Government of **Western Australia**
Department of **Health**

Western Australian Women's Health Strategy 2013-2017

Setting the Scene

Women and Newborn Health Service

Delivering a **Healthy WA**

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The Women and Newborn Health Service respectfully acknowledges the Noongar people, both past and present, the traditional owners of the land on which we work.

We affirm our commitment to reconciliation through strengthening partnerships and continuing to work with Aboriginal and Torres Strait Islander people.

Contents

Foreword

Setting the Scene has been developed to complement The Western Australian Women's Health Strategy 2013-2017 (The Strategy). Together these documents aim to promote better health for Western Australian women, particularly those who are vulnerable and at most risk of poor health outcomes. They provide a blue print for the Western Australian Government to guide decision-making to improve women's health and they highlight the priority needs of, and for, women to achieve better health into the future.

The Strategy and Setting the Scene are living documents that will be built upon and strengthened over time.

Setting the Scene provides a snapshot of women in Western Australia. It is a summary overview of conditions and issues for women's health including:

- social determinants of health – income, employment, education, social/physical environment, health practices and culture
- diversity of women
- health conditions at different life stages
- how men and women differ and
- difference in women's health across Western Australia and nationally.

Different illnesses share common risk factors. Often, more than one risk factor is present at any one time. It is important to note however that risk factors, or what determines health, can be broader than biological or medical issues. For instance, social determinants which are significant to women can lead to health inequalities. These include their experiences during childhood, their level of education and income or where they reside.

There are specific areas where Western Australian women experience adverse health outcomes when compared to men and, in some cases, when compared to national standards and statistics. Examples of these are mental and maternal health, health in regional and remote areas and lifestyle choices. It is essential these areas remain a priority in any future policy development.

Some of the following information specifically relates to Aboriginal and Torres Strait Islander women (herein referred to as Aboriginal women). This data has been highlighted because of the poorer health outcomes for Aboriginal women across almost all areas, when compared to non-Aboriginal women. The statistics however, need to be viewed with caution because of the low number of Aboriginal people in Western Australia.

Setting the Scene

Western Australia has the largest land area of all states and territories in Australia, yet accounts for only 10.2 per cent of the total Australian population. In 2010, 74 per cent of the State's population resided in the Perth statistical division (SD)[1]. In 2011, women accounted for 49 percent of the population[2].

Women in Western Australia are living longer than men. It is estimated that by 2051, 29 per cent of the total population will be aged 65 years and over[3].

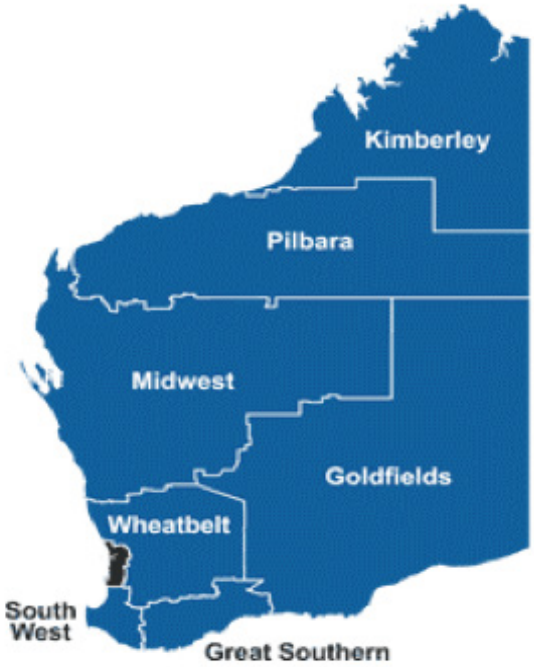
In 2012, the Aboriginal population in Western Australia is projected to reach 76,607[4].

Western Australia had the fastest growth in population between June 2010 to June 2011. This was higher than the national figure[5]. The South West had the fastest rate of growth increasing by 18 per cent, followed by the Perth SD and Pilbara SD[1] .

The largest population growth in Perth during this period was in the local government areas (LGAs) of Wanneroo, followed by Stirling and Rockingham. Strong growth was also recorded for Armadale, Joondalup and Swan[5].

Across Western Australia, the sex ratio (number of males to females) has gradually increased since 2005. Areas with mining resource activity have the highest male to female ratio, while the western suburbs of Perth such as Mosman Park, Claremont and Melville have the lowest ratio. Narrogin in the Great Southern SD and Mandurah in the South West SD are the only LGAs in the state with fewer males than females[6].

Health Regions in Western Australia



- In June 2011, the highest sex ratio (more men per 100 women) was the mining region of East Pilbara. This is also the highest in Australia[6].
- Western Australia has the second greatest proportion of people living in remote and very remote areas in Australia[7].
- In 2010, the number of people aged 20-24 years in the Perth SD was almost four times greater than the rest of the State[6].

In 2011, one-fifth of the population of Western Australia were children aged between 0-14 years.

The statistical areas with the highest proportion of children are Roebuck and Halls Creek, followed by the South West and Ellenbrook in Greater Perth[6].

The 2006 census found more Aboriginal people lived in remote and very remote areas in Western Australia than in Perth[8].

Over 60 per cent of Aboriginal children aged 0-5 years live in rural and remote areas. Of these, 35.5 per cent live in the Kimberley region[9].

Western Australia has the highest proportion of people born overseas than any other state or territory[10]. In 2006-07, net interstate and overseas migration accounted for 64 percent of population growth[3(pg9)].

The LGAs with the highest number of people born overseas are Perth (44.1 percent), Canning (38.4 percent), Wanneroo (35.4 percent) and Joondalup (34.8 percent)[11].

Geographic Location and Diversity of Population

The diversity of the population and the geographic expanse of the State means there are difficulties providing services to meet the health needs of the population. Women living in regional and remote areas have poorer health outcomes than women living in urban areas and this is a particular challenge[12(pg4)].

In 2010, there was a significantly higher prevalence in certain behaviours and risk factors experienced by women in the outer health regions of the State compared to the State as a whole and amongst the diversity of the population.

For example:

- Levels of smoking in the Goldfields and Midwest[13].
- Levels of obesity in the Great Southern and Wheatbelt[13].
- Drinking at risk/high risk levels leading to long term harm in the Pilbara[13].
- Use of hospital health services (e.g. overnight stay, emergency department or outpatients) in the Kimberley[13].
- The total number of all-cause drug hospitalisations in regional areas was greater for men aged 15-44 years than for women, however the percentage of all-cause drug hospitalisations was greater for women aged 15-44 years than men[14].
- Premature ageing of Aboriginal women relates to an earlier onset of chronic conditions. This has been acknowledged as a barrier to accessing appropriate care[15].
- Women with disabilities experience barriers to accessing health care. Barriers include transport, difficulty seeing a doctor who knows them and has knowledge of their health condition, and physical access to premises, examination beds and support workers. There was also a low prevalence of women with disabilities having pap smears[16].
- Women with intellectual disabilities living at home appear to have little awareness of preventable health[16].
- Newly arrived refugee women arrive in poor health. Their health continues to deteriorate over time as they experience higher rates of illness than the general female population[12(pg94)].

Employment and Income

Women in the most socio-economically disadvantaged groups are less likely to report 'excellent' or 'very good' health compared to women in the least socio-economically disadvantaged groups[17].

In 2011, 60 percent of Western Australian women were in the paid workforce. There are now more women in paid employment than there were 10 years ago[18(pg23)]. Of these, almost 45 per cent are employed part-time[18]. Paid employment can lead to improved health, including mental health. However, for some women, the responsibility of caring for families, working and low levels of income can lead to adverse health outcomes.

Western Australia has the largest gender pay gap in Australia. In February 2012, this stood at 25.8 percent, meaning that for every dollar earned by a full time male employee, a female employee would earn 74.2 cents. The national gap is 17.4 percent. This pay gap can result in lower lifetime earnings and retirement savings for women. It can also lead to longer working hours and a reduced work life balance[19].

Nationally, in 2006, 87 per cent of one-parent households with children under 15 years of age were headed by women[20]. Approximately 19 per cent of single women were employed full-time and 32 per cent part-time, compared with 24 percent and 39 percent respectively for women with partners[20]. In 2006, 59 percent of one-parent households had a weekly income of less than $1000 compared with 15 percent of couple households[18].

A household's net worth is based on the difference between assets and liabilities. Net worth provides some security and enables people to borrow money.

In 2003-04 the national mean net worth of one-parent households was $129,000. This was considerably lower than a mean net worth of $471,000 for couples with children under 15 years[20].

Women who experience financial difficulties have an increased likelihood of being diagnosed with anxiety or depression. Feelings of a lack of control over one's life in general, their personal life or their health adds to the likelihood of developing anxiety or depression. Women tend to perceive a lack of control in these areas more than men[21(pg70)].

Women as Carers

In Western Australia, Section 5 of the *Carers Recognition Act 2004*[22] provides a definition of 'carer'. In summary, a carer is defined as a person providing unpaid care to a family member or friend who has ongoing care needs due to a disability, including aged related frailty.

While many men in Western Australia (112,200) provide unpaid care to family members with a disability, women provide the majority of this care (139,800). Importantly, 70 percent of primary carers in Western Australia are women[23].

One in five respondents to a 2011 survey of people who provided care to a family member with a disability reported that this placed a 'big' or 'very big' burden on the family[24(pg21)].

Primary carers are less likely to be in the labour force[25] which impacts on their ability to earn a sufficient income and accrue superannuation, leading to higher levels of financial insecurity[26]. Primary carers also experience significantly higher levels of depression than the general population[27].

The estimated cost of replacing unpaid care in Western Australia is $4.1billion[28].

There is international evidence that identifying and supporting women as carers by acknowledging the gendered nature of the caring role and making provisions to meet the needs of women in a caring role, has a positive, preventative effect on potential adverse health outcomes for the carers themselves[29].

Life Expectancy

In Western Australia, Aboriginal women and women who are socially and economically disadvantaged, on average, live shorter and less healthy lives than the rest of the female population[30(pg8)].

The life expectancy of a non-Aboriginal female child born between 2005-07 is estimated to be 82.5 years. A non-Aboriginal male child is estimated to be 78.7 years[31].

Based on data from 2005-07, the life expectancy of an Aboriginal female child, is 70.4 years[32]. This is a gap of nearly thirteen years between Aboriginal and non-Aboriginal women in the state. In Western Australia, the difference in life expectancy between Aboriginal and non-Aboriginal women is greater than the rest of the country[31].

Change in life expectancy is slow to occur in Aboriginal communities, while non-Aboriginal life expectancy continues to grow[33].

Mortality

Between 2006-10, the top three causes of death in Western Australia for non-Aboriginal women were ischaemic heart diseases, cerebrovascular diseases and acquired and congenital brain disorders such as dementia. For Aboriginal women, it was impaired glucose regulation and diabetes, ischaemic heart diseases and cerebrovascular diseases[3(pg17)].

Nationally, cardiovascular diseases, specifically ischaemic heart disease, cause more deaths than any other disease group and are responsible for more than one-quarter of premature deaths among women. There is a low awareness of this fact amongst women[34(pg43)].

Australian women are four times more likely to die of heart disease than breast cancer[35].

Key findings from a 2010 Western Australian report outline that in the 25-54 year age group, age-standardised incidence rates of Acute Myocardial Infarction (AMI) show that Aboriginal males were 6.4 times more likely to have an AMI than non-Aboriginal males. In the same age group, female Aboriginals were 13.3 times more likely to have an AMI than non-Aboriginal women[36].

Five leading causes of death by gender and Aboriginality[3]

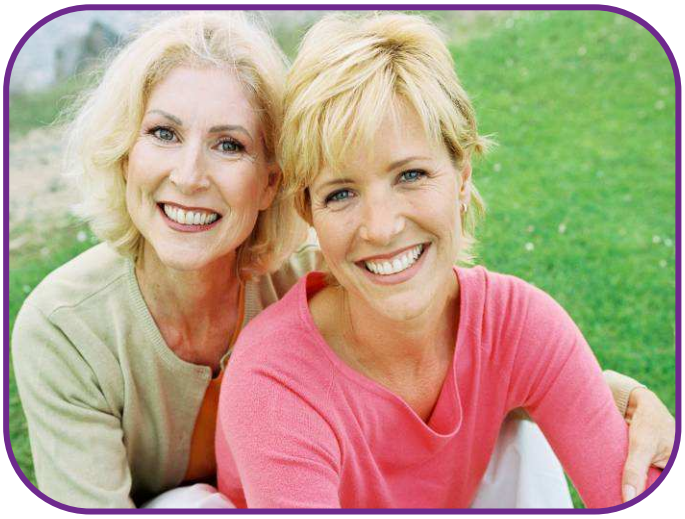
	Male		Female	
	Aboriginal (2001 – 10)	**Non-Aboriginal (2006 – 10)**	**Aboriginal (2001 – 10)**	**Non-Aboriginal (2006 – 10)**
1	Ischaemic heart diseases	Ischaemic heart diseases	Impaired glucose regulation and diabetes mellitus	Ischaemic heart diseases
2	Intentional self-harm	Cancer of the lung, bronchus or trachea	Ischaemic heart diseases	Cerebrovascular diseases (e.g. strokes)
3	Transport accidents	Cerebrovascular diseases (e.g. strokes)	Cerebrovascular diseases (e.g. strokes)	Acquired and congenital brain diseases (e.g.dementia)
4	Impaired glucose regulation and diabetes mellitus	Prostate cancer	Transport accidents	Cancer of the lung, bronchus or trachea
5	Cerebrovascular diseases (e.g. strokes)	Chronic obstructive pulmonary disease	Diseases of the liver	Breast cancer

In Western Australia, the second most common cardiovascular condition for women is cerebrovascular disease such as strokes. Whilst death from stroke has declined over the years, mortality rates are higher in the Kimberley and South West regions of the State for men and women[3(pg36)].

Dementia is the third leading cause of death for women and ranked second as a major burden of disease for women aged 65 years and over[3].

Nationally, dementia and Alzheimer's disease related deaths have increased by 99 percent since 1997. In 2009, 66.3 percent of deaths from dementia or Alzheimer's related disease in Australia were women[37].

In Australia, external causes such as transport accidents, endocrine, metabolic, nutritional disorders and respiratory system failure account for a higher proportion of deaths among Aboriginal women than non-Aboriginal women[38].



Tobacco, Alcohol and other Drugs

In 2007, the National Drug Strategy Household Survey undertook a survey of 2,400 Western Australians aged 12 years and over. The Survey was of households only and did not include homeless or institutionalised people.

The Survey highlighted that drug and alcohol use has a significant impact on people and the community. It impacts on illness, injuries, violence, crime rates and increased cost in both economic and social outcomes.

Smoking

Smoking has been identified as a major cause of heart disease, stroke, several different forms of cancer, emphysema, impotence, infertility and unhealthy birth-weights. Research shows that half of all smokers will die prematurely and half of these will die in middle age[39(pg2)].

In 2007, daily smoking was almost twice as high amongst people in socio-economically disadvantaged areas. In contrast, people in the more advantaged socio-economic areas were more likely to have tried cannabis, methamphetamines, ecstasy or other illicit drugs during their lifetime[39(pg25)].

The proportion of females in Western Australia who reported smoking daily in 2007 was higher than males in the 14-19, 20-29 and 50-59 year age groups[39(pg27)].

In a 2006 survey, of the one thousand women who identified as lesbian or bisexual, three in ten reported being smokers[40(pg27)].

Smoking during pregnancy is associated with premature labour, low birth weights and increased risk of sudden infant death syndrome[41(pg12)].

Figures show that in 2008, more than 50 percent of Aboriginal women smoked during pregnancy compared to non-Aboriginal women (13 percent)[42(pg38)].

In 2009-10, it was estimated that 3 in 5 Aboriginal women in the Kimberley region smoked during pregnancy[43(pg4)].

Alcohol

The risks associated with alcohol use are primarily related to the amount of consumption and the pattern of drinking. The actual effect on people is influenced by many other factors such as sex, age, pregnancy and underlying health conditions[39(pg3)].

Long term alcohol risk is assessed in terms of the amount of alcohol that is consumed over a week. Effects of high risk, long term alcohol use include chronic illnesses related to the liver, digestive system, brain and cardiovascular diseases[39]. There is also evidence that drinking increases the risk of developing breast cancer[44].

In 2007, 12.3 percent of women aged over 14 years were drinking at ‘risky’ or ‘high risk’ levels of long term harm compared to 10.7 percent of men. This has increased for women over time[39(pg32)].

In 2010, there was a significantly higher prevalence of women drinking at risk/high risk levels for long term harm in the Pilbara compared to the rest of the State[24(pg16)].

High risk drinking results in a relatively high burden of disease and injury and also places women at greater risk of sexual violence[34(pg36)].

In relation to short term risk, Western Australian women in 2007 drank at higher levels than women in the rest of the country[39(pg35)].

Other Drugs

According to the National Drug Strategy Household Survey 2007, cannabis was the most commonly reported illicit drug tried by women in Western Australia, followed by ecstasy and methamphetamines[39(pg7)].

The prevalence of women using ecstasy over a lifetime increased between 2004 and 2007 whilst remaining stable for men. The use of both ecstasy and cocaine by women was also higher than national figures[39].

In terms of violence, the Survey identified that six in ten Western Australian women aged 14 years and over reported being physically abused in their own homes by a person under the influence of alcohol or drugs[39(pg95)]. Overall, women were more likely to experience fear in their own home (28 percent) than men (4.7 percent)[39(pg96)].

The number of people in regional areas hospitalised for all-causes drug-related conditions between 2006-10 was significantly higher compared to the State overall. Whilst the total number of all-cause drug hospitalisations in regional areas was greater for men aged 15-44 years, the statewide percentage was greater for women in the same age range[14].

Burden of Disease

Burden of disease is a summary health measure that includes both mortality and non-fatal health outcomes.

When exploring burden of disease, pathways for prevention and treatment have been identified for policy and program development. One pathway to be taken into account in the development of health service policies and programs is factors that can lead to inequality for people[45].

Many of the causes of avoidable illness and death, including some cancers, cardiovascular and respiratory disease and type 2 diabetes, share risk factors. These risk factors are obesity, tobacco use, physical inactivity, high cholesterol, high blood pressure and harmful use of alcohol.

Different risk factors can co-exist, along with different illnesses, often making treatment complex. This can be further complicated by social and economic inequalities between men and women and between different groups of women.

In 2003, the top five causes of burden of disease for men and women in Western Australia were[3(pg17)]:

Female	Male
Anxiety and depression	Ischaemic heart disease
Ischaemic heart disease	Anxiety and depression
Dementia	Type 2 diabetes
Type 2 diabetes	Lung cancer
Breast cancer	Stroke

The 25-44 year age group is seen as a transition phase in disease burden. The impact of chronic illness is beginning to occur amongst this group. For women, mental health conditions are a significant burden of disease. This can start at a young age and continue across the life span[45]. For many, this includes their child-bearing years.

Current Mental Health status, 16 years and over, Health and Wellbeing of Adults in Western Australia 2011 (Department of Health Western Australia):

Percentage experiencing a mental health problem		
16 – 44 years	Males Females	11.1 18.8
45 – 64 years	Males Females	10.9 20.3
65 years and over	Males Females	8.2 12.3

Cancer

In 2010, 10,942 new cases of cancer were recorded in Western Australia. Of these, 43 percent were women. Breast cancer was the most common new cancer diagnosed, with bowel cancer as the second most common cancer[46].

Leading cancers by type and sex in Western Australia, 2010[46]:

Proportion of all cancer incidence

Females cancer type	Males cancer type
Breast 31%	Prostate 30%
Colorectal 12.1%	Colorectal 12.2%
Lung 8.4%	Melanoma 10.3%
Melanoma 8.3%	Lung 9.2%

Between 1997-2007, there was a higher than State average for the incidence of colorectal cancer for men and women in the Kimberley, Midwest and South metropolitan regions[3(pg42)]. During this period, the incidence of colorectal and lung cancer decreased in the total male population in Western Australia but remained stable for women[3(pg39&41)].

Between 2000-09, the all-cause cancer rate for Aboriginal women was significantly higher at 1.2 times, compared to non-Aboriginal women. In contrast, the all-cause cancer incidence for Aboriginal males did not significantly differ to non-Aboriginal men[47].

Breast Cancer

The increase in the incidence of breast cancer is believed to result from population growth and the ageing population[48].

Despite this increase however, mortality rates have declined. Based on 2010 data, 1 in 71 women in Western Australia could be expected to die before the age of 75 years[46]. This has fallen from 1 in 46 in 1982 and 1 in 56 in 2003[10(pg135)]. The mortality rate remained relatively constant between 1995-2007, which highlighted better treatment outcomes when breast cancer is detected earlier[44].

Over 75 percent of breast cancers occur in women over 50 years of age. BreastScreen WA encourages women aged 50 to 69 years to have a free screening mammogram every two years because the benefit is greater for this age cohort.

While breast cancer is the most common cancer experienced by Aboriginal women in Western Australia, it is less likely to be diagnosed in Aboriginal women than non-Aboriginal women (69 and 103 new cases per 100,000 women respectively)[49].

Cervical Cancer

In the two year period 2009-10, 57.5 percent of eligible Western Australian women aged 20-69 years participated in cervical screening. Despite this, in 2010, there were 90 new cases identified and 34 deaths were attributed to cervical cancer for women of all ages[50]. It should be highlighted that between 2000-09, the incidence and mortality rates from cervical cancer in Western Australia have fluctuated[50].

Incidence rates of cervical cancer between 2000-09 were 2.2 times higher and mortality rates 4.6 times higher for Aboriginal women compared to non-Aboriginal women[50].

The Western Australian Cervical Cancer Prevention Program (WACCPP) was established in 1992 as part of the National Cervical Screening Program. It aims to reduce cervical cancer cases (incidence), as well as illness and death (mortality) resulting from cervical cancer in Western Australia through an organised approach to cervical screening. This includes collaboration with health care providers, key stakeholders in women's health and women, including women from culturally and linguistically diverse backgrounds, women with disabilities and Aboriginal women. The WACCPP advocates for women aged 18-69, who have ever been sexually active, to participate in cervical screening every two years as regular screening is the most effective way to prevent cervical cancer.

Chronic Illness and Injury

Risk factors attributable to chronic conditions are weight and obesity, physical inactivity and smoking[34(pg7)].

Obesity is a primary cause of chronic illness in Australian women. The outcome includes diabetes, heart disease, certain cancers, depression, anxiety and social dysfunction[34(pg47)]. Since 2002, there has been a growing trend for both men and women in Western Australia to be classified as 'overweight' or 'obese'[24(pg16)].

Western Australian women who identify as lesbian and bisexual are more likely to be overweight and experience higher rates of obesity than the general female population.

Key findings in a Western Australian study revealed that lesbian and bisexual women consumed fast food more frequently than other women[40(pg21)].

In Western Australia, Aboriginal women are more likely to be classified as obese in each age group than non-Aboriginal women[51(pg29)].

In 2006, 56.2 percent of Aboriginal women in Western Australia had a disability or long term health condition, including sensory (especially sight), physical and intellectual disabilities, compared to 41 percent of non-Aboriginal women[51(pg29)].

Premature ageing of Aboriginal women is a particular concern because it relates to younger onset of chronic conditions and has been acknowledged as a barrier to accessing appropriate care[15].

Cardiovascular Diseases

Cardiovascular diseases cause more deaths than any other disease group and are responsible for more than one-quarter of premature deaths among women[34(pg43)].

In 2004-2005, the second highest national health expenditure for women was cardiovascular diseases. Cardiovascular disease also represents a significant proportion of a general practitioners workload[52] and is the second major cause of burden of disease[52].

Arthritis and Osteoporosis

Arthritis and osteoporosis have been designated as National Health Priority Areas in recognition of the major health and economic burden they place on the Australian community. In Western Australia, women are more likely to report arthritis and osteoporosis than men. Women aged 65 years and over are three times more likely to report osteoporosis than men[24(pg25)].

Osteoporosis is a source of acute and chronic disability. People are often not aware of this condition until they experience a fracture, curvature of the spine or loss of height[17(pg57)].

Twenty six percent of women aged over 65 years are more likely to experience a lifetime prevalence of osteoporosis compared to 7.8 percent of men[24(pg24)].

Injury

Injury is one of eight National Health Priorities and is a leading cause of hospitalisation.

The prevalence of injuries and falls recorded in the Health and Wellbeing of Adults 2011, An Overview and Trends records that women aged 45 years and over experienced a higher rate of injuries from falls. Since 2002, the prevalence of injuries which have required treatment by a health professional have remained stable for men but have significantly increased for women[24(pg35)].

Diabetes

In 2008, 44 percent of all hospital separations for the Western Australian Aboriginal population were due to encounters for dialysis[17(pg57)]. Diabetes is ranked as the third most common cause of 'avoidable mortality' among Aboriginal women in Western Australia[3(pg17)].

Diabetes results in a significant number of deaths and is a major complicating factor for other avoidable conditions such as ischaemic heart disease. Since 2002, the prevalence of diabetes has increased for both men and women[24(pg31)].

Mental Health

In 2005, it was predicted that by 2016 mental health would rank higher than cancer as the major burden of disease for women in Western Australia, and that it would be the most expensive health condition in the state[53].

Women's mental health needs to be considered within the multiple and interacting social, psychological and biological factors. Often lower levels of income, poor housing, social exclusion and a general feeling of having little control over one's life are common inequalities amongst high risk groups of women in the community, and this can impact on their mental health.

The link between physical illness and mental illness highlights an opportunity for achieving better general health by promoting better mental health. Adverse mental health conditions are associated with higher rates of death, exposure to physical and sexual violence and increased exposure to risk factors such as smoking, drinking alcohol and using other drugs[24(pg42)].

Consistently since 2002, women in Western Australia were twice as likely to report having a doctor-diagnosed mental health condition compared to men. The rate of hospitalisation for self-harm by females was almost double that of men in all socio-economic groups and in regional areas[17(pg31)].

In 2002, 16.2 percent of women over the age of 16 years were diagnosed with a mental health condition (depression, anxiety, stress-related or other mental health problem).

In 2011, this had increased to 18.2 percent. By contrast, the rate has remained stable for men with 10 percent in 2002 to 10.7 percent in 2011[24(pg42)].

Men are more likely to be successful in their suicide attempts and women are more likely to be hospitalised as a result of self–inflicted injury[3(pg28)]. In 2007-08 there were a total of 2,341 hospitalisations in Western Australia as a result of self-inflicted injury. Women accounted for 61 percent of this total[3(pg28)].

Annual statistics consistently show that a significantly higher proportion of women to men are reporting high or very high psychological distress[17(pg32)].

Between 2006-10, the number of women hospitalised for serious psychiatric disorders was higher than men[54]. The hospitalisation cost for serious psychiatric disorders is the highest of all the mental health disorders[54].

The rate of serious psychiatric disorders occasions of service for Aboriginal women between 2001-10 was 1.7 times higher than for non-Aboriginal women[55].

The rate of community mental health occasions of service for Aboriginal women between 2001-10 was 1.5 times higher than the rate for non-Aboriginal women[56].

A Western Australian study in 2006 found that almost one in five (19.3 percent) of women who identified as lesbian or bisexual reported receiving treatment for a mental health condition. This is higher than the general female population. It was concluded that increased rates of poor health for lesbian and bisexual women resulted from societal marginalisation and stigmatisation of sexual minorities and not as a direct result of sexual orientation[40(pg36)].

Maternal Mental Health

Women's mental health directly impacts on their ability to care for and nurture their children and care for their own wellbeing. This is more problematic for some Aboriginal women due to the added trauma associated with past and present cultural experiences[41(pg19).]

In 2011, almost 20 percent of women in their child-bearing years (16-45 years) experienced a mental health condition[24(pg41)]. Anxiety, depression and stress-related problems were the most common diagnosis[24(pg40)].

Between 13 and 25 percent of women experience a clinically significant episode of mental illness during the perinatal period. Australian research has identified psychiatric illness as a leading cause of maternal death and suicide has been listed as one of the most prominent causes of maternal death in the post natal period from 6 weeks to 12 months[57(pg7)]. Depression, anxiety disorder, suicide and self-harm are the top causes of disease burden for women during the childbearing years and this has a significant negative impact on women, their babies and their families if these problems go undetected[58].

In 2012, the total economic costs of perinatal depression was estimated at $433.52 million[59]. The far reaching effects of the direct and indirect costs of untreated perinatal depression and anxiety in Australia are estimated to be over $500 million for one year[60].

Women are at greater risk of intimate partner violence in the perinatal period, and this often results in adverse health outcomes for both women and serious problems for their children into the future.

In 2005, an Australian study found that one in six women reported intimate partner violence in the year following the birth of their first baby and that depressive symptoms were strongly associated with the violence[61].

Reproductive and Maternal Health

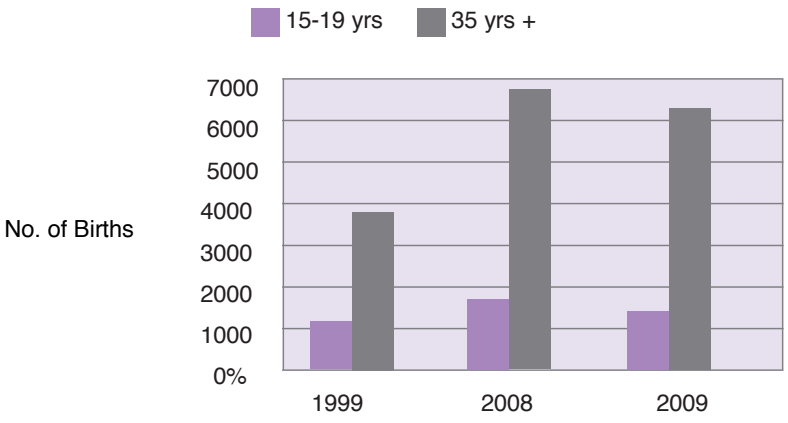
Women face unique sexual, reproductive and maternal conditions which can impact upon their ability to achieve good health and the health of their children.

Fertility Rates

In 2011 in Australia, a record number of women over 40 years of age gave birth[62]. Western Australia, has a peak fertility rate of 30-34 years with fewer women giving birth in their younger years[63]. In 2008, one in five women who gave birth were 35 years or older, compared with one in twenty in 1980[18(pg38)].

The age a woman gives birth can affect health outcomes for her babies. Very young women and older women for instance, are more likely to give birth to babies after shorter gestation periods and with lower birth weights than the average[62].

Number of Births, by Age of Mother (ABS Western Australian Statistical Indicators 2010);



In 2008, the birth rate for Aboriginal women in Western Australia was 101.7 per 1000. This represented 5.7 percent of all women who gave birth. This is a higher birth rate than non-Aboriginal women which is 66.3 per 1000[41(pg10)].

The birth rate for teenage Aboriginal mothers in the State is more than six times the rate of teenage non-Aboriginal mothers[41(pg10)]. Giving birth during the teenage years poses many risks for both mother and child in relation to their short and long term health and social and economic outcomes[41(pg12)].

In 2008, 16 percent of Aboriginal babies were born with low birth weights compared to 6.1 percent of non-Aboriginal babies. The rate of low birth weights for Aboriginal babies has not changed in the past 15 years[41(pg11)].

Childbirth Experiences

Early childhood health and wellbeing are priority areas for both Federal and State governments and keeping mothers well is an important factor in keeping children well. A woman who is healthy and does not smoke or drink at risky levels is more likely to have a healthy baby who will grow into a healthy child[63].

Refugee and migrant women in particular can experience stress from relocating to new countries and having babies in unfamiliar surroundings, often with unfamiliar practices. A qualitative study during the perinatal period of the social and emotional experiences of women from three culturally and linguistically diverse groups highlighted a number of difficulties. These included accessing services, the difference in services compared to their 'homelands', lack of partner support and increased feelings of loss and isolation in the absence of known cultural practices[64].

Breastfeeding

Breastfeeding provides significant health benefits for women and their babies. It enables babies to increase their resistance to infections and disease, assists with reducing allergic reactions and hastens women's recovery after child birth. Over time there has been a growing awareness of the benefits of breastfeeding and in 2004-05, 88 percent of children in Australia under three years had been breastfed[62].

However, the *Australian National Breastfeeding Strategy 2010-2015* outlines that there is a sharp decline in breastfeeding with each month after birth. While it is believed that rates have remained static over the last ten years, there is also concern that recent findings of breastfeeding can vary significantly between local government areas.

Whilst data comparison should be viewed with caution, Australia compares well with other OECD countries in breastfeeding initiation and at three months, however lags behind in the continuation of breastfeeding[65].

There are many reasons why women breastfeed or not and at a range of varying levels. Environmental and societal factors can impact on a woman's ability to breastfeed65 and stressful life events can increase the odds of early cessation[66].

Caesarean Sections

Australia has a high rate of caesarean sections compared to other countries. While the risks associated with caesarean births have been well documented, the numbers in WA have continued to increase over the past 25 years. In 2007, the percentage increased from an overall rate of 20.9 percent to 32.7 percent. Of these, 17.9 percent had an elective caesarean section[67].

Induced Abortions

WA has a relatively high rate of induced abortions, with 8885 induced abortions in 2009. The rate of induced abortions was 19.1 per 1000 women in the reproductive age (15-44 years). This represented 22.3 percent of pregnancies[68].

The highest proportion of pregnancies ending in induced abortions is at the extremes of reproductive age, that is amongst teenagers and women over 40 years of age. Between 2006 and 2009, a higher termination rate than live births was recorded for teenagers between 15 and19 years[68(pg7)].

In 2009, non-Aboriginal women aged 15-44 years recorded a higher proportion of induced abortions than Aboriginal women[68(pg1)].

Sexual Health

Sexually Transmitted Infections

In Western Australia, notifiable sexually transmitted infections include chlamydia, gonorrhoea and syphilis. In 2010, the highest recorded rates for all three infections were reported in the Kimberley[69(pg1)].

The crude notification rate for chlamydia and gonorrhoea in women is two to three times higher in Western Australia than the rest of the country[10(pg79)]. The chlamydia rate for both sexes has more than tripled in the past ten years[70] and in 2011, there were increased reports of infectious syphilis[71].

Between 2000-09, the rate of sexually transmitted infection notifications was 18.4 times higher for Aboriginal women than for non-Aboriginal women[72].

Although the rates of sexually transmitted infection has stabilised since 2000, the rate nevertheless has consistently been two to three times higher than the national rate[10(pg179)]. If left untreated women can experience long term adverse health outcomes, such as in the case of chlamydia which can cause tubal infertility and chronic pelvic pain[34(pg59)].

There remains a poor understanding and lack of knowledge particularly amongst the younger age groups, regarding sexually transmitted infection and unsafe sexual practice[34].

Sexual Assault and Sexual Abuse

The ABS *Personal Safety Survey 2005* found that since the age of 15, almost one in five women have experienced sexual violence in Australia. The research confirmed that younger women experience sexual violence at higher rates than older women[73].

The Survey found that since the age of 15 years, 5.5 percent of men reported experiencing sexual violence compared to 19 percent of women; 39 percent of women reporting had experienced sexual violence by a family member or friend, 32 percent by an other known person, 22 percent by a stranger and 21 percent by a previous partner[73].

Whilst there has been an increase in women reporting sexual violence[73], it is still notoriously under reported and there are many reasons for this. Of those that are reported to the police, the majority of cases do not result in prosecution[18].

In Western Australia, during 2010, there were a total of 3149 reports of sexual assault to police. This represents one in 728 of the total population. In 2009-10, three times the number of girls to boys in Western Australia were subject to a substantiated report of sexual abuse[74].

There is a strong correlation between women who have been sexually abused as children and mental health illnesses for women in adulthood[34(pg53)].

Violence against Women

It is estimated that the total cost of violence against women and children in Australia will reach $15.6 billion by 2021-22 [75].

Family and domestic violence (FDV) is a community-wide issue that can affect any woman. Some groups are at greater risk, such as refugee and newly arrived migrant communities, as well as some established culturally and linguistically diverse communities[34(pg91)].

Between 1996 - 2005, more women in Australia reported both physical and sexual violence by a male perpetrator to police[73].

Between July 2002 and December 2003, 48 percent of interpersonal violence related hospitalisations in Western Australia resulted from intimate partner violence. Women were over-represented[76].

Between 2006-10, the rate of hospitalisation of women in all age groups apart from the 15-24 year group for assault and other injury caused by other person(s) was greater than for men[77]. Although the total number of men hospitalised was greater than women in the same period, the number of men aged 25-44 was lower than that of women in the same age group who live in regional areas[78].

The number of assault by bodily force, sexual assault by bodily force and hospitalisations due to injury and poisoning was also significantly higher for men and women in regional Western Australia. Whilst for men the rate has decreased overtime, the rate for women has not significantly changed[79].

It is estimated that Aboriginal women are 45 times more likely to be victim of family violence than non-Aboriginal women. This accounts for nearly 50 percent of all victims[80].

The rate of assault and other injury caused by other person(s) hospitalisation for Aboriginal women has increased significantly over the five years from 2006-1081.

Between 2002-04, 74 percent of repeat hospital admissions for interpersonal violence were Aboriginal people. Of these, 65 percent were Aboriginal women.

In contrast, 79 percent of non-Aboriginal repeat admissions were men[82(pg572-575)].

The *National Drug Strategy Household Survey 2007* found that six in ten Western Australian females aged 14 years and over reported being physically abused in their own homes (64 percent) by someone under the influence of alcohol or drugs[39(pg95)]. Overall, females aged 14 years and over were more likely to experience fear in their own home (28 percent) than males (4.7 percent)[39(pg96)].

There is a strong correlation between substance abuse and domestic violence, particularly during pregnancy. Evidence suggests that abuse of drugs is a factor for pregnant women exposed to violence. The subsequent health outcomes for babies can include low birth weights and fetal contusions[83(pg199-208)].

In 2007, of 1000 lesbian and bisexual women surveyed, a third were found to have experienced physical violence in a relationship and almost half of respondents had experienced some form of emotional abuse[40(pg33)].

In 2003, of 107 agencies surveyed which offer services to women with disabilities, 72 reported providing services to 709 women who had been subjected to FDV in the two years preceding the survey; 38 percent of these had acquired a disability as a result of the violence, 43 percent experienced abuse by a male partner or spouse and 11 percent by a female partner. A parent or parents were responsible for an estimated 15 percent of abuse against their female children[84].

Women with disabilities are less able to escape violent situations and relationships. They are often dependent on others for care and transport and experience difficulties with accessing suitable services. As with many other women, financial limitations restrict living options[84].

Agencies who provide services for sexual violence and FDV are usually separate entities which can result in inadequate responses and services for women. Victims/survivors report that sexual violence as a form of FDV can be the most personally damaging[85(pg19)].

There is no doubt that FDV contributes to adverse mental health conditions both for the person subjected to the violence and those who might witness it, such as children. They can similarly experience emotional problems such as feelings of helplessness and fear. It can also emanate in behavioural problems such as being in a constant ‘state of alert’ or difficulties in dealing with stressors later in life[86(pg4)].

Setting the Scene - Tying it Together

The information provided in *Setting the Scene* highlights the links between the biological, social, cultural, psychological and economic dynamics and interaction that women experience and how that can affect the ability to stay well. It is a complex web that raises the need for a multi-focussed, multi-agency approach.

Mental health and maternal mental health, the health of women in regional areas of Western Australia, violence against women and obesity and lifestyle choices have all been identified as key areas to be addressed. Lifestyle choices often overlap and are the source of many different health conditions.

High risk groups experience many adverse health outcomes and at greater rates. More detailed information on these women, such as newly arrived refugee women and migrants, needs to be brought into greater focus.

Setting the Scene also highlights the intergenerational issues for children when a mother's health is compromised.

The health of Aboriginal women in Western Australia must remain a priority because they experience poorer health outcomes in nearly all areas. The greater rate of Aboriginal babies born highlights the importance of keeping Aboriginal women well to ensure a more positive future for their children.

In the development of both *The Strategy* and *Setting the Scene*, information on the health of men in Western Australia was also taken into consideration. Everyone in the community is entitled to basic standards of living and health care - it is a human right. *The Strategy* is one part of a larger process and whilst its focus is on women and keeping women well, the ultimate aim for WA Health is that everyone in the State will experience a high level of health and have access to appropriate healthcare.

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