Submission to the consultation for a new Women's Strategy in Queensland (Qld) with a focus on health equity for women in Qld.

This is a joint submission informed through consultation and supported by the following organisations:

- Women's Health Queensland Inc.
- Respect Inc.
- Sisters Inside Inc.
- Queensland Women's Health Network Inc.
- Women's Health Services Alliance Queensland
- True Relationships and Reproductive Health
- Maternity Consumer Network
- Children by Choice
- QENDO
- Micah Projects
- Friends of the Birth Centre
- Homebirth Queensland
- Maternity Choices Australia
- Lutheran Services
- Multicultural Australia
- Disability Queensland

For enquiries relating to this submission please contact Women's Health Queensland on 07 3216 0976 or admin@womenshealth.org.au

Contents

1.0 A Women's Health Strategy for Qld will provide a road map to achieving health equity across the State

1.1 Qld context and consultation

2.0 Increased health service access across Qld

3.0 Trauma-informed, culturally appropriate, and person-centred care model

4.0 Preventative health care and research

5.0 Health literacy and access to health information

6.0 Concluding statement

7.0 References

8.0 Appendix

Proposed Framework for a Qld women's health strategy

- Outcomes
- Indicators

1.0 A Women's Health Strategy for Qld will provide a road map to achieving health equity across the State

Qld has an opportunity to actively address and improve gender equality across all areas of society by new introducing strategies and policies that take a specific gendered and intersectional approach. The concept of gender mainstreaming has been integral in the creation of international policies and more recently Australian policies, including the *National Women's Health Strategy 2020-2030*. It is an important concept that acknowledges the social determinants which can affect the impact of policies on different populations.

The World Economic Forum's Global Gender Gap report for 2021 elucidates the progress where 96.8% of the gender gap in health and survival has been closed. [1] However, Australia ranks 99 among 156 countries in the health and survival index, reflecting 'the last mile' of progress for gender mainstreaming in the Australian health system. [1] This requires both federal and state attention.

The *United Nations Country Teams Performance Indicators for Gender Equality* has been adapted to develop a *Policy Scorecard* with rating of 1 (poor policy performance) to 5 (best policy performance). [2] Using this Policy Scorecard for gender mainstreaming, Qld received an average rating 1.75 across several Qld policies. [2] To achieve the top rating of 5, policy must go beyond minimum standards and gender mainstreaming should be clearly identified. The indicators include explicit reference to issues that are women specific, extensive gender analysis with reference to the determinants of gender differences, that policy is informed by relevant National women's policy, indicators/ outcome measures that are gender sensitive are identified, and there have been consultations with women's/ community organisations and NGOs. [2]

Concurrently with the introduction of a new Women's Strategy the Qld government should introduce a Women's Health Strategy. A strategy specifically addressing health for women in Qld would assist *Queensland Health* (*Qld Health*) to deliver on the outcomes from the *National Women's Health Strategy 2020-2030*. [3] Qld faces unique challenges in achieving health equity across the state including the large geographical area and comparatively high rural, regional, and remote populations. These challenges are additional to the inequity faced by women and other priority groups.

A strategy developed to improve health equity of women should consider all social determinants that may have an effect. These include:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict

- Access to affordable health services of decent quality. (WHO) [4]

1.1 Qld Context and Consultation

Identifying priority groups and disaggregating data specific to Qld is an important part of addressing social determinants and developing a women's health strategy.

Priority Groups in Qld include women living non-urban areas, Aboriginal and Torres Strait Islander women, women with socio economic disadvantage, culturally and linguistically diverse (CALD) women, women who belong to the LGBTIQA+ community, women living with disability (WWD), mothers and women impacted by the criminal justice system.

Consultation was conducted with a diversity of health specific women's organisations, researchers and NGOs to understand gaps faced by women in Queensland and how to address these in a women's health strategy.

The key gaps and priority areas for women in Queensland identified through consultation are:

- **Access to appropriate health care, particularly in regional, rural and remote Qld including**
  - Consistency and continuity of services,
  - sexual and reproductive health,
  - maternity, and abortion care,
  - mental health care,
  - appropriate (culturally, trauma-informed, women-led) services for all women of all ages,
  - improved health care access for women experiencing socio-economic disadvantage and homelessness, and
  - improved health care access for women in prisons.
- **Trauma-informed and person-centred care across all health services including**
  - state-wide requirements of health practitioners to provide trauma-informed care,
  - introducing trauma-informed person-centred care principles in higher education for all health qualifications,
  - embedding health practitioners within established safe spaces for women such as gendered violence/ women's services,
  - consistent training across Qld for health professionals in recognising and responding to gendered violence,
  - mechanisms for women to leave or transfer from a service that has created trauma,
  - bundled funding in maternity care,
  - confidential and trauma-informed care for women in prisons, and
  - an end mandatory testing for sex workers.

- **Person centred care across all health services including**
  - sexual and reproductive health care informed by consent,
  - life stages approach to care,
  - appropriate care informed by individual choice,
  - expansion of services to ensure choice of practitioner and type of health care is consistently available, and
  - increased maternity care options and birthing choices.
- **Culturally appropriate care across all health services including**
  - using interpreters and not relying on family members or partners,
  - respectful care informed by the individual, and
  - understanding diversity in cultural approaches to health and wellbeing.
- **Mental health care including**
  - increase in available services,
  - simplification of referral pathways,
  - reducing threshold for receiving mental health services,
  - mental health practitioners have a better understanding of the effects of gendered violence, and
  - increased follow-up and community outreach where safe to do so.
- **Prevention focussed care including**
  - preventative mental health care,
  - integration of services to improve holistic approaches, prevention and early detection,
  - increased research that takes an intersectional and gendered approach to prevention, and
  - improved awareness of chronic conditions faced by women including prevention and treatment,
  - continuity of midwifery carer in and out of hospital birthing, and
  - health promotion campaigns using a co-design model.
- **Health literacy including**
  - access to health information across variety of platforms and delivery methods,
  - central accessible and accurate health information sources relevant to Qld are available,
  - translation and co-design of health information,
  - community led and informed implementation plans to increase distribution and create appropriate campaigns for health information and care options,
  - outreach community health education programs led and informed by communities, and
  - appropriate health education across all year levels in Qld schools and tertiary programs.

In conclusion from consultation and with consideration of the *National Women's Health Strategy 2020-2030* there are five priorities that need to specifically be addressed in a Qld women's health strategy. These are:

- Increased health service access across Qld.
- Trauma-informed, culturally appropriate, and person-centred care models.
- Supporting health care focussed on prevention.
- Improving health literacy and access to health information.
- Increasing state-based gender specific research and disaggregated data, which will inform and sit under each of the forementioned areas.

2.0 Increased health service access across Qld

A woman may face many intersecting barriers in accessing health care in Qld. These include geographic barriers (e.g. distance to nearest clinic or hospital) [5], economic hurdles (e.g. high out-of-pocket spending), [6,7] inability to access Medicare or MBS rebates [8,9], available services being inappropriate for patient's needs, [10] long waitlists [11] preventing practical and timely care and/ or unclear referral pathways. [12,13] This burden is not shared equally amongst Qld women, whereby women living in non-urban areas and Aboriginal and Torres Strait Islander women disproportionately face hurdles when accessing health service. [10,14]

In 2016-2018, 60.3% of Aboriginal and Torres Strait Islander women in Qld who were pregnant did not attend antenatal care within the first 10 weeks, higher than the national average for Aboriginal and Torres Strait Islander women (55.3%), showing deficits in Qld service access and appropriateness compared to other states as highlighted by the *Growing Deadly Families Strategy.* [15,16] Mental health service access in Qld is another focus area. There is a lack of access to, and high burden on, public and community mental health care services. The lack of continuity in care, and more specifically midwifery carer models, in publicly provided antenatal, birthing, and postnatal services is also leading to increased intervention without clinical indication as well as isolation in a high-risk period for women and increased rates of trauma and postnatal depression. [17] These risks are most felt by non-urban women and other vulnerable groups. [17] COVID-19 has meant certain services were either reduced, ceased or switched to telehealth; the impact being more emphasised in areas of women's health, such as maternity services. [18-21] Interruptions to these important services may exacerbate existing gaps in access for women, resulting for example in increased rate of obstetric violence [22] and inappropriate care. Delays in access to health services can result in later detection and poorer prognosis, resulting in less favourable health outcomes for these groups and an increased burden on the health system. [20,23,24] These shortcomings to health access in Qld are a structural issue which could best be addressed through the implementation of Qld women's health strategy.

It is important that Qld takes steps to ensure consistent and holistic services are provided across the state with a gendered and intersectional approach. These solutions can include up-skilling current health professionals and services to offer more comprehensive range of maternity

services, [25] supporting greater diversity of and accessibility to available services (e.g. Level 2 maternity services, PFHB and community birthing options) [26] via funding and resources, ensuring all health and hospital services provide abortion services [12] and providing consistent infrastructure standards and requirements across Qld. A key component in improving health service access and increasing engagement is increased diversity of health staffing, continuity and choice of carer and including these priority groups of women in the development and design of local, women-led health services.[27] For example, a Qld women's health strategy could increase Aboriginal and Torres Strait Islander community led and informed strategies for increasing Aboriginal and Torres Strait Islander women's access to health services. [16] Community engagement, shared decision making and formal partnerships, incentives for recruitment and retention, as well as staffing which reflects the population it seeks to serve is particularly important when introducing new services for vulnerable and underserved communities, such as in non-urban areas or minority groups. [13,16,27] For example, the introduction of voluntary, free and confidential STI and HIV testing for all sex workers, regardless of Medicare eligibility would address poor health services experienced by this community in Qld.

Funding and resources should be allocated to encourage place-based care models, regular outreach clinical programmes, embedding of practitioners in existing community-based services, increasing availability of sexual and reproductive health services (especially for younger women), and better coordination and options for women who face physical [28] or geographic barriers to access. Investing in community mental health care services with and/or without referrals, addressing the unique mental health needs of women at different life stages, better incorporating telehealth, and routine mental health screening in all clinical setting, improving continuity of inpatient and outpatient mental health care by midwifes during antenatal, birth and the postnatal period, and increased treatment options may also help redress mental health care access issues. [9,29]

3.0 Trauma-informed, culturally appropriate, and person-centred care model (TICAPCC)

Care that is appropriate and serves the diversity of women in Qld is imperative to an equitable and fair health system. Women in Qld have a diversity of cultural values, experiences and backgrounds which shape their unique needs when accessing health care. [27] Care which lacks cultural competence and fails to engage with the ubiquity of trauma including systemic coercion can foster stigma and discrimination for women when accessing health as well as result in omissions and oversights in care. [27,30] Inappropriate and insensitive care can in turn result in poorer treatment and health outcomes for already vulnerable women, further exaggerating these existing inequalities. [31,32]

Aboriginal and Torres Strait Islander women, CALD, WWD, LGBTIQA+, sex workers, domestic and sexual violence survivors are groups of people who may disproportionately experience these deficits in care due to their vulnerability and exposure to systemic and personal traumas. While appropriate and sensitive care must be implemented for these groups across health services, each group may have sectors/areas of health where these issues with care may be especially overemphasized and thus must require unique attention in a women's health strategy. An example of this can be seen in the stigma and discrimination WWD can encounter in sexual and reproductive health, where their needs are understated and overlooked by health professionals, which can be detrimental to their outcomes in these areas of health. [28,33] Understanding and respecting an individual's cultural values and linguistic background, as well as recognizing the unique experiences of trauma each person

may have faced can help prevent miscommunication, better align treatment with patients' needs, foster informed consent, build patient-physician rapport, improve patient engagement and treatment adherence, and foster better health services. [34, 35]

Inclusion of a trauma-informed [30,36], culturally appropriate, [13, 37] and person-centred [38] model of care within a Qld women's health strategy, can help integrate this model of care into practice to help Queensland strive towards equity where all Qld women receive effective, quality treatment. The national Maternity strategy, *Woman-Centred Care: Strategic directions for Australian maternity services* [38] was tabled and signed off at COAG in 2019 by Qld so we strongly recommend Qld should implement it in full. TICAPCC would significantly decrease instances of obstetric violence. Women-led and designed services, prioritization of informed care, improved interpreter access, consistent and ongoing cultural and trauma competency training for health staffing and capacity building program can help implement this mode of care. [13,27,37, 40] Additionally, community led health services and organizations, which engage and have partnerships with leaders and individuals in vulnerable communities and groups, may help redress these issues with health care experiences. [40]

Trauma-informed and sensitive care that utilises a gendered lens is a key priority of the *National Women's Health Strategy 2020-2030*, which recommends systemic capacity building and professional development across the health sector in TICAPCC. The National health strategy recommends a shift away from a purely medical model towards a more holistic person-centred model of care that embeds consideration of psychosocial factors. It also recommends that services engage in re-design to reduce or remove systemic barriers for women and girls and increase access to appropriate health care. Qld can engage women, particularly from priority populations, in the re-design of health services to ensure they best meet the needs of the populations they serve. Women with diverse experiences and needs should also inform a state-wide training rollout to ensure that every individual working in the health system is trained and skilled in the delivery of trauma-informed and sensitive, and person-centred care that is culturally appropriate and utilises a gendered lens. For example, health staff should complete sex worker sensitivity training to address privacy and confidentiality gaps sex workers experience. Ensuring Qld Health services are designed collaboratively with women and require all staff to employ TICAPCC will create positive health outcomes for women, decreasing health system costs through increased prevention and early intervention.

4.0 Preventive health care and research

Preventive health can be categorized into three levels of prevention: primary (I.e., intervening before onset of health issue), secondary (I.e., early intervention) and tertiary (I.e., reducing impact of disease). Women from more vulnerable communities or priority groups often have poorer outcomes of health, alongside the social gradient of health. [41] They are both exposed to greater risk factors for poor health and are more likely to receive poorer health care for several reasons (e.g. access issues, poor health literacy, inappropriate or insensitive care). [41] These women, who may benefit most from preventive health, are often overlooked, or missed by current preventive health initiatives or care.

[42, 43] The need for a Qld women's health strategy addressing preventive health is further emphasised through the cost-effectiveness of preventive health care, particularly at the primary and secondary levels. [44]

Targets areas in preventive health for women cover all aspects of chronic disease management, including an awareness of chronic conditions faced by women (e.g. endometriosis and PCOS), participation in screening programs (e.g. breast and cervical cancer screening, STIs, etc), continuity of integrated care and services (e.g. screening and treatment of mental health in antenatal and postnatal care), [45] and awareness and prioritization of preventative mental health services/sector. Accessible and accurate sources of health information relevant to Qld, which foster both cultural and digital inclusion, are integral to encouraging engagement with preventive health, especially considering current gaps in participation with prevention scheme by priority groups. [46-48] Addressing these targets through a Qld women's health strategy could assist in achieving the goals of the prospective national Preventive Health Strategy to be launched in mid-2021. [49, 50] Many aspects of improving and prioritizing preventive care in Qld intersect with the other three key areas for the Queensland women's health strategy, reflecting the interdependency and importance of each area.

Research is a key area which informs preventive health and service delivery. Evidence-based care is the foundation of an effective, functional health system, thus the gap between research and practice must be prioritized by a Qld women's health strategy. Currently, the lack of disaggregated and/or up-to-date data on women in Qld, particularly those who belonging to certain priority groups, inhibits the ability for research to inform health priorities and goals for Qld women, such as policy, funding, and resource allocation. [42] Redressing these gaps within the data, through focusing research as a priority in a Qld women's health strategy can help coordinate a state-wide approach towards filling these gaps in research.

5.0 Health literacy and access to health information

Health literacy describes the way in which individuals' access, understand and use health information. [51] Many factors can affect health literacy including age, gender, socioeconomic background, employment, nationality, and health status. [52] Qld women may find themselves experiencing an intersection of many socio-cultural factors which shape their health literacy. [52] This may be especially true as women navigate women's health in a health care system and health policy environment which can often fail to integrate gender equity and adopt gender mainstreaming into goals and structural change [48,53,54] For example, structural change such as the decriminalisation of sex work is associated with improved access to health information. [55] Low health literacy leaves individuals at increased risk of poorer health outcomes and health behaviours affecting a range of areas such as health service engagement, health care system navigation, hospital readmission, treatment adherence and medication use. [51, 56-58] High levels of health literacy however have protective effects, helping to foster patient-centred care, thereby promoting better healthcare and more favourable health outcomes.[59]

The largest issues identified from the *2018 Health Literacy Survey* were that Australians found it difficult to appraise health information (17.3%), navigate health system (14.3%), find good information (12.4%) and engage with health care providers (11.5%). [51] Australia has taken a national approach to tackling health literacy, however women, and more specifically women in Qld, may face unique barriers and challenges in terms of health literacy. [51, 60] Health literacy forms a key area of improvement for a prospective Qld women's health strategy, requiring coordinated action by both state- and local- governments and organisations to adequately address the needs of Qld women.

Priority groups across Qld, including Aboriginal and Torres Strait Islander women [51,60-62], CALD women [13,48,51,63] and women with disability, [64] experience compounding and intersecting risk factors which result in lower health literacy. A similar discrepancy in health literacy is found in non-urban groups. [65] These gaps may be particularly evident in sexual, [66] reproductive and mental health as well as maternity care[i]. Accordingly, these groups require particular focus and attention when considering health literacy in Qld.

Funding and support for current organisations and initiatives should be expanded to broaden their reach and accessibility for the communities and groups of women they seek to serve. [66,68] Nurse, midwife and community led care which prioritises informed care may help to restore autonomy to individuals with low health literacy, providing them with accessible and sensitive sources for information and helping them navigate their healthcare. [68]

Other solutions lie in continuous and increased training for staff, particularly for health staff in disciplines where women typically show low levels of health literacy, to help improve the health literacy environment and embed these solutions within the health system itself. [13,70] Training should recognise the unique challenges to health literacy across diverse priority groups and ensure practice standards reflect the *Human Rights Acts 2019 (Qld)* to its upmost potential. Incentivized professional development for practitioners and health staff may be a feasible way to address this solution. [13, 61]

Both in-person and online pathways, programs and resources to health information should be available and delivered in multiple languages, set-up in a clear, coordinated, and seamless manner to avoid confusion. [61, 70, 71] Additionally, a coordinated, official, and authoritative source of online Qld health information across disciplines may also offer the ability to redress these issues in health literacy in Qld. These resources must be advertised and promoted in spaces with high exposure to priority groups of women and complemented with program that facilitate digital literacy and digital inclusion.

6.0 Concluding statement

It is recommended that the Qld government introduces a women's health strategy for Qld to advance health equity across the state and commits to delivering on all actions established under the *National Women's Health Strategy 2020-2030*. Qld faces unique challenges with a diverse population spread across a large geographical area. The strategy must be informed by the communities it serves, address women's

needs, increase health care access and achieve good health for the diversity of women across Qld. It is also integral that the strategy contains measures that can be used to clearly evaluate success. Consultation has identified five priority areas that must be included in a Qld women's health strategy using a gendered and intersectional approach. These are:

- Increased health service access across Qld.
- Trauma-informed, culturally appropriate, and person-centred care models.
- Supporting health care focussed on prevention.
- Improving health literacy and access to health information.
- Increasing state-based gender specific research and disaggregated data, which will inform and sit under each of the forementioned areas.

The signatories to this submission welcome the opportunity to work collaboratively with the Qld government to ensure the best possible outcomes for women's health and wellbeing is achieved in Qld.

7.0 References:

1. World Economic Forum. Global Gender Gap Report 2021 INSIGHT REPORT [Internet]. Geneva; 2021 p. World Economic Forum. Available from: https://www3.weforum.org/docs/WEF_GGGR_2021.pdf
2. Keleher H. Policy scorecard for gender mainstreaming: gender equity in health policy. Australian and New Zealand Journal of Public Health. 2013;37(2):111-117.
3. Department of Health. National Women's Health Strategy 2020-2030. Canberra: Australian Government; 2019.
4. World Health Organisation. Social determinants of health [Internet]. Who.int. 2021 [cited 7 October 2021]. Available from: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3
5. Tennett D, Kearney L, Kynn M. Access and outcomes of general practitioner obstetrician (rural generalist)-supported birthing units in Queensland. Australian Journal of Rural Health. 2020;28(1):42-50.
6. Callander E, Fenwick J, Donnellan-Fernandez R, Toohill J, Creedy D, Gamble J et al. Cost of maternity care to public hospitals: a first 1000-days perspective from Queensland. Australian Health Review. 2019;.
7. Australian Institute of Health and Welfare. People with disability in Australia. Canberra: Australian Government; 2020.
8. Spike E, Smith M, Harris M. Access to primary health care services by community-based asylum seekers. Medical Journal of Australia. 2011;195(4):188-191.
9. Loxton D, Townsend N. Mental Health Policy Brief. Australian Longitudinal Study on Women's Health; 2019.
10. Mengesha Z, Perz J, Dune T, Ussher J. Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives. PLOS ONE. 2017;12(7):e0181421.

11. Queensland Government. Queensland Reporting Hospitals Specialist Outpatient Hospital Performance. Queensland Government; 2021.
12. Cashman C, Downing S, Russell D. Women’s experiences of accessing a medical termination of pregnancy through a Queensland regional sexual health service: a qualitative study. Sexual Health. 2021;18(3):232.
13. Komaric N, Bedford S, van Driel M. Two sides of the coin: patient and provider perceptions of health care delivery to patients from culturally and linguistically diverse backgrounds. BMC Health Services Research. 2012;12(1).
14. Hennegan J, Kruske S, Redshaw M. Remote access and care: A comparison of Queensland women's maternity care experience according to area of residence. Women and Birth. 2014;27(4):281-291.
15. PHIDU Torrens University Australia. DATA ARCHIVE: ABORIGINAL & TORRES STRAIT ISLANDER ATLASES OF AUSTRALIA [Internet]. PHIDU Torrens University Australia. 2021 [cited 7 October 2021]. Available from: https://phidu.torrens.edu.au/social-health-atlases/data-archive/data-archive-aboriginal-atlases-of-australia#aboriginal-torres-strait-islander-social-health-atlas-of-australia-data-released-january-february-june-and-august-2020
16. Queensland Health. Growing Deadly Families: Aboriginal and Torres Strait Islander Maternity Services Strategy 2019 - 2025. State of Queensland (Queensland Health); 2019.
17. Donnellan-Fernandez R, Creedy D, Callander E, Gamble J, Toohill J. Differential access to continuity of midwifery care in Queensland, Australia. Australian Health Review. 2021;45(1):28.
18. Sutherland K, Chessman J, Zhao J, Sara G, Went A, Dyson S et al. Impact of COVID-19 on healthcare activity in NSW, Australia. Public Health Research & Practice. 2020;30(4).
19. University of Queensland, University of Newcastle. Annual Report 2020. Australian Longitudinal Study on Women's Health; 2019.
20. White J, Cavenagh D, Byles J, Mishra G, Tooth L, Loxton D. The experience of delayed health care access during the COVID 19 pandemic in Australian women: A mixed methods exploration. Health & Social Care in the Community. 2021;.
21. Wilson A, Sweet L, Vasilevski V, Hauck Y, Wynter K, Kuliukas L et al. Australian women's experiences of receiving maternity care during the COVID-19 pandemic: A cross-sectional national survey. Birth. 2021;.
22. Sadler M, Leiva G, Olza I. COVID-19 as a risk factor for obstetric violence. Sexual and Reproductive Health Matters. 2020;28(1):1785379.
23. Kraft A, Quimbo S, Solon O, Shimkhada R, Florentino J, Peabody J. The Health and Cost Impact of Care Delay and the Experimental Impact of Insurance on Reducing Delays. The Journal of Pediatrics. 2009;155(2):281-285.e1.
24. Huang Q, Thind A, Dreyer J, Zaric G. The impact of delays to admission from the emergency department on inpatient outcomes. BMC Emergency Medicine. 2010;10(1).
25. Longman J, Pilcher J, Donoghue D, Rolfe M, Kildea S, Kruske S et al. Identifying maternity services in public hospitals in rural and remote Australia. 2021.
26. Callander E, Bull C, McInnes R, Toohill J. The opportunity costs of birth in Australia: Hospital resource savings for a post–COVID-19 era. Birth. 2021;48(2):274-282.

27. Mander S, Miller Y. Perceived Safety, Quality and Cultural Competency of Maternity Care for Culturally and Linguistically Diverse Women in Queensland. Journal of Racial and Ethnic Health Disparities. 2015;3(1):83-98.
28. Women With Disabilities Australia (WWDA). Brief Submission to the Special Rapporteur on the Rights of Persons with Disabilities on the Right of Persons with Disabilities to the Highest Attainable Standard of Health. Hobart: WWDA; 2018.
29. Ayres A, Chen R, Mackle T, Ballard E, Patterson S, Bruxner G et al. Engagement with perinatal mental health services: a cross-sectional questionnaire survey. BMC Pregnancy and Childbirth. 2019;19(1).
30. Berliner L, Kolko D. Trauma Informed Care. Child Maltreatment. 2016;21(2):168-172.
31. Henry B, Houston S, Mooney G. Institutional racism in Australian healthcare: a plea for decency. Medical Journal of Australia. 2004;180(10):517-520.
32. Ziersch A, Gallaher G, Baum F, Bentley M. Responding to racism: Insights on how racism can damage health from an urban study of Australian Aboriginal people. Social Science & Medicine. 2011;73(7):1045-1053.
33. Women with Disabilities Victoria. Access to Health Services for Women with Disabilities. Melbourne: WDV;.
34. Laverty M, McDermott D, Calma T. Embedding cultural safety in Australia's main health care standards. Medical Journal of Australia. 2017;207(1):15-16.
35. Wallin Lundell I, Eulau L, Bjarneby F, Westerbotn M. Women's experiences with healthcare professionals after suffering from gender-based violence: An interview study. Journal of Clinical Nursing. 2018;27(5-6):949-957.
36. Jankowski M, Schifferdecker K, Butcher R, Foster-Johnson L, Barnett E. Effectiveness of a Trauma-Informed Care Initiative in a State Child Welfare System: A Randomized Study. Child Maltreatment. 2018;24(1):86-97.
37. Liaw S, Lau P, Pyett P, Furler J, Burchill M, Rowley K et al. Successful chronic disease care for Aboriginal Australians requires cultural competence. Australian and New Zealand Journal of Public Health. 2011;35(3):238-248.
38. COAG Health Council. Woman Centred: Strategic directions for Australian maternity services. Department of Health, 2019. Available from https://www.health.gov.au/resources/publications/woman-centred-care-strategic-directions-for-australian-maternity-services
39. Pirhonen L, Olofsson E, Fors A, Ekman I, Bolin K. Effects of person-centred care on health outcomes—A randomized controlled trial in patients with acute coronary syndrome. Health Policy. 2017;121(2):169-179.
40. Women's Health West. The health inequities of Australian Aboriginal and Torres Strait Islander women and girls: A review of the literature. Melbourne: Women's Health West; 2017.
41. Australian Institute of Health and Welfare. 4.1 Social Determinants of Health. Canberra: Australian Government; 2016.
42. World Wellness Group. Multicultural health inequity [Internet]. Brisbane: WWG; 2020. Available from: https://worldwellnessgroup.org.au/wp-content/uploads/2020/07/World-Wellness-Group-Multicultural-Health-Inequity.pdf
43. Dasgupta P, Aitken J, Condon J, Garvey G, Whop L, DeBats C et al. Spatial and temporal variations in cervical cancer screening participation among indigenous and non-indigenous women, Queensland, Australia, 2008–2017. Cancer Epidemiology. 2020;69:101849.

44. Vos T, Carter R, Barendregt J, Mihalopoulos C, Veerman JL, Magnus A et al. Assessing Cost-Effectiveness in Prevention (ACE–Prevention): Final Report. University of Queensland, Brisbane and Deakin University, Melbourne; 2010
45. Townsend N, Chan H, Chojenta C, Schoenaker D, D'Arcy E, Reilly N et al. Pregnancy and Maternal Health Policy Brief. Australian Longitudinal Study on Women's Health; 2019.
46. Whop L, Garvey G, Baade P, Cunningham J, Lokuge K, Brotherton J et al. The first comprehensive report on Indigenous Australian women's inequalities in cervical screening: A retrospective registry cohort study in Queensland, Australia (2000-2011). Cancer. 2016;122(10):1560-1569.
47. Nagendiram A, Bougher H, Banks J, Hall L, Heal C. Australian women's self-perceived barriers to participation in cervical cancer screening: A systematic review. Health Promotion Journal of Australia. 2019;31(3):343-353.
48. Tapia K, Garvey G, McEntee M, Rickard M, Lydiard L, Brennan P. Breast screening attendance of Aboriginal and Torres Strait Islander women in the Northern Territory of Australia. Australian and New Zealand Journal of Public Health. 2019;.
49. Department of Health. Draft National Preventive Health Strategy - Australian Government Department of Health - Citizen Space [Internet]. Consultations.health.gov.au. 2021 [cited 7 October 2021]. Available from: https://consultations.health.gov.au/national-preventive-health-taskforce/draft-national-preventive-health-strategy/
50. Department of Health. National Preventive Health Strategy. Canberra: Australian Government; 2021.
51. Australian Institute of Health and Welfare. Health literacy - Australian Institute of Health and Welfare [Internet]. Australian Government. 2020 [cited 7 October 2021]. Available from: https://www.aihw.gov.au/reports/australias-health/health-literacy
52. Migrant and Refugee Women's Health Partnership. Enhancing health literacy strategies in the settlement of migrant and refugee women. Canberra: Migrant and Refugee Women's Health Partnership; 2018.
53. Doran F, Hornibrook J. Barriers around access to abortion experienced by rural women in New South Wales, Australia. Rural and Remote Health. 2016;.
54. Australian Medical Association. Women's Health - 2014 [Internet]. 2021. Available from: https://www.ama.com.au/position-statement/womens-health-2014
55. Stardust Z, Treloar C, Cama E and Kim J (2021) 'I wouldn't call the cops if I was being bashed to death': Sex work, whore stigma and the criminal legal system. International Journal for Crime, Justice and Social Democracy. Advance online publication. Available from https://www.crimejusticejournal.com/article/view/1894
56. Berkman N, Sheridan S, Donahue K, Halpern D, Crotty K. Low Health Literacy and Health Outcomes: An Updated Systematic Review. Annals of Internal Medicine. 2011;155(2):97.
57. Jayasinghe U, Harris M, Parker S, Litt J, van Driel M, Mazza D et al. The impact of health literacy and life style risk factors on health-related quality of life of Australian patients. Health and Quality of Life Outcomes. 2016;14(1).
58. Miller T. Health literacy and adherence to medical treatment in chronic and acute illness: A meta-analysis. Patient Education and Counseling. 2016;99(7):1079-1086.

59. Moreira L. Health literacy for people-centred care: Where do OECD countries stand?. Paris: OECD Publishing; 2018.
60. Choudhry F, Ming L, Munawar K, Zaidi S, Patel R, Khan T et al. Health Literacy Studies Conducted in Australia: A Scoping Review. International Journal of Environmental Research and Public Health. 2019;16(7):1112.
61. Rheault H, Coyer F, Jones L, Bonner A. Health literacy in Indigenous people with chronic disease living in remote Australia. BMC Health Services Research. 2019;19(1).
62. Vass A, Mitchell A, Dhurrkay Y. Health literacy and Australian Indigenous peoples: an analysis of the role of language and worldview. Health Promotion Journal of Australia. 2011;22(1):33-37.
63. Rogers C, Earnest J. A Cross-Generational Study of Contraception and Reproductive Health Among Sudanese and Eritrean Women in Brisbane, Australia. Health Care for Women International. 2013;35(3):334-356.
64. Matin B, Williamson H, Karyani A, Rezaei S, Soofi M, Soltani S. Barriers in access to healthcare for women with disabilities: a systematic review in qualitative studies. BMC Women's Health. 2021;21(1).
65. Bartlett H, Travers C, Cartwright C, Smith N, Bartlett H, Travers C et al. Mental Health Literacy in Rural Queensland: Results of a Community Survey. Australian & New Zealand Journal of Psychiatry. 2006;40(9):783-789.
    Mishra, G
66. Chan H, Mishra G. Sexual Health Policy Brief. Australian Longitudinal Study on Women's Health; 2019. https://alswh.org.au/wp-content/uploads/2020/02/2019_Major-Report_Sexual-Health-Policy-Brief.pdf
67. Metro North Hospital and Health Service. Culturally and Linguistically Diverse Community Data – Metro North Hospital and Health Service. State of Queensland (Metro North Hospital and Health Service); 2018.
68. Randall S, Crawford T, Currie J, River J, Betihavas V. Impact of community based nurse-led clinics on patient outcomes, patient satisfaction, patient access and cost effectiveness: A systematic review. International Journal of Nursing Studies. 2017;73:24-33.
69. National Association of People with HIV Australia. HIV Health Literacy Framework Project Health Care Provider’s Consultation in Cairns QLD on 23 August 2019. NAPWHA; 2019.
70. Cullerton K, Gallegos D, Ashley E, Do H, Voloschenko A, Fleming M et al. Cancer screening education: can it change knowledge and attitudes among culturally and linguistically diverse communities in Queensland, Australia. Health Promotion Journal of Australia. 2016;27(2):140-147.
71. Ireland S, Maypilama E. “We are sacred”: An intercultural and multilingual approach to understanding reproductive health literacy for Yolŋu girls and women in remote Northern Australia. Health Promotion Journal of Australia. 2021;32(S1):192-202.

8.0 Appendix

The following is a proposed model framework for a Qld Women's Health Strategy developed through consultation and informed by available current QLD Health data, relevant data from the *Australian Longitudinal Study on Women's Health*, the *National Women's Health Strategy 2020-2030*, other current national health strategies and consultation with a wide variety of organisations and services.

	Prevention, Health Promotion and Literacy	**Health Care Access**	**Service Delivery**	**Capacity Building**	**Research and Evaluation**
			OUTCOMES		
Priority Groups	*Accessible, authoritative sources of health information relevant to Qld.*	*Non-urban areas (rural/remote, very remote)*	*Trauma informed culturally appropriate care*	*Resourcing for women's health needs*	*Bridging gap between research and practice*
Aboriginal and Torres Strait Islander Women	**1.** Aboriginal and Torres Strait Islander women design, are aware of and engage in available organisation, programmes, resources, and groups focused on Aboriginal and Torres Strait Islander women's health and wellbeing promotion.	**1.** Aboriginal and Torres Strait Islander women have equitable access to health clinics.	**1.** Aboriginal and Torres Strait Islander women are provided culturally sensitive care, informed consent, greater choice, and integration of holistic services. 2. Aboriginal and Torres Strait Islander women control and own health services.	**1.** All Staff are trained to deliver culturally appropriate trauma informed care.	**1.** Aboriginal and Torres Strait Islander women lead and control research. **2.** Ensure Aboriginal and Torres Strait Islander Data Governance and Sovereignty.
Culturally and Linguistically Diverse Women	**1.** CALD women hold attitudes and beliefs that challenge mental, sexual and reproductive health stigmas, **2.** CALD women seek help and actively engage in available organisation and programmes **3.** CALD women are aware of gendered violence, reject gender inequality and have access to gendered violence prevention services for CALD women.	**1.** CALD women have equitable access to medical care and choice of female GPs.	**1.** CALD women, specifically refugee and asylum seekers, experience ongoing culturally appropriate evidence-based care, informed consent, and trauma-informed care. 2. Co-design of health services.	**1.** Health staffing is diverse and female GPs are well-supported.	**1.** Current and up-to-date research related to CALD women's health and engagement/access to services is available
Women with disabilities	**1.** WWD have access to WWD inclusive community-based services and programmes	**1.** WWD have equal access to medical care	**1.** WWD experience fair, disability appropriate care, informed consent,	**1.** All staff are trained in care for WWD and are educated and aware of appropriate care.	**1.** Rigorous and current research is available regarding WWD health outcomes, and is

	2. WWD are health literate, particularly with sexual and reproductive health		and discrimination free medical care, especially when accessing reproductive and sexual health services. 2. Co-design of health services.		applicable to practice, especially maternal care, and sexual health.
Mental Health	**1.** QLD women hold attitudes and belief that reject and challenge stigmas around mental health and encourage women to seek help. **2.** QLD women engage in a range of lifestyle and preventative strategies for mental health.	**1.** Women across Queensland have equitable access to high quality women's mental health care facilities.	**1.** QLD health system provides women with seamless and compassionate mental health care across health disciplines. **2.** Mental health programs are embedded within community led women's health organisations. **3.** Continuity of care is provided through hospital mental health services.	**1.** Staff are supported and linked between mental health and other health discipline and are trained to deliver culturally appropriate trauma informed care. **2.** Mental health practitioners are trained in understanding the impacts of gendered violence on mental health.	**1.** Research specific to women's mental health is available and existing hospital system programmes for women's mental health are rigorously evaluated.
Sexual and Reproductive Health	**1.** QLD women reject and challenge myths and stigmas around reproductive and sexual health, particularly regarding contraceptive options and reproductive disease.	**1.** All QLD women have equitable access to sexual and reproductive health clinics and allied health services. 2. All QLD women can access abortion services in their local area.	**1.** Women have access to informed and patient centred care in sexual and reproductive health in QLD.	**1. S**taff are trained to provide stigma-free trauma-informed care that preserves patient autonomy.	**1.** Rigorous research is available regarding women's health allied health practices and interventions, and research specific to reproductive health and female sexual health.
Maternity Care	**1.** QLD women are health literate in maternity care options, including antenatal, perinatal and postnatal physical and mental health. **2.** Community led, and midwife supported maternal health and	**1.** All QLD women have equitable and quality access to maternity care and birthing units **2.** Increase birthing choices.	**1.** QLD women encountering the health system receive care that prioritises informed consent, and have access to perinatal and	**1.** Staff are adequately trained in mental health and provided support to facilitate follow-up. 2. All staff are trained in trauma-informed person-centred using a best practice approach to informed consent.	**1.** Research regarding mental health and maternity care is up-to-date and rigorous **2.** Woman-informed data is used to inform quality improvement in maternity care.

	maternity information programmes are provided state-wide.		post-partum follow-up system **2.** Ensure hospital continuity of maternity care and carer.		
Gendered Violence	**1.** Queenslanders understand gendered violence and abuse, its characteristics and are aware of respective services and programmes. **2.** Queenslanders reject and challenge attitudes and behaviours that enable gendered violence.	**1.** All QLD women have access to health services, particularly primary and women's health clinics. **2.** Increase in outreach clinics for women in safe spaces.	**1.** Women encounter appropriate trauma informed primary care which prioritises informed consent **2**. Embedded gendered violence practitioners in health settings e.g. social workers and counsellors with sector experience. **3.** Embedded health practitioners in safe spaces with trauma-informed practice.	**1.** All staff are trauma aware and sensitive and have a healing centred focus. **2.** All staff can recognise and respond to gendered violence; including support for children.	**1.** Research regarding gendered violence and interventions are thorough and accurate and incorporate the experience of the victim/survivor of violence.
Chronic Conditions	**1.** All QLD women understand the importance of lifestyle intervention for chronic conditions and implement these strategies. 2. Increased investment in prevention programs for priority populations.	**1.** All QLD women have equitable access to screening services and health services.	**1.** QLD women receive fair and equal access to health services, are able to navigate the health system seamlessly, and are actively engaged with informed consent.	**1.** Health practitioners provide trauma-informed, culturally sensitive care and are linked across health disciplines. 2. Health practitioners are skilled in recognising the ways in which chronic disease may manifest differently between genders, and recommending gender specific prevention and treatment options.	**1.** Research into chronic conditions which disproportionately affect women (e.g. Endometriosis, arthritis, autoimmune conditions, dementia, etc) is up-to-date, rigorous and adopted into practice
Life Stages - Girls and young women, Older Women	**1.** QLD women across the life stage are health literate and engage with the appropriate services and programmes for their life stage. **2.** Queenslanders across the life stage hold attitudes and beliefs that challenge gender inequality in health and dispel myths	**1.** All QLD women have equitable access to sexual and reproductive health clinics. **2.** Older women's autonomy is preserved for longer.	**1.** All QLD women encounter evidence-based practice and services which prioritise choice of practitioner, informed consent, and autonomy/ choice	**1.** Staff are trained in the unique health challenges facing women across life stage. **2.** Staff in aged care services and facilities are trained to provide trauma-informed and person-centred care appropriate to women in later stages of life.	**1.** Research into unique health challenges across life stage is strong and applicable to practice. **2.** Research into the views, experiences and needs of women through the life stages is ongoing and used to continually inform practice, program and service design.

	surrounding sexual and reproductive health.		**2.** Consistent, accessible, and safe aged care services provided across the QLD. **3.** Young women can access services designed specifically to meet their needs.	**3.** Address and provide appropriate training to shift ageist attitudes in health services and our communities.	
Children's Health	**1.** Parents in QLD are aware of the available health services and preventative programmes for their children **2.** Incentives and support for reproductive and sexual health education included in schools state-wide. Programs should use whole of school approach and include sex positivity, gender diversity, diversity of sexuality, equality and respect.	**1.** All parents in QLD can access and coordinate services for their children. **2.** Mental health care access for children experiencing and witnessing gendered violence.	**1.** All parents in QLD and their children encounter health services seamlessly and with choice/autonomy.	**1.** Staff are trained to provide patient centred, trauma-informed care to children of QLD.	**1.** Research focussed on children's mental health used to increase and support access. **2.** Community led and informed research and data on the impacts of gender.

	Prevention, Health Promotion and Literacy	Health Care Access	Service Delivery	Capacity Building	Research and Evaluation
INDICATORS					
General	● Attitudes towards health ● Diversity of participants engaging in programmes, initiative and services provided by community organisations ● Number of available programmes and their distribution based on locality ● Diversity and no. of participants in preventative screening programmes ● Level of health literacy in women ● Positive experiences by participants in services ● Awareness of available health services for women ● Awareness of common health problems affecting women ● Reduction in no. Of preventable and avoidable deaths for women ● Decrease in DALY's for women ● Reduced prevalence of illness and disease ● Reduced risk factors ● Increased protective factors	● Diversity and number of patients in available services ● Distribution and no. Of health services ● Distance to nearest clinic (median distance across different subclasses of region e.g. rural, regional, urban) ● Equitable access to services ● Range of available women-led and women-focused services ● Wait times for patients ● Patient perception of accessibility of services	● Quality of patient experiences in services ● Patient engagement from follow-up systems Quality of patient-physician relationship ● Participation in screening ● Increase in evidence-based practice ● Increase in co-designed service models	● Structured referral pathways ● Increased sharing of information between disciplines ● Decreased wait times between primary care and specialist apt ● Diversity of choice of physicians ● Number of female practitioners ● Positive evaluation of training and support by health professionals ● Diversity of health professionals ● Diversity of team involves in service development ● Quality and continuity of training and programmes for health professionals ● Increased availability of screening ● Increased number of health staff trained in TICAPCC ● Increased number of health services using whole of organisation TICAPCC	● Disaggregation of research based on priority groups ● Inclusion of various priority group status options in data collection ● Diversity of female research participations ● Relevance and usefulness of available research for priority populations ● Quality of available research for priority groups and across key issues affecting women's health ● Availability of funding for various women's health research, particularly for priority groups ● Increase in research which informs practice

Aboriginal and Torres Strait Islander	● Increased Aborigin al and Torres Strait Islander women participation in organisation, programmes, resources, and groups ● Increased number of Aboriginal and Torres Strait Islander women-led women's health and wellbeing initiatives ● Distribution of Aboriginal and Torres Strait Islander women's health promotion and prevention programmes based on locality ● Increased support to and number of Aboriginal and Torres Strait Islander -led women's health specific promotion, literacy, and prevention initiatives ● Increased knowledge about chronic conditions such as PCOS and Endometriosis	● Decreased distance travelled to nearest health clinic ● Wait times ● Number Of locally led Aboriginal and Torres Strait Islander health clinics ● Number Of female practitioners ● Increased support for female GPs ● Aboriginal and Torres Strait Islander women's participation and use of health services ● Increased support to Aboriginal and Torres Strait Islander led clinics	● Aboriginal and Torres Strait Islander women's patient experiences ● Aboriginal and Torres Strait Islander women's participation and use of health services ● Quality of patient-physician relationship for Aboriginal and Torres Strait Islander women	● Diversity of service development teams and representation of Aboriginal and Torres Strait Islander women ● Number of female practitioners ● Continuity and quality of culturally sensitive training ● Attitudes and bias of health professionals towards Aboriginal and Torres Strait Islander women	● Availability of Aboriginal and Torres Strait Islander women's health research ● Disaggregation of Aboriginal and Torres Strait Islander women in current health research and data ● Increase in Aboriginal and Torres Strait Islander controlled and led research.
Culturally and linguistically diverse women	● Decrease in stigma and negative attitudes towards mental, sexual, and reproductive health in CALD women ● Increased participation of CALD women in mental, sexual, and reproductive health promotion, prevention, and health care services ● Improved level of health literacy surrounding	● Number Of female general practitioners ● Increased access to translators ● Wait times for translators ● Use of translators ● Increased technological literacy ● Increased diversity of	● Participation of CALD women In health care services ● Improved quality of patient-physician relationship for CALD women ● Improved experiences of CALD individuals in aged care	● No. Of female GPs ● Diversity of health professional ● Continuity and quality of culturally sensitive care ● Awareness in health professionals regarding the unique health challenges facing CALD women ● Increase staff training for the specific issues that may be unique to CALD women (e.g. Female genital mutilation) ● Increase culturally sensitive training in aged care	● Useful and current research regarding CALD women health outcomes, disease/illness prevalence, service use and, screening participation ● Useful and current research regarding trauma experience by CALD women ● Inclusion of CALD status in health data surveys and research ● Disaggregation of research for CALD women

	sexual, reproductive, and mental health ● Improved understanding of gendered violence in CALD women ● Decreased prevalence and incidence of gendered violence ● Increased participation of CALD women in gendered violence presentation services ● Increased knowledge about chronic conditions such as PCOS and Endometriosis ● Increased participation in cervical screening	translations in terms of language			
Women with a Disability	● Increased No. Of WWD inclusive community-based services and programmes ● Participation of WWD in health promotion and preventative services ● Level of health literacy regarding sexual and reproductive health in WWD	● Increased number of medical consulting rooms and health facilities that are accessible to WWD ● Increased WW D sexual and reproductive services use ● Decreased wait times and barrier to healthcare from home	● Positive experiences of WWD in health care ● Improved quality of patient-physician relationship for WWD ● WWD sexual and reproductive services use	● Attitudes of health professionals towards WWD ● Continuity and quality of WWD appropriate care training ● Clarity and applicability of guidelines and practice for care of WWD ● Better clinical guidelines and practice for care of WWD	● Useful and current research for recommended practice for treating WWD ● Inclusion of disability status in research and data collection
Mental Health	● Decrease in attitudes which perpetuate stigmas regarding mental health and create fear and shame around seeking help	● Prevalence of mental health ● Increased use and engagement of services	● Women's quality of patient experience in mental health care ● Women's engagement and use of mental health services	● Improved coordination between primary care and mental health services ● Increased mental health training for staff	● More funding for research in women's mental health ● Increase in available data and research about women's mental health

	• Use of mental health services in women • Number of mental health prevention initiatives and programmes • Prevalence and incidence of mental illness • Increased engagement in traditional and social media around women's mental health	• Routine screening for mental health in all clinical settings • Increased number of mental health care facilities for rural and remote areas	• Increase in funding and availability of local community mental health services	• Increased number of health staff from practitioners to allied health that can offer mental health services • Consistent provision of mental health training in primary and maternity care • Lower wait times between primary care to specialist appointment • Increased training around the unique challenges facing priority groups in mental health • Increased use and availability of community mental health services and mental health services provided without referral from GP • Reduction in misdiagnosis of trauma and the impacts of gendered violence as mental health disorders • Reduction of over-medication	
Sexual and Reproductive	• Improved attitudes towards sexual and reproductive health • Decrease in stigma surrounding STI's and contraception • Decrease in beliefs in myths and false information in sexual and mental health, particularly surrounding contraception, and reproductive disease • Increased in understanding of reproductive disease, contraception options and sexual health • Increased in no. Of educational campaigns and screening programmes specific to STI knowledge and prevention in young	• Increased no. Of sexual and reproductive health clinics in rural and remote areas • Increased engagement in sexual and reproductive health clinics by priority groups • Greater support for female GP's • Increased distribution of pregnancy termination services • Decrease in distance QLD women travelled to receive an abortion	• Improved patient experiences in accessing contraception • Increase in QLD women engaging in women-centred/women's health specialised allied health services • Increase in treatment option awareness women • More positive sex workers experiences when accessing care	• Better linkage between GP's and women's health allied health services • Increase in no. Of women-centred/women's health specialised allied health services • Additional training on contraceptive-specific GP consultation • Increased training for health professionals in terms of sexual workers and appropriate care	• Strengthened research into women's health allied health practices and interventions, and research specific to reproductive health and female sexual health

	women, and particularly queer women ● Increased presence of organisation and awareness campaigns regarding sexual and reproductive health in traditional and social media ● Increased engagement in traditional and social media around sexual and reproductive health ● Increased engagement of women-centred/women's health specialised allied health services				
Maternity Care	● Greater health advocacy around maternal health ● Increased awareness and understanding of health and care options, during and after pregnancy ● Decrease in attitudes which create stigma around seeking mental help before, during or after pregnancy ● Availability of a trusted, cohesive source of health information and resources for pregnant women	● Increased No. Of services available for rural and remote areas in terms of maternity care and birthing units ● Level of birthing units available to women in rural and remote areas ● Decreased distance travelled to nearest maternity care and birthing unit ● Increased depression and anxiety screening in antenatal, perinatal, and postnatal care	● Improved quality of experience by women seeking maternity care ● Increased engage ment with continuity in care by women in maternity care ● Increase in option awareness women ● Increase in mental health screening in women in maternity care	● Increased engagement with mental health services by women before, during and after pregnancy ● Increased use of mental health screening and treatment as part of antenatal, perinatal, and postnatal care ● Increased ability and use of follow-up systems/ continuity of care by staff ● Increased mental health training for maternity care staff ● Increased training for staff for culturally appropriate trauma informed care ● Increased training for the unique challenges in maternity care across priority groups	● Increased mental health and maternity care research ● Increased research into maternity health for priority groups ● More research into urinary incontinence postnatally
Gendered violence	● Increased awareness and knowledge	● Increased number of services available to rural and	● Quality of survivors of violence's	● Increased training/appropriate care/integrated systems for trauma and	● Strengthened research for best time for intervention for abuse

	about gendered violence and abuse ● Increased engagement with gendered violence prevention programmes ● Decreased stigma surrounding seeking help for domestic or family violence ● Increased use of strength-based approach in existing programmes ● Increased prevention programmes for gendered violence ● Increased rejection of gendered violence in traditional and social media, as well as by public figures	remote women, particularly primary care clinics ● Decreased distance for women travelling to nearest clinic ● Increased participation in health care	experiences in primary care ● Quality of relationships between practitioners and patients ● Reduced instances of re-traumatisation while accessing health services	gendered violence across health care with a specific focus in primary care ● Increased training across all health care services in recognising and responding to gendered violence; including supporting children ● Improved patient experience in primary care ● Improved quality of patient-physician experience ● Increased engagement with social workers, primary care and support workers by victims of gendered violence ● Decrease in distance and time to nearest trauma-informed GP	● Improved data collection methods ● Reduced underreporting of abuse and violence ● Better research regarding the mechanisms and pathways for early adversity to adult female experience of abuse
Chronic Conditions	● Increased partnerships between health care and community organisations ● DALY's of common chronic conditions in women	● Increased participation in breast and cervical screening services in remote and very remote areas ● Increased Aboriginal and Torres Strait Islander women's participation in cervical and breast cancer screening ● Incidence and prevalence of common chronic conditions in women ● Incidence and prevalence of common chronic conditions for women in rural vs urban areas	● Decreased wait times between referral from GP and specialist appointment ● Increase in treatment option awareness women	● Increased service linkage between primary care and specialist services for women ● Quality and continuity of patient physician relationships ● Lower wait times between primary care to specialist appointment ● Incidence and prevalence of common chronic conditions in women ● Increase in availability and no. Of nurse led clinics	● Improved research in chronic conditions which disproportionately face women ● Inclusion of endometriosis as a chronic illness in research and committees rather than only a reproductive illness

		● DALY's of common chronic conditions in women			
Life stages *Teens* *Menopause* *Older women*	● Increased use of intersectional and gender equity approach in awareness programmes ● Increased awareness of available health services in younger women ● Improved understanding of early menopause ● Increased awareness of services for menopause ● Increase no. Of wellbeing and health community services for older women ● Improved parent and child relationships	● Number of sexual and reproductive health clinics for young women, especially those in rural and remote women ● Distance and time travelled to nearest health clinic across life stages ● Increased number of community services in Retirement villages ● Increased number of home-based health services options	● Increase in time older women can preserve autonomy and independent living ● Improved patient-physician relationships across life stages ● Improved patient experiences in health system	● Increased linkage between primary care and mental health services ● Increased use of mental health services across life stages ● Use of services by adolescent young women ● Shift in ageist attitudes of health professionals, and others towards older women.	● Increased research into preserving autonomy for older women ● Increased research into adolescent women's health
Children's Health	● Increase in awareness and understanding in women of available services for their children ● Increase in consistent reproductive and sexual health education throughout QLD schools with understanding of sex positivity, gender diversity, diversity of sexuality, equality, and respect	● Wait times for children to see health practitioners and allied health professionals ● Increased service use of specialist and allied health services for children	● Positive experiences by women when seeking help for their children ● Increase in nurse-led clinics	● Decreased over-prescription of medication for children for mental health disorders.	• Increase in data to support children's mental health programmes both through hospital system and community services