health outcomes for Western Australian women and their families. In order to reduce the burden of ill health and disease for better health outcomes for Western Australian women, the Women's Community Health Network recommends further investment in women's community health services to implement initiatives arising from the evidence above and the Western Australian Women's Health Strategy 2013-2017.

We call on the next State Government to continue to show commitment to gender equity through increased funding to Western Australian women's community health services, in recognition that:

- The activities of women's community health services are directed at the social determinants of women's health and the gender-based inequities that shape them;
- Women's community health services have a vital role in leading and supporting responses to women's health and wellbeing across regions and the state.
- Women's community health services have a unique place in the health service system. As a sector, these services have reach into metropolitan and regional areas and are well positioned to implement government response and prevention initiatives on women's health. As a network, women's health services lead coordinated and consistent strategies across the state.
- As regionally located organisations, women's community health services engage with health and community planning and lead area-based health prevention and community based initiatives in tandem with community, local, state and federal governments, and other organisations.
- Women's health services straddle the health, human services and development sectors. Their partnerships with local government, community health, community organisations and peak bodies, as well as with the acute sectors in health, family violence, sexual assault, crime, emergency relief and mental health, result in alliances and expertise that enable effective response and prevention approaches.

With greater recognition of the value of these unique capacities, women's community health services can be further employed to support government response and prevention initiatives on women's health. Western Australian women's health services look forward to meeting with government and other political parties to discuss their commitment to women's health in Western Australia.

[73] Rural Doctors Association of Australia [RDAA], (2009). *Development of a new National Women's Health Policy: Response to the discussion paper and guidance consultation questions.* RDAA: Canberra.