



Submission to End Gender Bias in Australia's Healthcare System Survey

13 October 2023

Contents

Introduction.....	2
Survey responses	3
Research.....	3
Access, care and outcomes	11
Safety.....	20
Additional evidence	25

Introduction

Women's Health Victoria (WHV) welcomed the opportunity to provide feedback to the National Women's Health Advisory Council [End Gender Bias in Australia's Healthcare System Consultation Survey](#) in October 2023.

The aim of the survey was to hear from women, along with experts, health care professionals, consumer representatives and peak stakeholder groups to better understand the unique barriers and gender bias women face in Australia's healthcare system.

Note: This submission was originally made as a response to an online survey, and has been reformatted, including section headings for ease of navigation.

Survey responses

Research

Q1. Please describe the gaps in research on women's health and gender bias in the health system

At Women's Health Victoria, we are acutely aware of significant gaps in research on women's health and gender bias across all areas of health. For much of history, women have been excluded from medical research both as researchers and study participants. As a result, most of our current medicine and healthcare, from dosage calculations for drugs to diagnostic and treatment protocols, is a one-size-fits-all model based on the study of men¹. Growing evidence from pre-clinical and clinical research demonstrates that females and males can differ significantly in susceptibility to common diseases (such as cardiovascular disease, cancers and COVID-19) and response to treatment, including efficacy and adverse events². Ignoring sex and gender differences in medical research carries significant implications for the health of women and gender diverse people, compromises accuracy and puts patients at risk².

Despite this, most health and physiological research continues to be conducted in men, including pre-clinical trials, which remain focused on male cell lines and male animals³. Where women are present in trials, the influence of sex and gender is often not analysed and reported. Consequently, the evidence base for women's health remains limited. For example, women are currently under-researched in coronary artery disease, stroke, respiratory diseases and dementia. These are the top causes of mortality and disability of women (and men) in Australia and globally.

In the mental health context, despite widespread acceptance of sex and gender as a key determinant of mental health, there is little readily available sex-disaggregated data about the prevalence of mental health conditions. Such data is either not published (e.g., sex-disaggregated mental health data routinely collected by many health services), not collected or exists as raw data only, yet to be analysed. Failure to centre sex and gender considerations in mental health research and data collection has contributed to gendered inequalities in mental health experiences and outcomes, inadequate understanding of women's mental health needs, and ineffective interventions.

Conditions that predominantly or only affect women are particularly under-researched. For example, little is known about the causes, prevention and effective treatment of miscarriages, fibroids, endometriosis and PCOS - all common and often debilitating health conditions and experiences that can significantly affect quality of life. There is also a lack of data collection relating to sexual and reproductive health conditions in Australia, including abortion, contraception, menstrual health, pelvic pain and birth trauma. Concerningly, data

¹ Leeder J (2020) Why women have been excluded from medical studies about their own bodies. *MaRS Magazine*. (Apr 30): 1 webpage. Available from: [URL](#)

² Wainer Z, Carcel C (2020) Sex and gender in health research: updating policy to reflect evidence. *Medical Journal of Australia*. 212(2): 57-62. Available from: [URL](#)

³ Jackson G (2019) The female problem: how male bias in medical trials ruined women's health. *The Guardian*. (Nov 14): 1 webpage. Available from: [URL](#)

on metastatic breast cancer is also not properly collected or reported nationally, meaning that the total number of people currently living with the condition is unknown⁴.

For transgender and gender diverse people, the evidence base is even more sparse. Research is needed to understand the impact of health conditions and treatments on transgender people's bodies, particularly around the interaction with and impact of various treatment modalities on gender-affirming surgery and hormone therapy.

The current lack of such data is significant for policy development, funding allocations and service planning relating to the treatment of transgender and gender diverse people, as well as women's health issues. To better support access to services (including sexual and reproductive health, mental health, breast cancer etc.), a greater understanding of demand and service provision across the country is required. Comprehensive data collection relating to this service provision and population level need is necessary to enable meaningful planning and needs-based funding allocation.

Q2. How can health research studies, including inclusion and participation, be improved? This can include how research is more accessible to consumers, avoids gender bias, and support access to research.

To address gender bias in health research, Women's Health Victoria recommends that:

1. Consideration of sex and gender be a prerequisite for grant funding to ensure these concepts are incorporated in all health research design, analysis and translation (unless justification is provided as to why this may not be appropriate).
2. Additional funding be provided for research to investigate the incidence, prevalence, prevention and treatment of conditions that predominantly affect women, gender diverse and transgender people.

Mandating sex and gender analysis for grant funding

Australia lags behind other countries in incorporating policies and practices requiring sex and gender analysis in competitive research grants and/or publications in journals.⁵ A study conducted in 2020 found that eight of Australia's top ten research funding agencies and four of the country's top ten journals still do not have policies on the collection, analysis and reporting of sex- and gender-specific health data⁶.

In an attempt to address this, the NHMRC and the Commonwealth Department of Health and Aged Care (responsible for implementation of the [Medical Research Future Fund, MRFF](#)) have recently announced that they are developing a *Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research*, which is anticipated to recognise and promote the importance of integrating sex and gender considerations in health and medical research. However, it does not appear that this

⁴ Breast Cancer Network Australia (2022) Making metastatic breast cancer count: no longer hidden in plain sight. BCNA, Camberwell Vic. – (*BCNA Issues Paper 1*).

⁵ Swannell C (2019) Sex and gender in health research: Australia lags behind. *Medical Journal of Australia*. (Nov 25): 1 webpage. Available from: [URL](#)

⁶ Wainer Z, Carcel C (2020) Sex and gender in health research: updating policy to reflect evidence. *Medical Journal of Australia*. 212(2): 57-62. Available from: [URL](#)

statement will be accompanied by any measures that would enforce integration of these considerations in research or incentivise researchers to study female populations. Consequently, it is unlikely that the statement will have much impact on improving female representation in health and medical research. Indeed, where medical journals have previously subscribed to sex and gender guidelines but have not enforced them, integration of these elements has largely not occurred. A study that reviewed the 10 leading journals in Australia found that sex and gender are poorly incorporated into Australian medical research publications and this was not improved by journals endorsing the International Committee of Medical Journal Editors guidelines⁷.

Policies that mandate the incorporation of sex and gender dimensions in health research are therefore necessary to ensure that gender bias is addressed in government-funded research. For instance, it should be a requirement that research funded by Australian government agencies have an equitable number of male and female research participants (or demonstrate why this is not required), include trans and gender diverse participants where possible, and that all data be analysed by sex and gender and reported on to improve knowledge gaps.

The UK Government's Women's Mental Health Taskforce report (2018)⁸ provides an example of how to incorporate gender at all stages of the research cycle:

- **Study Design:** To improve consideration of sex and gender, research should be informed by involving women and considering gender from the outset.
- **Collect Data:** More should be done by researchers to collect data on topics that are relevant to women and their health, such as violence and abuse, poverty, physical health and the impact of different medications on women of different ages.
- **Data Access:** To make progress in women's mental health research and to understand women's lives and use of services, it is important to be able to access timely, affordable, research-quality data.
- **Data Analysis:** Research gaps must be identified and addressed that currently limit understanding of women's mental health and their service needs.
- **Publish Data:** Statistics and routinely collected data, disaggregated by sex and other characteristics, must be published in meaningful and accessible formats.

Mandating the incorporation of sex and gender dimensions across all stages of the research cycle will increase our understanding of social and biological risk factors for health conditions and how to address them, supporting better targeting of prevention initiatives and treatments for women and gender-diverse people.

Better funding of women's health research

Australia urgently needs to fund research to redress the data and knowledge gaps formed by decades of sex and gender bias in medical research. Additional grant funding should be provided to support sex and gender analysis in health-related studies. More specific funding

⁷ Hallam L, Vassallo A, Hallam C, Thompson K, Shanthosh J, Chappell L, et al. (2023) Sex and gender reporting in Australian health and medical research publications. *Australian and New Zealand Journal of Public Health*. 47(1):1-6. Available from: [URL](#)

⁸ Women's Mental Health Taskforce (2018) The Women's Mental Health Taskforce: final report. United Kingdom. Department of Health and Social Care, and Agenda Alliance for Women and Girls at Risk. Available from: [URL](#)

is also required to investigate causes and treatment options for women’s health conditions (including sexual and reproductive health, mental health, and cancer), and the health needs of transgender and gender diverse people. It is important that future research and evaluation of interventions are co-designed with people that they affect to ensure safety, inclusivity, and responsiveness to needs.

Sex and gender-disaggregated data should routinely be collected, analysed and reported to monitor the incidence and prevalence of common health conditions among people of different genders. Where possible, data should also be disaggregated by other demographic characteristics such as ethnicity, age, socio-economic status, and disability. It is recommended that federal and state government health data bodies develop a standard approach to analysing sex and gender in all health reporting, ensuring that sex and gender are treated as separate constructs. To support access to research, all sex-disaggregated health data collected by health services should be made publicly available.

Incorporating these policy and practice recommendations across the medical research sector will lead to better science, more reliable and reproducible research findings, better care, and contribute to achieving true gender equity in health outcomes into the future.

Q3. To what extent do you think Australian research guidelines[^] foster inclusion of sex and gender in the design of health research?

[^]*Australian research guidelines: eg. National Health and Medical Research Council guidelines*

Q3. Response Options	WHV Response
<i>Not at all</i>	YES
<i>Slightly</i>	Not selected
<i>Moderately</i>	Not selected
<i>Mostly</i>	Not selected
<i>Completely</i>	Not selected
<i>Unsure</i>	Not selected

Q4. What are the barriers and enablers to the development of research guidelines that better consider gender bias in health research?

Barriers to the development of research guidelines that better consider gender bias in health research

Lack of either capacity or leadership from both government agencies and research institutes to tackle gender bias in health research are significant barriers to the development of guidelines to address this issue.

Leading universities and research institutions in Australia have previously called for the development of guidelines that consider gender bias in health research⁹. Women's Health Victoria has also raised the need for the MRFF to specifically address this issue by updating policies and practices to stipulate sex- and gender disaggregated data collection, analysis and reporting in the research they fund¹⁰. However, to date no action on this has been observed.

Persistent inaction from universities and research institutions reflects a broader culture of deprioritising women's health in Australia and internationally, stemming from a long history of gender bias and exclusion of women from medical research, both as researchers and research participants.

Reluctance to incorporate sex and gender considerations in health research guidelines could also reflect a misperception among study sponsors and investigators that it takes more time and money to recruit women as research participants than men. Studies have found that the high cost associated with funding sex- and gender-specific research is perceived as a barrier to changes in policy¹¹. The constrained research funding environment in Australia likely exacerbates these concerns, with national research and development spending at an all-time low of just 0.49 percent of GDP in 2022-23¹².

Enablers of the development of research guidelines that better consider gender bias in health research

Provision of additional grant funding for health research may therefore be an enabler to accommodate the cost of comprehensive research incorporating people of all genders, along with high-level leadership from research institutions, universities, research funding bodies and academic publishers.

⁹ The George Institute for Global Health Australia (2019) Medical research community calls time on health gender bias. *George Institute Media Release*. (Nov 25): 1 webpage. Available from: [URL](#)

¹⁰ Women's Health Victoria (2021) Response to the Medical Research Future Fund strategies and priorities consultation. Women's Health Victoria, Melbourne. Available from: [URL](#)

¹¹ Wainer Z, Carcel C (2020) Sex and gender in health research: updating policy to reflect evidence. *Medical Journal of Australia*. 212(2): 57-62. Available from: [URL](#)

¹² Sinclair J (2023) Australian R&D spending drops as percentage of GDP. *Research Professional News*. (Agu 28): 1 webpage. Available from: [URL](#)

Q5. What are the barriers and enablers to the implementation of research guidelines that would provide better consideration of sex and gender in health research?

If health research guidelines that better consider sex and gender were introduced in Australia, potential barriers to implementation include existing structural and social obstacles to women's participation in medical research, and a lack of policies and procedures that enforce the use of such guidelines.

Structural and social barriers to women's participation in medical research that currently exist include:

- Lack of knowledge regarding how different medical conditions present in women, leading to women not being diagnosed in a timely fashion or at all, and therefore not referred to relevant research studies or trials.
- Women bearing a disproportionate share of caring and other responsibilities, meaning they are less likely to have time to participate in research than men¹³.
- Concerns about preventing foetal exposure to research interventions that can place an additional burden on women study participants¹⁴. These concerns have motivated requirements that reproductive-aged women avoid pregnancy while participating in biomedical research studies by taking oral contraceptives, often irrespective of risks and benefits or a woman's actual potential for pregnancy¹⁴. For the same reason, pregnant women also continue to be excluded from most medical trials¹⁴.

To facilitate the implementation of research guidelines that provide better consideration of sex and gender, obstacles to women's research participation, such as the lack of adequate childcare, must be specifically addressed in policies and procedures that hold researchers accountable.

As noted, it is important that journals and research funding agencies require recruitment of adequate numbers of women, as well as sex and gender analysis in all medical studies, even when the relevance of sex is not known at the time of study design. Without such requirements, it is unlikely that guidelines will be adhered to, and women will continue to be excluded from medical research. Funding to train researchers and clinicians in how to undertake research that includes comprehensive sex and gender analyses¹⁵ will also support implementation of guidelines.

¹³ Leslie K (2020) Why are women ignored by medical research? *Pursuit (University of Melbourne)*. (Mar 7): 1 webpage. Available from: [URL](#)

¹⁴ Sullivan KA, Little M, Rosenberg N, Zimba C, Jaffe E, Gilbert S, et al. (2019) Women's views about contraception requirements for biomedical research participation. *PLoS One*. 14(5): e0216332. Available from: [URL](#)

¹⁵ Wainer Z, Carcel C (2020) Sex and gender in health research: updating policy to reflect evidence. *Medical Journal of Australia*. 212(2): 57-62. Available from: [URL](#)

Q6. To what extent are research findings in relation to women’s health being implemented into clinical practice?

Q6. Response Options	WHV Response
<i>Not at all</i>	Not selected
<i>Slightly</i>	Not selected
<i>Moderately</i>	Not selected
<i>Mostly</i>	Not selected
<i>Completely</i>	Not selected
<i>Unsure</i>	YES

Q7. What are the barriers and enablers for translating evidence into clinical practice?

Translation of evidence into clinical practice is impacted by the lack of evidence on gender-responsive programs, treatments and services. Where research does exist, a significant barrier to its implementation is that women’s health issues are not seen as a standard part of mainstream healthcare.

There is insufficient training for medical professionals regarding the need to consider sex and gender in areas of health outside of sexual and reproductive health. In general, medical education treats gender and sex considerations as ‘important but of low status’¹⁶. Gender consequently occupies a marginal position in medical curricula, which often equates gender with biological sex and positions gender neutrality as a naturally occurring phenomenon¹⁶.

As more sex and gender disaggregated research becomes available, it is important that this is incorporated and mainstreamed into all areas of the medical curriculum and tailored to specific settings, so that information pertaining to female cohorts is presented alongside that of male cohorts where relevant. The difference between sex and gender and the implications of these concepts for patient care should also be better integrated in medical education to build gender competency among healthcare practitioners.

¹⁶ Yang H (2020) What should be taught and what is taught: integrating gender into medical and health professions education for medical and nursing students. *International Journal of Environmental Research and Public Health*. 17(18):6555. Available from: [URL](#)

Q8. To what extent are research findings in relation to women’s health being implemented into public health and public policy settings?

Q8. Response Options	WHV Response
<i>Not at all</i>	Not selected
<i>Slightly</i>	Not selected
<i>Moderately</i>	Not selected
<i>Mostly</i>	Not selected
<i>Completely</i>	Not selected
<i>Unsure</i>	YES

Q9. What are the barriers and enablers for translating evidence into public health and public policy settings?

A barrier to the translation of evidence into public health and public policy is the general lack of understanding regarding the need to incorporate sex-disaggregated data and health research in these fields of practice. In relation to public policy, there is a misconception that health policy is predominantly gender neutral and therefore does not require the consideration of gender elements, particularly in regard to conditions that affect both women and men. Women’s specific health needs are still treated as niche and, in policy areas outside of sexual and reproductive health, are commonly only considered in relation to pregnancy and the wellbeing of children.

For example, the only gendered life stage mentioned in the Productivity Commission’s Mental Health report¹⁷ is in relation to perinatal depression and anxiety, with the recommendation to *put in place strategies to reach universal screening for mental ill-health of new parents*. This recommendation is made in the context of improving children’s mental health, not improving mothers’ and parents’ mental health. The lack of consideration for women’s specific mental health needs over the life course is a critical oversight. While mental health is an issue that affects both women and men, there are often sex and gender based- differences in the risk factors, rates, and outcomes of mental health conditions¹⁸. To understand and address these issues effectively, targeted gender-sensitive research and policy responses are required.

¹⁷ Australia. Productivity Commission (2020) Mental Health Inquiry Report. Productivity Commission, Canberra. – (*Productivity Commission Report*; 95) - Available from: [URL](#)

¹⁸ Barr M, Anderson R, Morris S, Johnston-Ataata K (2023) Towards a gendered understanding of women’s experiences of mental health and the mental health system. Women’s Health Victoria, Melbourne. - (*Women’s Health Issues Paper*; 17). Available from: [URL](#)

Access, care and outcomes

Q10. How much choice do you think women have about their healthcare?

Q10. Response Options	WHV Response
<i>None at all</i>	Not selected
<i>A little</i>	YES
<i>A moderate amount</i>	Not selected
<i>A lot</i>	Not selected
<i>A great deal</i>	Not selected
<i>Unsure</i>	Not selected

Q11. What are the barriers and enablers of choice for women in health care?

There are significant barriers to women’s choice in healthcare, particularly in relation to sexual and reproductive health (SRH) services. Choice is impacted by the cost, accessibility, stigma associated with accessing these services, and the limited number of providers that deliver SRH care.

Cost

Cost is a prohibitive factor impeding access to sexual and reproductive health services¹⁹. This reflects the limited role of the public health system in SRH provision in most parts of Australia - the time-sensitive nature of contraception and abortion services pushes those able to afford it into the private system.

In Victoria, most abortions are performed by private providers (GPs, private clinics or specialists) and most abortion-seekers also need to pay for blood tests and ultrasound scans. Surgical abortions under 12 weeks' gestation in the private abortion system range from \$500-\$700, and medical abortions cost between \$100-\$600. A small proportion of public hospitals provide bulk-billed abortion services, and provision across the hospital system is limited, inconsistent, often ad hoc, has strict access criteria (including Medicare eligibility), gestational limits, or has significant wait times - leading to further barriers to abortion access²⁰.

To lower costs for pregnant people accessing abortion services and increase accessibility of care, Women’s Health Victoria recommends that Australian services adopt international best

¹⁹ Shankar M, Black K, Goldstone P, Hussainy S, Mazza D, Petersen K, et al. (2017) Access, equity and costs of induced abortion services in Australia: a cross-sectional study. *Australian and New Zealand Journal of Public Health*. 41(3): 309-314. Available from: [URL](#)

²⁰ Dawson A, Bateson D, Estoesta J, Sullivan E (2016) Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia. *BMC Health Services Research*. 16:612. Available from: [URL](#)

practice regarding abortion care²¹ – including evidence-based guidance around nurse-led care, self-management, medication abortion (see specifically gestation limits) and the necessity of ultrasound.

For Victorians seeking to prevent pregnancies with the most effective hormonal IUD devices, insertions generally cost \$400-\$600 in private clinics under sedation, or \$100-\$400 in general practice. Low-cost LARC services are uncommon, and thus often have significant wait times.

Accessibility

Several communities are particularly underserved by mainstream SRH services in Australia:

- Women with disabilities have minimal to no access to sexual and reproductive health programs, and reduced access to health information, screening, prevention and care services, alongside experiencing higher rates of sexual violence, and forced abortion, contraception and sterilisation²². Women with disabilities experience inadequate and non-responsive health services including being refused the right to consent to medical treatment including abortion and are more likely to experience reproductive coercion than women without disabilities²³.
- Trans and gender diverse people report experiencing very high rates of marginalisation in sexual health care due to transphobia, resulting in lower STI testing rates, low uptake of PrEP and heightened vulnerability to STIs²⁴.
- Aboriginal and Torres Strait Islander women identify gaps in appropriate sexual and reproductive health education, as well as higher rates of pregnancy risk factors, adverse perinatal outcomes, and adolescent pregnancy²⁵. Data from a 2018 study indicated that 22% of Aboriginal and Torres Strait Islanders had experienced racial discrimination from healthcare workers in the last 12 months²⁶.
- Australians living in rural areas have poorer SRH outcomes than those in metropolitan centres, including higher rates of unplanned pregnancies and STIs²⁷. These outcomes are due to a lack of local services, high costs and misinformation, exacerbated by the uneven distribution of the healthcare workforce in rural areas²⁸. In Victoria, most private surgical abortion options are in metropolitan Melbourne, with

²¹ WHO (2022) Abortion care guideline. World health Organization, Geneva. Available from: [URL](#)

²² Frohmader C (2013) Dehumanised: The forced sterilisation of women and girls with disabilities in Australia: WWDA submission to the Senate Inquiry Into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia. Women with Disabilities Australia, Rosny Park, Tas. Available from: [URL](#)

²³ Horner-Johnson W, Moe E, Ryan S, Klein K, Edelman A, Eden K, et al. (2019) Contraceptive knowledge and use among women with intellectual, physical, or sensory disabilities: a systematic review. *Disability and Health Journal*. 12(2): 139-154.

²⁴ Callander D, Wiggins J, Rosenberg S, Cornelisse V, Duck-Chong E, Holt M, et al. (2019) The 2018 Australian Trans and Gender Diverse Sexual Health Survey: report of findings. The Kirby Institute, UNSW Sydney. Available from: [URL](#)

²⁵ Botfield J, Griffiths E, McMillan F, Mazza D (2022) Unintended pregnancy among Aboriginal and Torres Strait Islander women: where are the data? [Letter] *Medical Journal of Australia*. 217(1):59. Available from: [URL](#)

²⁶ Reconciliation Australia (2020) Australian reconciliation barometer: full report. Polity Research and Consulting, Sydney. Available from: [URL](#)

²⁷ Newman P, Morell S, Black M, Munot S, Estoesta J, Brassil A (2011) Reproductive and sexual health in New South Wales and Australia: differentials, trends and assessment of data sources. Family Planning NSW, Sydney. Available from: [URL](#)

²⁸ AIHW (2018) Survey of Health Care: selected findings for rural and remote Australians. Australian Institute of Health and Welfare. Canberra. Available from: [URL](#)

few public hospitals providing abortions for large geographical areas – complicating access to this essential service.

Stigma

Stigma associated with the provision of abortion services also contributes to the difficulties women experience accessing these services. A study in Victoria estimated that around 15% of health care professionals are conscientious objectors to abortion²⁹. Furthermore, the study found that some doctors were directly contravening the law by not providing referrals, while some were deliberately delaying women's access or attempting to make women feel guilty for seeking the procedure²⁹. Women's access to abortion thus remains susceptible to the moral and religious beliefs of doctors, even where the legal framework seeks to ensure that such beliefs do not operate as a barrier to access.

Many doctors who are not conscientious objectors have also been reluctant to become involved in the provision of abortion services due to reputational concerns and the risk of personal attacks. Research has found that the decriminalisation of abortion and the introduction of safe access zones in Victoria have not removed the shaming and threats that remain a concomitant of abortion practice, particularly in some rural and regional areas²⁹.

Limited SRH providers

There are currently insufficient SRH services and service providers in Australia to meet demand. One quarter of Australian women experience an unintended pregnancy and 30% of unintended pregnancies end in abortion, with higher rates of unintended pregnancy in rural areas. However, most GPs are not trained and/or do not provide abortion or contraceptive care to women. While a person may be able to see any GP for common health conditions – such as asthma (affecting 11% of Australians) or diabetes (5% of Australians), only 11% of Australian GPs were registered to prescribe medication abortion in June 2023³⁰, despite between 25%-33% of women having an abortion in their lifetimes. Similarly, in one study 37% of GPs had received IUD insertion training but only 12% practiced this training³¹.

Furthermore, in Australia, not all hospitals provide public abortion services. Those that do often rely on a single champion or small team of champions who provide the service. As a result, there are few choices for women in terms of where they can access abortion care and from whom. Similarly, there are not enough providers who are knowledgeable about and provide access to long-acting reversible contraception (LARC) - currently the most effective method of contraception available. Women's choice in contraceptives often depends on health professional advice about the complete range of contraceptive options, cost, referrals and follow-up required³². Yet, there is lower familiarity with LARC among health professionals and misperceptions about their use³³.

²⁹ Sifris R, Penovic T (2021) Barriers to abortion access in Australia before and during the COVID-19 pandemic. *Women's Studies International Forum*. 86:102470. Available from: [URL](#)

³⁰ MS Health (2023) Dispenser and prescriber program: June 2023 update. MSI Reproductive Choices, Melbourne. Available from: [URL](#)

³¹ Mazza D, Watson C, Taft A, Lucke J, McGeechan K, Haas M, et al. (2023) Pathways to IUD and implant insertion in general practice: a secondary analysis of the ACCORd study. *Australian Journal of Primary Health*. 29(3): 222-228. Available from: [URL](#)

³² Taft A, Shankar M, Black KI, Mazza D, Hussainy S, Lucke J (2018) Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes. *Medical Journal of Australia*. 209(9): 407-8. Available from: [URL](#)

³³ Mazza D, James S, Black K, et al (2022) Increasing the availability of long-acting reversible contraception and medical abortion in primary care: the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPs) cohort study protocol. *BMJ Open*. 12(12): e065583. Available from: [URL](#)

There is a need for greater investment in and coordination of the national SRH workforce in Australia. Coordinating, accreditation and training bodies including the RACGP, RANZCOG, PHNs, AHPRA, AMA and ANMAC must ensure that critical SRH components are included in standard training and assessed as part of competency measures. Currently, standard pre-medical and nursing training does not consistently include standardised or structured information or training relating to surgical abortion, medical abortion, LARC, menopause, pelvic pain or other SRH conditions; nor practitioner obligations in relation to conscientious objection laws³⁴.

Access to training is not consistent across Australia and is particularly problematic for practitioners in non-metropolitan areas and for overseas trained health practitioners. A non-existent or reduced healthcare workforce in rural areas, alongside aforementioned lack of services in public hospitals, limits SRH training opportunities for the entire healthcare workforce. This lack of workplace exposure compounds inconsistencies in formal education, further contributing to a workforce ill-equipped to address the lack of adequate SRH services including surgical abortion.

Q12. Please outline any barriers and enablers that have an impact on whether care for women is:

- **timely**
- **appropriate**
- **accessible**
- **affordable**

Significant barriers exist to appropriate, timely, affordable and accessible healthcare for women in Australia, including:

1. Lack of research and knowledge regarding how health conditions present in women
2. Healthcare workforce attitudes
3. Dominance of the biomedical model of mental health
4. Lack of universal access to sexual and reproductive health care

1. Lack of research and knowledge regarding how health conditions present in women

As most medical research has been conducted in men, symptoms of disease as they usually present in men tend to be viewed as the norm. Conversely, symptoms that more commonly present in women are less well-known and less likely to be recognised by medical professionals. As a result, it is common for symptoms in women to be overlooked, misattributed, or minimised, leading to delays in the provision of appropriate care. For example, women who experience a heart attack often do not display the male typical symptoms and are consequently more likely to be misdiagnosed with a non- heart related condition³⁵. In 2022, The Journal of the American Heart Association reported that women

³⁴ Desai A, Maier B, James-McAlpie J, Prentice D, de Costa C (2022) Views and practice of abortion among Queensland midwives and sexual health nurses. *Australian and New Zealand Journal of Obstetrics and Gynaecology*. 62(2): 219-225. Available from: [URL](#)

³⁵ Chien L, Dahm M (2023) It's time to stop gaslighting women when it comes to their health. *ANU Reporter*. (Mar 8). Available from: [URL](#)

who visited emergency departments with chest pain waited 29 percent longer than men to be evaluated for possible heart attacks³⁶.

2. Healthcare workforce attitudes

Conscious and unconscious bias among health professionals is another important barrier to appropriate and timely care. Such biases include gender stereotypes around women's pain thresholds, weight stigma, and prejudicial attitudes towards trans and gender diverse people.

The gender stereotype that women have a lower pain threshold than men influences how women who present with pain are perceived, often resulting in their pain being minimised or dismissed. A 2018 study of doctors' perceptions of people with chronic pain found men were often seen as "brave" or "stoic," while women were seen as "emotional" or "hysterical"³⁷. Such gendered stereotypes can result in delays to diagnosis and misdiagnosis, as well as impact on treatment.

Women experiencing pelvic pain, a common symptom of endometriosis, routinely have their pain discounted as 'normal'. This leads to considerable delays in receiving appropriate care, with women waiting on average 6-8 years to be diagnosed. Even the time taken to diagnose cancer varies across genders, in part due to pain symptoms in women being overlooked by healthcare professionals³⁸. Furthermore, women who present with pain are often misdiagnosed with 'stress' or 'mental health issues'³⁵. Historical 'hysteria' discourses, which attribute women's pain to psychological rather than physical conditions, still influence the perception and treatment of female patients³⁵.

The minimisation and dismissal of women's pain has also been shown to impact treatment. Studies have found that women tend to receive less intensive and effective pain care³⁹. An example of this is the lack of appropriate pain treatment provided to many women during the insertion of an IUD. Ibuprofen and paracetamol are often the only forms of pain relief offered for this invasive procedure, though these have been found to be no more effective than a placebo in this context⁴⁰. While mild sedation and numbing creams are generally regarded as the most effective pain-prevention methods for IUD procedures, these are often unavailable or very expensive in Australian clinics⁴⁰. When experiencing pain, women are less likely to be prescribed analgesics and opiates and more likely to be provided antidepressant prescriptions than men³⁹. Furthermore, when male and female patients express the same type of pain, female patients are more likely to be referred to psychotherapy, while men are more likely to receive pharmacological medications³⁹.

Biased medical research and clinical assumptions about women relating to their appearance and weight also contribute to disparities in diagnosis and health outcomes. Women who are deemed overweight and report pain commonly experience discrimination based on their

-
- ³⁶ Banco D, et al. (2022) Sex and race differences in the evaluation and treatment of young adults presenting to the emergency department with chest pain. *Journal of the American Heart Association*. 11(10): e024199. Available from: [URL](#)
- ³⁷ Anke Samulowitz A, Gremyr I, Eriksson E, Hensing G (2018) "Brave men" and "emotional women": a theory-guided literature review on gender bias in health care and gendered norms towards patients with chronic pain. *Pain Research And Management*. 2018: 6358624. Available from: [URL](#)
- ³⁸ Dusenbery M (2018) How gender bias affects your healthcare. *BBC Future*. (May 30). Available from: [URL](#)
- ³⁹ Moretti C, De Luca E, D'Apice C, Artioli G, Sarli L, Bonacaro A (2023) Gender and sex bias in prevention and clinical treatment of women's chronic pain: hypotheses of a curriculum development. *Frontiers In Medicine*. 10: 1189126. Available from: [URL](#)
- ⁴⁰ Burke H (2022) Calls for better pain management for women choosing IUD as contraception. *ABC News*. (May 29). Available from: [URL](#)

size - also known as weight stigma. Women report higher rates of weight stigma than men⁴¹, and also report experiencing this discrimination at lower weights than men.⁴²

Some health professionals have reported that they have less respect for patients in bigger bodies and are less likely to engage with these patients as they believe the patients will not follow their recommendations. Australian and international research shows that health professionals may over-attribute a patient's symptoms and health issues to weight, therefore failing to consider treatment beyond weight loss or to recommend further diagnostic testing.⁴³ For example, while some PCOS symptoms can be alleviated with improved diet and regular physical activity, some symptoms, including poor quality sleep, heavy periods and depression and anxiety, can make it much harder to exercise. Women with PCOS have reported poor treatment by health professionals due to weight stigma⁴³.

Weight stigma also contributes to misdiagnosis of eating disorders due to the misconception they predominantly affect people with low body weight. Though eating disorders are increasing in prevalence among people with higher weight, the condition is under-recognised and undertreated. People in bigger bodies are often misdiagnosed, dismissed by health professionals and sidelined from eating disorder services⁴⁴.

Additional barriers to appropriate care exist for transgender and gender diverse people, who often face transphobia, discrimination, and lack of gender-affirming care when accessing health services. One study investigating experiences of transgender patients receiving cancer treatment found that there was a consistent lack of consideration of the patients' transgender identities during and after treatment⁴⁵. Medical providers largely overlooked the transgender status of patients as an important part of their cancer experience and did not consider the potential impact of cancer or treatment on their bodies⁴⁵. Some patients were denied gender-affirming hormone therapy as part of their treatment for testicular cancer and consequently were forced to de-transition, which had significant mental health impacts⁴⁵. Other patients were able to continue hormone therapy throughout their treatment but did not receive appropriate follow-up care. Participants described an absence of support that was relevant to them and their needs, as well as a lack of information and resources where transgender people were represented⁴⁵.

The highly gendered nature of health services (particularly screening services) is also a barrier to appropriate and accessible care for transgender patients⁴⁵. There is a lack of inclusivity in paperwork and administrative processes, where transgender identities are largely not accommodated. This includes not having the required fields or options on patient records to input a patients' gender, pronouns, and preferred or chosen name, and not having processes in place to ensure that correct names and pronouns are used by healthcare

⁴¹ Sattler K, Deane F, Tapsell L, Kelly P (2018) Gender differences in the relationship of weight-based stigmatisation with motivation to exercise and physical activity in overweight individuals. *Health Psychology Open*. 5(1): 2055102918759691. Available from: [URL](#)

⁴² King K, Puhl R (2013) Weight bias: does it affect men and women differently? Obesity Action, Tampa, Florida. Available from: [URL](#)

⁴³ Phelan, S M, et al. (2015) Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews*. 16(4): 319-26. Available from: [URL](#)

⁴⁴ National Eating Disorders Collaboration (2021) Management of eating disorders for people with higher weight: clinical practice guidelines, 2021 [draft guidelines for comment]. NEDC, Sydney. Available from: [URL](#)

⁴⁵ Lisy K, Kerr L, Jefford M, Fisher C (2023) "Everything's a fight": a qualitative study of the cancer survivorship experiences of transgender and gender diverse Australians. *Cancer Medicine*. 12(11): 12739-12748. Available from: [URL](#)

providers, both verbally when attending services or in any subsequent documentation that is provided to the patient⁴⁵.

Provision of training around transgender health for current healthcare practitioners, and greater inclusion of transgender health in medical and nursing curricula moving forward are important to support access to better and more appropriate care for transgender people. Further research is also required to understand the impact of cancer and other medical treatments on transgender bodies.

3. Dominance of the biomedical model of mental health

The continued dominance of the biomedical model of health is a significant barrier to appropriate mental health care for women. This model emphasises biological causes of mental ill-health and ignores both the social causes and contexts of women's distress. As a result, it positions their responses to stressors, such as gendered violence and trauma, as psychologically abnormal. This can lead to women's mental health concerns being overlooked, dismissed or misdiagnosed and/or the pathologisation of adaptive responses to traumatic experiences⁴⁶.

A key consequence of the biomedical approach to treatment of mental ill-health is heavy reliance on medication and hospitalisation, while largely ignoring the impacts of trauma. Research has found that, when describing the impacts of complex trauma arising from experiences of gendered violence, health professionals often downplay women's distress and misattribute it to flawed personalities and dysfunction⁴⁷. Women are frequently perceived as attention-seeking, difficult and unworthy, which often leads to re-traumatisation when receiving mental health services⁴⁷.

4. Lack of universal access to sexual and reproductive health care

The current absence of a commitment in Australia to provision of universal access to sexual and reproductive health care continues to impede accessible, affordable and timely SRH care. Similar service provision issues exist in relation to gender responsive mental health. For more detail please see our responses to Q11 and Q10.

⁴⁶ Barr M, Anderson R, Morris S, Johnston-Ataata K (2023) Towards a gendered understanding of women's experiences of mental health and the mental health system. Women's Health Victoria. Melbourne. - (*Women's Health Issues Paper; 17*). Available from: [URL](#)

⁴⁷ Salter M, Conroy E, Dragiewicz M, Burke J, Ussher J, Middleton W, et al. (2020). "A deep wound under my heart": constructions of complex trauma and implications for women's wellbeing and safety from violence. ANROWS, Sydney. – (*ANROWS Research Report; 12*). Available from: [URL](#)

Q13. To what extent do you think women feel heard about their health issues?

Q13. Response Options	WHV Response
<i>Not at all</i>	Not selected
<i>Slightly</i>	YES
<i>Moderately</i>	Not selected
<i>Mostly</i>	Not selected
<i>Completely</i>	Not selected
<i>Unsure</i>	Not selected

Q14. To what extent do you think women feel believed about their health issues?

Q14. Response Options	WHV Response
<i>Not at all</i>	Not selected
<i>Slightly</i>	YES
<i>Moderately</i>	Not selected
<i>Mostly</i>	Not selected
<i>Completely</i>	Not selected
<i>Unsure</i>	Not selected

Q15. What are the barriers and enablers to women feeling confident they will be heard and believed about their health issues?

The main barrier to women feeling confident they will be heard or believed about their health issues is health professionals' attitudes and behaviours that demonstrate they are consistently not hearing or believing women.

Q16. What is the impact of not being heard and believed?

Dismissal of women's pain and disbelief about their reported symptoms can:

- cause women to avoid accessing healthcare,
- lead to delayed or incorrect diagnoses, and
- result in poor health outcomes and/ or death.⁴⁸

Avoidance of medical care

Women who have experienced sexism and discrimination from healthcare providers often avoid accessing healthcare. Studies have found that these experiences create expectations of further discrimination and poor treatment in healthcare settings, increasing feelings of anxiety and stress around attending appointments. For example, as a result of weight stigma, women in bigger bodies have been found to delay going to the doctor for health issues. This can lead to increased morbidity, with women later presenting with more advanced conditions.⁴⁹

Experiences of transphobia in the health system, where healthcare providers consistently misgender patients or do not take on board their preferences for treatment can also lead to healthcare avoidance⁵⁰. One study investigating transphobia in cancer care found that, as a result of transphobic experiences, patients chose not to attend follow-up appointments, despite knowing the importance of cancer follow-up care, or delayed seeking care even when experiencing concerning symptoms⁵⁰.

Delays in diagnosis and treatment

Failure to take women's pain seriously has been shown to lead to significant delays in diagnosis and treatment. Gender discrepancies in time to diagnosis have been observed in cancers, including bladder, colorectal, gastric, head and neck, lung, and lymphoma cancers⁵¹, heart conditions and a range of other chronic health conditions. A survey of women with chronic conditions in Australia demonstrated that women wait an average of 4 years for a definitive diagnosis and almost half of these women are re-diagnosed at least once⁵².

Delays in diagnosis and misdiagnosis often mean that women live with pain for extended periods of time. This can carry significant implications for their social and economic participation. The economic impact of these delays may be further compounded by the cost of unnecessary tests and treatment if an incorrect diagnosis is provided.

⁴⁸ Chien L, Dahm M (2023) It's time to stop gaslighting women when it comes to their health. *ANU Reporter*. (Mar 8). Available from: [URL](#)

⁴⁹ Mensinger J, Tylka T, Calamari M (2018) Mechanisms underlying weight status and healthcare avoidance in women: a study of weight stigma, body-related shame and guilt, and healthcare stress. *Body Image*. 25: 139-147.

⁵⁰ Lisy K, Kerr L, Jefford M, Fisher C (2023) "Everything's a fight": a qualitative study of the cancer survivorship experiences of transgender and gender diverse Australians. *Cancer Medicine*. 12(11): 12739-12748. Available from: [URL](#)

⁵¹ Din N, Ukoumunne O, Rubin G, Hamilton W, Carter B, Stapley S, et al. (2015) Age and gender variations in cancer diagnostic intervals in 15 cancers: analysis of data from the UK Clinical Practice Research Datalink. *PLoS ONE*. 10(5): e0127717. Available from: [URL](#)

⁵² Merone L, Tsey K, Russell D, Nagle C (2022) "I just want to feel safe going to a doctor": experiences of female patients with chronic conditions in Australia. *Womens Health Reports*. 3(1): 1016-1028. Available from: [URL](#)

Inadequate symptom management

Dismissal of women’s pain can impact the quality of care that women receive. When women are not believed, they are often not provided appropriate treatment. For example, doctors who dismiss the severity of chronic pain may not provide women with the necessary pain medication. They may also provide less intensive treatment options. Research has found that physicians are four times more likely to recommend a knee replacement for a man than a woman with the same knee injury⁵³.

Increased mortality

International evidence has demonstrated that misdiagnosis and delays in diagnosis due to women not being believed increase the risk of patient mortality. There is an extensive evidence base showing that, because of gender bias, women are less likely than men to survive traumatic health episodes⁵⁴. For example, the poorer quality care women received compared to men after suffering a heart attack led to 8,243 preventable deaths between 2003 and 2013 in England and Wales⁵³.

Safety

Q17. Can women access tailored care?

Q17. Response Options	WHV Response
<i>Never</i>	Not selected
<i>Rarely</i>	Not selected
<i>Sometimes</i>	YES
<i>Mostly</i>	Not selected
<i>Always</i>	Not selected
<i>Unsure</i>	Not selected

⁵³ Ki B, Zoumenou E, Chobli M, le Polain de Waroux B, Robert, A, Baele P (2023) Gender and graduating results in the Anesthesiology and Intensive Care Abomey-Calavi (Cotonou, Benin) program. *Acta Anaesthesiologica Belgica*. 73(4): 215-220.

Q18. Can women access safe care?

Q18. Response Options	WHV Response
<i>Never</i>	Not selected
<i>Rarely</i>	Not selected
<i>Sometimes</i>	YES
<i>Mostly</i>	Not selected
<i>Always</i>	Not selected
<i>Unsure</i>	Not selected

Q19. What are the barriers and enablers to culturally safe care for women? How does culturally safe care differ between different priority populations^?

^Some examples of priority populations are:

- *Pregnant women and their children*
- *Women and girls from rural and remote areas*
- *Aboriginal & 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 LGBTIQ+ communities*
- *Women and girls who experience violence and/or abuse*

Barriers and enablers to culturally safe care for women differ across priority populations, such as culturally and linguistically diverse (CALD) communities and Indigenous communities.

Culturally and linguistically diverse communities

Barriers to safe care

For many CALD communities, access to culturally safe care is impacted by a lack of culturally appropriate and multilingual health promotion materials, insufficient interpreter services in healthcare settings, and low cultural competency among health professionals.

Language and health literacy are significant barriers to culturally safe care. The lack of targeted health promotion campaigns, and lack of inclusive information accessible and relevant to CALD communities in wider health promotion campaigns has contributed to reduced health literacy among some groups of women. Compared to Anglo-Australian

patients, culturally diverse patients report greater difficulties understanding the health system⁵⁴.

Access to culturally safe care for CALD women in Australia is further compounded by the lack of interpreter services, particularly in regional areas. Minimal interpreting support is available for diagnostic, emergency (e.g., labour and delivery), and GP services⁵⁵. Furthermore, current policy does not allow family members and relatives to act as interpreters. This contributes to difficulties negotiating services and accessing appropriate care, especially among refugee populations⁵⁵.

Poor cultural competency of healthcare providers is also a barrier to culturally safe care. Insufficient understanding among providers of patients' cultural needs can lead to inappropriate and ineffective treatment. For example, a recent study found that gestational diabetes practices in Australia did not adequately meet the needs of South Asian women and were therefore not effectively adopted⁵⁶. Lack of cultural competency among providers may also be influenced by racial bias. Research has found that people from CALD backgrounds are overrepresented in involuntary admissions and acute inpatient units in Australia and are more likely to be exposed to quality and safety risks⁵⁷. These outcomes are often due to misunderstandings and misdiagnosis that result from language and cultural barriers⁵⁷.

Enablers of safe care

It is important that bilingual health education and promotion is available for migrant communities from non-English speaking backgrounds. Education should be delivered by trained bilingual educators and community leaders who are supported, remunerated, and recognised for their work. Similarly, public health campaigns should be developed in consultation with relevant communities, to ensure that both English content and translated content are widely accessible, appropriate and that information provided is meaningful for all audiences.

Furthermore, in order to deliver culturally appropriate services for people from migrant and refugee communities, health services and organisations must employ multilingual and multicultural staff. Victorian Transcultural Mental Health and the Ethnic Communities Council of Victoria have emphasised the importance of 'cultural connectors' in liaising between mental health practitioners and consumers from migrant and refugee backgrounds – staff dedicated to liaising and advocating between practitioners and consumers, providing information and explaining it in a culturally relevant way⁵⁸. Embedding cultural safety requirements into funding and service agreements, as well as quality assurance mechanisms and accreditation, would provide both incentives and mechanisms to ensure that cultural safety is prioritised and maintained by healthcare services.

⁵⁴ Smith A, Agar M, Delaney G, Descallar J, Dobell-Brown K, Grand M, et al. (2017) Lower trial participation by culturally and linguistically diverse (CALD) cancer patients is largely due to language barriers. *Asia-Pacific Journal of Clinical Oncology*. 14(1): 52-60.

⁵⁵ Khatri, R, Assefa, Y (2022) Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. *BMC Public Health*. 22: 880. Available from: [URL](#)

⁵⁶ Bandyopadhyay M (2021) Gestational diabetes mellitus: a qualitative study of lived experiences of South Asian immigrant women and perspectives of their health care providers in Melbourne, Australia. *BMC Pregnancy and Childbirth*. 21:500. Available from: [URL](#)

⁵⁷ Mental Health in Multicultural Australia (2014) Framework for mental health in multicultural Australia: towards culturally inclusive service delivery. MHiMA, Upper Mt. Gravatt, Qld. Available from: [URL](#)

⁵⁸ Plowman M, Izzo S (2021) Recommendations for a culturally responsive mental health system. Ethnic Communities' Council of Victoria and Victorian Transcultural Mental Health, Melbourne. Available from: [URL](#)

Indigenous populations

Barriers to safe care

Barriers to culturally safe care for Aboriginal and Torres Strait Islander populations include power imbalances in doctor/ patient interactions, lack of knowledge among healthcare providers regarding the cultural needs of Indigenous people and lack of coordination in service provision across the Australian healthcare system.

Provision of culturally safe care to Indigenous communities first and foremost requires the redress of inherent power imbalances between healthcare providers and patients, which stem from the colonisation and dispossession of Indigenous peoples⁵⁹. Culturally safe care is possible only where the patient is empowered and involved in decision making regarding all aspects of their care. This is achieved through healthcare providers being aware of cultural difference, decolonising healthcare approaches, considering power relationships, implementing reflective practice, and allowing the patient to determine what safety means⁵⁹.

Service providers' lack of knowledge about the needs of Aboriginal and Torres Strait Islander peoples has been identified as a major issue impeding optimal health outcomes. The Australian Institute of Health and Welfare reports that 32% of Indigenous Australians who did not access health services when they needed to in 2018-19 indicated this was due to cultural reasons, such as language problems, discrimination and cultural appropriateness⁶⁰. The need for more culturally appropriate services for Indigenous people is required across the continuum of healthcare from health promotion and prevention through to treatment and palliation.

A further barrier to culturally safe care in Australia is the lack of coordination across the various levels of Government and healthcare services⁶¹. Improving the health of Aboriginal and Torres Strait Islander peoples requires a patient-focused, culturally safe approach at every level and component of the healthcare system, from national healthcare policy to local primary healthcare services⁶¹. Such an approach would require coordination at a national level as well as an appreciation of the interconnectedness of the entire healthcare system which may be achieved by adopting an ecological, or ecosystem perspective⁶¹.

⁵⁹ Lavery M, Dennis R, McDermott D, Calma T (2017) Embedding cultural safety in Australia's main health care standards. *Medical Journal of Australia*. 207(1): 15-16. Available from: [URL](#)

⁶⁰ Australian Institute of Health and Welfare (2023) Cultural safety in health care for Indigenous Australians: monitoring framework. AIHW, Canberra. Available from: [URL](#)

⁶¹ Nolan-Isles D, Macniven R, Hunter K, Gwynn J, Lincoln M, Moir R, et al. (2021) Enablers and barriers to accessing healthcare services for Aboriginal people in New South Wales, Australia. *International Journal Of Environmental Research and Public Health*. 18(6): 3014. Available from: [URL](#)

Q20. What are the barriers and enablers to ensuring health care is tailored to the needs of women in all health care settings?

To ensure healthcare is tailored to the needs of women in all healthcare settings, it is important that gender is considered in the design of all services, health workforce gender capability is improved, and further investment is provided to build the evidence base regarding the needs of women in different health settings.

Consideration of women in service design:

It is critical to ensure that universal health services – not just targeted programs – effectively respond to the diverse needs and experiences of consumers, including being gender-responsive, culturally safe and trauma-informed. This is best achieved through the meaningful inclusion of diverse groups of women in the design of services. While it may be challenging to ensure all sub-populations are represented in co-design processes for mainstream services, there is little chance of this being achieved if it is dismissed from the outset; a representative co-design process must be the goal, even if it is sometimes imperfectly realised.

One of the most egregious examples for a lack of concern for women's safety is the lack of priority addressing the widely known high rates of sexual assault of women in mental health inpatient units. Women routinely report feeling unsafe when accessing mental health services and continue to experience unacceptably high rates of gendered and sexual violence within mental health facilities – both from other patients/consumers and from staff⁶². The Royal Commission into Victoria's Mental Health System noted that one of the reasons that 'meaningful change to keep women safe in inpatient units has not been achieved' is the false perception among staff that male-only areas would increase aggression⁶³, implying that women patients' safety is less important than that of staff.

Long overdue work is finally underway to upgrade new and existing mental health facilities to enable gender separation in Victoria following the recommendation of the Royal Commission into Victoria's Mental Health System⁶³. Safer Care Victoria is also leading an improvement project to adapt inpatient units' operating models to increase sexual safety. However, sexual violence in mental health facilities remains a significant problem in other jurisdictions around Australia, requiring a national response. Disappointingly, though the 2021 Productivity Commission's report on Mental Health recognised that no-one should have to face concerns about their safety during their stay in a mental health inpatient unit, rather than address this as an immediate priority they recommended that merely *considering* gender-separated wards in future design of acute inpatient wards was sufficient⁶³.

Health workforce capacity building

Capacity and capability-building of the health workforce is essential to achieving optimal healthcare for women and trans and gender diverse people. This requires both training of staff and addressing organisational structures and culture. Strategies to improve health workforce capacity should focus on:

⁶² Mental Health Coordinating Council (2018) Because mental health is everyone's business: MHCC Annual Report 2017/18. Mental Health Coordinating Council, Sydney. Available from: [URL](#)

⁶³ Royal Commission into Victoria's Mental Health System (2021) Final report, summary and recommendations. RCVMHS. Melbourne. Available from: [URL](#)

- **ensuring the health workforce is gender competent.** This means having the capacity to recognise gender-based discriminatory attitudes and behaviours; knowing about gender-based anti-discriminatory policies and initiatives; and implementing actions to counter gender-based stereotypes in research, training and clinical practice. Gender competence seeks to comprehend and address gendered experiences of discrimination, interpersonal violence and being devalued, and to counter internalised beliefs about roles, rights and responsibilities.⁶⁴ Gender competence should also incorporate cross-cultural awareness.
- **promoting system and cultural change to address entrenched attitudes and behaviours** - and fundamentally shifting the values and approach embedded in current health practices, which are based on a male model or standard.

Building the evidence base for women's health

To enable the provision of tailored care in all health settings, the evidence base for diagnosing and treating health conditions in women must be expanded. It is important that women-specific health conditions are investigated, and that sex and gender are incorporated into the design, analysis and translation of all relevant medical research. For more detail, please see our responses to Q1.

Additional evidence

Q21. If you would like to share any attachments, such as any research or evidence for the Council to be aware of, please attach. (List or include links for any relevant docs here).

The answers WHV have provided on mental health and research can be found cited in the following publications:

- Barr M, Anderson R, Morris S, Johnston-Ataata K (2023) [Towards a gendered understanding of women's experiences of mental health and the mental health system](#). Women's Health Victoria. Melbourne. (*Women's Health Issues Paper*; 17).
- Women's Health Victoria (2021) [Response to the Medical Research Future Fund Strategies and Priorities consultation](#). Women's Health Victoria. Melbourne
- Women's Mental Health Alliance (2021) [Women's Mental Health Alliance response to the Department of Health consultation on the recommendations from the Productivity Commission's Report on Mental Health](#). Women's Health Victoria. Melbourne
- Women's Mental Health Alliance (2021) [Response to the Victorian Mental Health and Wellbeing Workforce Forum Summary Report](#). Women's Health Victoria. Melbourne
- Women's Mental Health Alliance (2021) [Submission to Parliamentary Inquiry into Mental Health and Suicide Prevention](#). Women's Health Victoria. Melbourne.

⁶⁴ Fisher, J (2020) Gender competence and mental health promotion. *World Psychiatry* 19(1): 34-35. Available from: [URL](#)