

Report on the
**ACT Survey of
Women's Health**

July 2023

the voice for women's health and wellbeing in the ACT



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Acknowledgment of Country

Women's Health Matters acknowledges the Ngunnawal and Ngambri people who are the traditional custodians of the land on which we live and work. We pay our respects to their Elders past and present. We recognise the strength of Aboriginal women and their continuing connection and contribution to this land, these waters, and our communities. May we walk gently and treat the earth and each other with care and respect.

About Women's Health Matters

Women's Health Matters is an independent, non-partisan think tank that works to improve the health and wellbeing of women in the ACT and surrounding region. Women's Health Matters believes that the environment and life circumstances which each woman experiences affects her health outcomes. Women's Health Matters focuses on areas of possible disadvantage and uses research, community development and health promotion to provide information and skills that empower women to enhance their own health and wellbeing. Women's Health Matters undertakes research and advocacy to influence systems change with the aim to improve women's health and wellbeing outcomes. Women's Health Matters is funded by ACT Health. The findings and discussion presented in this report are those of Women's Health Matters, and not necessarily those of the ACT Health Directorate.

Dr Merri Andrew and Dr Romy Listo were the principal researchers working on the survey project.

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Executive Summary

About the survey

The survey aims to investigate the state of women's health and wellbeing in the ACT. Findings will be used to make the state of women's health and wellbeing in the ACT visible through high quality data, complementing the ACT Wellbeing Framework and other datasets, and enabling Women's Health Matters and our community partners to advocate for gender responsive health and wellbeing services for all ACT women.

Between November 2022 and February 2023, Women's Health Matters collected responses to the survey online. The questions in the survey were mainly closed (checkbox/multiple choice) questions, as well as some options for open-ended responses. The survey was promoted through our email newsletter, Facebook, Instagram, radio, print media, and the social media accounts and networks of our government and community sector partners. Participants self-selected to be part of the survey, which was hosted on the *SurveyMonkey*® platform. As an incentive, participants received a chance to win one of two \$100 gift vouchers.

In total, 1668 valid responses were collected, on topics including:

- health and health services
- mental health
- sexual and reproductive health
- pregnancy and parenting
- violence and safety

This report presents a summary description of the results across the whole survey. Further analysis over the coming months and years will provide more detail about the issues covered and relationships between different indicators. Future iterations of the survey will be considered; any future iterations will be used

as an opportunity to build on and improve the survey method.

Women's Health Matters gratefully acknowledges the people and organisations who contributed to the survey project.

Demographic profile: Who did the survey?

Our target population comprised women, femme-identifying people and people who align themselves with this group who were aged 18+ years and living in the ACT or region.

The 1668 respondents included:

- 1.7% Aboriginal and/or Torres Strait Islander people (similar to the ABS 2021 Census figures for ACT women aged 18 and over)
- 28% aged 35-44 - the largest group (proportionally fewer young [under 24] and older [55+] women than in the census)
- 83% born in Australia (compared with 64% in the ABS census)
- 14% from a migrant background
- 2% temporary visa holders
- 96% spoke English as their main language at home (compared with 70% in the ABS census)
- 23% had a disability (similar to the ACT population of women)
- 81% were employed (compared with around 70% in the ABS census)
- 51% reported at least one indicator of financial stress (higher levels of financial stress than previous surveys of ACT women)
- 79% identified as heterosexual

Although the sample is broadly representative of the ACT community, future surveys will be designed to represent young women and older

women, and to better represent women from migrant and refugee backgrounds.

Findings

Except where indicated otherwise, the percentages reported in this Executive Summary refer to the full survey sample. Where only a subset of the full sample were asked the question, this is indicated in the text.

Health and healthcare

Participants were asked to rate their health over the past four weeks. The results show that while the most common response was 'Good,' more respondents rated their health as 'Fair' or 'Poor' (39.8%) than rated their health as 'Very good' or 'Excellent' (27.6%).

We asked respondents whether they had consulted a range of types of services/professionals in the last 12 months. The results show that by far the most commonly consulted type of service/professional was General Practitioners (GPs) (91.9% consulted), followed by allied health professionals (60.4%).

We asked respondents to rate their overall access to GP consultations. Over a third rated their access as 'Excellent' or 'Very good,' while around a quarter rated their access as 'Fair' or 'Poor.' Those who reported their access to a GP was only 'Fair' or 'Poor' were asked about their main reasons for this being difficult. The key factors most commonly reported were difficulty getting an appointment (61%) and problems with it being too expensive (24%).

For all respondents, we asked them to rate different aspects of access to a GP (access to bulk-billing, access to a female GP if wanted, and access to preferred GP each time). Respondents rated access to bulk-billing poorly, with over three-quarters (79%) saying their

access to bulk-billing was only 'Fair' or 'Poor.' A significant portion of people (45%) also answered that their access to their preferred GP each time was only 'Fair' or 'Poor.'

We asked further questions about how well respondents rated several aspects of their experience with their most recent consultation with a GP. The cost of seeing a GP is rated poorly, with almost 70% of respondents rating this aspect as only 'Fair' or 'Poor.' Time spent waiting for an appointment and time spent waiting in the waiting room were also rated poorly, whereas respondents rated the quality of doctors' skills, their explanations, opportunities to ask questions, how well the doctor listened and their respect for patients' dignity and different backgrounds, and the accessibility of facilities fairly well overall.

Respondents were asked to rate their access to different kinds of medical care. The kinds of care rated most poorly for access were mental health services, specialists, medical care at short notice and medical care after hours. For every type of care (except Telehealth) more people rated their access as 'Fair' or 'Poor' than rated it as 'Excellent/Very good.' (Other types of care listed were family planning/sexual health services and medical care in an emergency.)

We asked a series of questions about people's experiences of receiving care and their inclination to seek help from a doctor. The results show overall positive assessment of the care received from doctors, with over three quarters agreeing or strongly agreeing that the care they had received in the last few years had been good. However, there were some concerning findings about people's inclinations to seek health care, with over a third agreeing or strongly agreeing that they only go to the doctor if there is no other option, and a quarter of respondents agreeing or strongly

agreeing that they avoid seeing a doctor wherever possible.

In a separate question, we asked to what extent respondents felt they had been taken seriously by doctors when explaining symptoms or health concerns over the last few years. While a majority felt they had been taken 'Completely seriously' or 'Mostly seriously', over a third of respondents felt that doctors had taken them only 'Somewhat seriously' or 'Not at all seriously'.

Health information

Our survey found that almost all respondents (93% of the full sample of 1668) get some of their health information from online sources, with 92% using the internet (webpages), and around 28% using social media.

The most commonly used online sources were government websites (78% used), *Healthdirect* (62%) and *Facebook* (21%).

For the people who indicated that they used online sources for health information, we asked about their reasons for using these online sources. The most common responses were "To improve my understanding of symptoms/health condition after seeing a health practitioner or receiving a diagnosis" (83%) and "To decide whether or not to see a health practitioner about my symptoms/health condition" (71%). A significant minority (44% or nearly 700 people) reported using online health information instead of seeing a health practitioner.

The most common non-online sources of health information were doctors (80% used), family members (46%) and friends (44%).

Mental health

The Kessler Psychological Distress scale (K6) is a measure of psychological distress developed by

Kessler et al (2002). The K6 is delivered as set of six questions asking how often in the past 4 weeks respondents felt: nervous; hopeless; restless or fidgety; that everything was an effort; that nothing could cheer them up; or that they were worthless. The results are used to indicate whether the person is likely to have a serious mental illness.

Our survey found that around 19% of respondents had a K6 score indicating probable serious mental illness (of the 1649 people who answered enough of the questions). This is higher than the ACT General Health Survey.

We asked respondents whether they had ever been diagnosed or treated for a range of mental health conditions, and whether they had been diagnosed with or treated for mental health conditions in the last two years. Only just over a third reported never having been diagnosed or treated for a mental illness. Around 45% of all respondents had been diagnosed with or treated for a mental health condition in the last two years.

Around 46% of respondents reported having been diagnosed or treated for anxiety at some point, and a similar proportion reported having been diagnosed or treated for depression. Around 13% reported having been diagnosed with or treated for Post Traumatic Stress Disorder (PTSD). A third of respondents reported anxiety in the last two years, while nearly 30% reported depression and 7% reported PTSD.

Sexual and reproductive health

Most respondents (69%) had engaged in physical sexual activity with another person in the last 6 months, although a substantial proportion had not (27%).

We asked people what forms of contraception they used. For the 714 people who had sex in

the last six months that could result in pregnancy, the most common answers were:

- 39% condoms
- 25% progestogen IUD
- 19% combined pill
- 19% withdrawal

Overall, 39% of the 714 had used some form of LARC (long-acting reversible contraceptives) including progestogen IUDs, copper IUDs, injections, implants and vaginal rings. This is higher than other Australian studies. Some people used contraceptives for reasons other than preventing pregnancy.

Most people (56%) were either extremely satisfied or very satisfied with their current form of contraception, while 13% were either dissatisfied or very dissatisfied.

People who were dissatisfied or very dissatisfied with their contraceptive method were asked what was preventing them from changing it. The main reasons selected from pre-defined options were:

- Cost (23%)
- Advice from doctor that other methods are not suitable (23%)

Many people who gave open-ended responses expressed concerns about side effects, pain and discomfort.

A significant proportion of respondents (434 or 26% of the full sample) reported some form of difficulty with getting pregnant or having children, while 8% reported that access to fertility services was a factor influencing their parenting intentions.

We asked people if they had ever been diagnosed with or treated for endometriosis. Overall, 260 people (or 16% of the full sample) said they had. There were overall low levels of satisfaction with endometriosis healthcare, with over 50% of people who had

endometriosis saying they were dissatisfied or very dissatisfied with their healthcare for the condition.

Around 14% (or 229 of the full survey sample) had been diagnosed with or treated for polycystic ovary syndrome (PCOS). As with endometriosis, there were overall low levels of satisfaction with endometriosis healthcare, with around 54% of people who had PCOS saying they were 'Dissatisfied' or 'Very dissatisfied' with their healthcare for the condition.

We asked respondents whether, in the last 12 months, they had experienced persistent pelvic pain (PPP), defined as pain below your belly button and above your legs that is present on most days (or more than 2 days of your period, for people who have periods) for six months or more. Of the full sample of 1668 respondents, 26% (of 428) had experienced persistent pelvic pain (PPP). Of these 428, 79% (or 340) had sought treatment from a healthcare professional for this pain. Satisfaction with treatment for PPP was in general low, with nearly 60% of the respondents who had sought treatment reporting they were either 'Dissatisfied' or 'Very dissatisfied.'

Of those who had experienced PPP (n=428), around two thirds (or 280) had missed work/study as a result in the last 12 months. This represents 17% of the survey sample as a whole.

For all people who indicated they had ever been pregnant, we asked how many abortions they had ever had. Results showed 261 people had ever had one or more abortions, representing 24% of people aged 18-44 years in our survey (n=1078). Just over half of the 261 indicated that one or more of their abortions had been in the ACT. For the 136 people who had ever had an abortion in the ACT, we asked how satisfied they were with their ability to access the procedure. Of these,

the majority (56%) were either 'Extremely satisfied' or 'Very satisfied,' while 14% were 'Dissatisfied' or 'Very dissatisfied.'

Just over a fifth (n=361) of all respondents indicated they had reached menopause, with the majority (just over 60%) having gone through menopause between 45 and 55 years of age.

We asked people who had experienced menopause how satisfied they were with their access to support services in relation to menopause. The results show significant levels of dissatisfaction, with over 40% of people reporting they were 'Dissatisfied' or 'Very dissatisfied,' compared with only 23% 'Extremely satisfied' or 'Very satisfied.'

Pregnancy and parenting

The majority of respondents (58% of n=1668) reported having a biological child or children only (including adult children), while a significant portion (39%) do not have children. A small number (3%) have people in their care who are not their biological children (in some cases together with their own biological child).

We also asked people about their parenting intentions (regardless of their parenting status). Nearly two thirds (62% of the full sample of 1668) said they were not currently trying to get pregnant or have a baby and did not plan to in the future, around 14% said they were not currently trying and were unsure about whether they would in the future, and a similar proportion said they were not currently trying but intended to in the future. Only around 4% were currently pregnant/having a baby, and a similar proportion were currently trying.

Looking closer at the parenting intentions of people who do not have children (n=643), we found that a smaller but still substantial

proportion of this group (42%) were not trying and do not plan to have children.

We asked all respondents (n=1668) about factors influence their current parenting intentions. 'Age' (56%) and 'personal choice' (42%) were the factors most commonly selected, with substantial numbers also indicating 'finances' (33%), being 'happy with family size' (31%) and 'fertility' (27%) as important in decisions about parenting.

When asked about whether they had ever been pregnant, 33% (of the full sample) told us they had never been pregnant, while 67% (n=1109) had been pregnant one or more times. The most commonly reported number of pregnancies was 2, with just over a fifth of all respondents reporting they had been pregnant twice.

Of those who had ever been pregnant (n=1109), 33 people (3%) had had a stillbirth. Among the people in our survey who had experienced stillbirth, satisfaction with access to support services in relation to stillbirth was low, with half (50%) of all people who had experienced a stillbirth reporting they were 'Dissatisfied' or 'Very dissatisfied' with their access to support services.

Of the 1109 people who had ever been pregnant, 432 people (39%) had had a miscarriage. While most people who had experienced a miscarriage reported having just one, almost 15% of the 1109 people who had ever been pregnant reported having had two or more miscarriages. Twenty-nine people (or 3% of the 1109 people who had ever been pregnant) had had one or more ectopic pregnancies.

For people who had ever been pregnant (n=1109), we asked how many times they had ever given birth to a living baby. The most commonly reported number of times that

respondents had given birth to living babies was two (43%).

All people who had given birth to a living baby (n=982) were asked what type of maternity care they had for the most recent time they gave birth (we did not ask how recent the birth was). The most commonly reported type of maternity care was private obstetrician (28%), followed by continuity of midwifery care (21%). However, this differed by respondents' age, with proportionally fewer people in younger age groups having used private obstetricians for their most recent birth, and proportionally more having continuity of midwifery care.

Looking at all those who had given birth to a living baby (n=982), 59% of respondents were 'Extremely satisfied' or 'Very satisfied' with their care, compared with around 12% of respondents 'Dissatisfied' or 'Very dissatisfied'. Levels of satisfaction with maternity care did not differ greatly by age.

Homebirth remains rare according to our survey, with only 1.5% of the 982 people who had ever given birth to a living baby reporting they had a homebirth at some point. Over a third of the 982 people had had a caesarean.

We asked people who had given birth to a living baby (n=982) whether they had been diagnosed or treated for a range of conditions in relation to their most recent pregnancy. The results show that postnatal depression affected one in six people in our study (18%), while significant numbers experienced gestational diabetes (14%), hypertension (13%) and/or postnatal anxiety (13%).

We found high levels of traumatic birth experiences among those who had given birth to a living baby (n=982), with almost a quarter of respondents (24%) reporting emotional distress during labour, and over a fifth reporting caesarean section after labour started (22%). Almost 14% reported labour

lasting longer than 36 hours. Overall, 45% of people who had given birth to a living baby reported some form of traumatic birth.

Discrimination, safety & violence

Discrimination

In our survey 32% of people (n=528) reported having experienced discrimination in the last 12 months. Of these 528 people, almost two thirds (63%) reported that gender was a factor, while 40% indicated age and 30% appearance as factors in the discrimination. One in five (23%) reported having been discriminated against on the basis of disability.

Our survey sample overall under-represented people from migrant and refugee backgrounds and from language backgrounds other than English, so it is likely that our findings underestimate the prevalence of discrimination on the basis of cultural and language background.

Using public transport alone after dark

Two out of every five people (40% or 565 people) reported that they had used public transport alone after dark in the ACT in the last 12 months (of the n=1412 who answered). The majority (59% or 332) of those who had used public transport alone after dark (n=565) reported that they did not feel safe *waiting* for public transport, while a small majority (54% or 306 people) reporting that they felt safe while *using* public transport alone after dark. For those who answered that they did not use public transport alone after dark (n=847), we asked why not. Two thirds answered that they had no need to do so, while a quarter said it was because they did not feel safe.

Taken together, over 558 people in our survey either do not use public transport alone after dark because they do not feel safe, or do use public transport alone after dark it but feel unsafe while waiting for or using it. This

represents at least 40% of people in our survey (as a proportion of the 1412 who answered the questions on violence and safety) whose ability to participate in activities and public life at night is impacted by safety concerns relating to public transport.

Walking alone in local area after dark

Of the 1412 people who answered the question, 725 people or just over 50% reported that they had walked alone in their local area after dark in the last year. A small majority (416 people or 57% of the 725), reported that they did feel safe in that situation. Of those who answered that they had not walked alone in their area after dark in the last year (n=687), 382 (56%) reported that the main reason for not walking alone in their area after dark was because they did not feel safe.

Reproductive coercion

In our survey we asked a set of questions about experiences that could indicate possible reproductive coercion (behaviour intended to limit another person's ability to make reproductive choices and have autonomy over the reproductive functions of their body). We found that 124 people, or around 12% of the 1052 respondents who agreed to answer questions about reproductive coercion, reported experiencing one or more of the indicators at some point.

Sexual violence

Of the 1412 people who answered the question, 44% indicated that they had experienced some form of sexual violence at some time in their lives. Of the 1412 respondents answering, around 3% had experienced sexual violence in the last year.

Domestic violence

Of those who answered the question (n=1412), 28% reported that they had experienced some form of domestic violence in their lifetime. Around 3% of the 1412 respondents had experienced domestic violence in the last year.

Family violence

Looking at family violence, 31% (of n=1412) indicated that they had experienced some form of violence from a family member other than a partner/spouse at some point in their lives. We found that just under 5% of respondents overall (n=1412) had experienced family violence in the last year.

Workplace sexual harassment

Of the 1412 people who answered, 40% indicated that they had experienced workplace sexual harassment at some time in their lives (almost 4% in the last year and 15% in the last five years).

Institutional violence

Institutional violence is a structural form of violence that occurs not only at an individual level but at the level of facilities and organisations, and involving the people who staff them. People who are subjected to multiple forms of marginalisation and discrimination are particularly likely to experience this form of violence. Of the 426 people who chose to answer this optional question, 69 people (16.2%) said that they had experienced institutional violence at some point.

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We wish to thank the following people and organisations for their contributions to the survey:

- The people who completed the survey
- The people who participated in the focus group and interviews to give feedback after testing the survey
- ACT Health for funding Women's Health Matters and for promoting the survey through social media networks
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- ACT Office for Women, for support throughout the project
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 - The Australian Longitudinal Study on Women's Health
 - The University of Canberra
 - The Epidemiology Section at ACT Health
 - Women With Disabilities ACT
 - ACT Council of Social Service
 - Health Care Consumers' Association
 - Mental Health Consumer Network
 - Meridian
 - Multicultural Hub
 - Alo Women
 - A Gender Agenda
 - Carers ACT
 - Sexual Health and Family Planning ACT
 - YWCA Canberra

Introduction

Background and purpose

Gender is recognised by the World Health Organisation as a determinant of health, and gender inequality and discrimination have a negative impact on women's health and wellbeing outcomes.¹ Most of the existing datasets available for the ACT population, however, lack a gender lens or have sample sizes too small to provide sufficient detail on key indicators of women's health and wellbeing, such as sexual and reproductive health.

Women's Health Matters (WHM) has developed this survey as a tool to investigate the state of women's health and wellbeing in the ACT. The survey findings will be used to make the state of women's health and wellbeing in the ACT visible through high quality data, complementing the ACT Wellbeing Framework and other datasets, and enabling Women's Health Matters and our community partners to advocate for gender responsive health and wellbeing services for all ACT women.

WHM regularly conducts surveys on the experiences of specific groups of women in the ACT, and on specific topics relating to women's health and wellbeing. The current survey provides a larger and more representative sample, and a survey format that can be repeated in subsequent years to monitor trends over time.

Survey design

Scope in relation to other studies

We prepared the survey instrument by considering the range of topics that are important in women's health, as indicated by previous studies and policy development², our own organisation's scanning of issues in the ACT³, and the history of advocacy by women's health organisations and researchers over the previous several decades⁴.

We considered the other surveys that are conducted in the area of women's health (and intersecting with women's health). These included the Australian Longitudinal Study of Women's Health (ALSWH), the ACT General Health Survey, data collected for the ACT Wellbeing Framework, the Jean Hailes Women's Health Survey, the YWCA Canberra 'Our Lives' surveys, the Personal Safety Survey, and other Australian Bureau of Statistics (ABS) data collections.

Our focus as WHM is on making women's experiences of their health and health needs visible, on addressing the barriers women face in trying to maintain and improve wellbeing, and on improving the

¹ World Health Organization (2021) Gender and health Q&A, <https://www.who.int/news-room/questions-and-answers/item/gender-and-health>

² Australian Institute of Health and Welfare (2023) *The health of Australia's females* (web report), <https://www.aihw.gov.au/getmedia/0260a910-fe72-4d6b-8c7d-519557d465c8/The-health-of-Australia-s-females.pdf>; Australian Government Department of Health (2018) *National Women's Health Strategy 2020-2030*, <https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030.pdf>

³ See Women's Health Matters reports, <https://www.womenshealthmatters.org.au/resources/reports/>

⁴ For example, the work of the Australian Women's Health Network (www.awhn.org.au)

social and economic factors that can lead to better health. We have therefore left it to other studies to consider 'lifestyle' and behaviour factors in health, such as diet, smoking, and drug and alcohol intake.

Where possible we aimed to complement rather than replicate existing data; however, our aim was to provide a larger sample of ACT women than other studies, so in some cases we chose to replicate or adapt questions from other surveys.⁵ This will enable baseline comparisons with previous findings, as well as deeper opportunities to explore differences between groups of ACT women and relationships between different variables.

The study closest in approach and topics to ours, the Australian Longitudinal Study on Women's Health, collected data from around 600 women in the ACT in three of their cohorts (born 1946-51, 1973-78 and 1989-95) as part of their Australia-wide surveys in 2019-2022.⁶ Our study, with a larger sample covering all ages 18+ (conducted as a snapshot rather than a longitudinal study), will enable us to explore how women in the ACT experience their health and wellbeing (using similar topics and questions as the ALSWH), while making further comparisons between experiences of different groups and exploring relationships between the variables.

Women's Health Matters intends to conduct more detailed analysis in relation to other datasets over the coming months and years, as part of deeper explorations of particular topics and population groups in our study. The current report mainly presents an overview of our own findings, with some limited comparison to contextualise results where appropriate.

Consultation and testing

The survey instrument was developed in consultation with stakeholder organisations (listed in Acknowledgements above). This included drawing on the expertise of organisations that serve and advocate for people experiencing different kinds of marginalisation, as well as services that support health and wellbeing.

We also tested the survey instrument with a focus group of ACT women, and made refinements as a result, to help ensure that the online survey worked correctly and that the questions made sense.

We did not commission an external ethics committee review of the survey; however, the project was conducted in line with Women's Health Matters' *Research Guidelines* and consideration was given throughout to the potential impacts on people completing the survey. Measures to minimise potential negative impacts included the clear information provided to prospective respondents about the survey⁷, including about the sensitive topics covered, the extensive opportunities for respondents to opt out of sensitive or inapplicable questions, and information about support options provided at multiple points through the survey.⁸

⁵ See survey instrument reproduced as Appendix 1, available at <https://www.womenshealthmatters.org.au/resources/reports/>, which includes the sources for adapted questions.

⁶ Unpublished data, Australian Longitudinal Study on Women's Health, 2023, A1327 The health and wellbeing of women in the ACT Databook.

⁷ Women's Health Matters (2022) FAQ: Survey of Women's Health in the ACT, <https://www.womenshealthmatters.org.au/faq-survey-of-womens-health-in-the-act/>

⁸ Women's Health Matters (2022) Support Options: Survey of Women's Health in the ACT, <https://www.womenshealthmatters.org.au/support-options-survey-of-womens-health-in-the-act/>

The questions in the survey were mainly closed (checkbox/multiple choice) questions, as well as some options for open-ended responses. The final survey instrument is available online as Appendix 1.⁹

Gender scope of the survey

One of the aspects of the survey we consulted on was its gender scope. The scope as ultimately defined for the survey is **women, femme-identifying people and people who align themselves with this group** (who were 18 years or over and living in the ACT or surrounding region). This includes trans women who were assigned male at birth and non-binary people who align themselves with the term “women” for whatever reason.

Consideration was given to the fact that “women’s health services” (such as services assisting with uterine or ovarian health) should be inclusive of all people who need them, including trans men and some non-binary people. We are also conscious that there are few avenues for trans men and nonbinary people to give feedback on their experiences of accessing or not accessing such services.

Women’s Health Matters understands that where we are researching services of this kind, we need to encompass the experiences of trans and non-binary people, beyond the category “women”. In our recent work on Assisted Reproductive Technology and abortion care, for example, we defined the scope in relation to the service itself, to include people of all genders who might need or use those services.

In contrast, the current survey is intended to report on women’s health needs, experiences and determinants of health and wellbeing in a broad sense. Sex-based services are only a small aspect of this. While the survey’s findings may have implications for some sex-based services, the survey is not intended to evaluate how those services meet the needs of the full range of people who might use them.

We considered extending the scope of the survey to include people assigned female at birth who are not women or femme-identifying, on the basis that they may need to use “women’s health services”. However, we ultimately decided against this approach, because we lack expertise on the full range of needs and experiences of trans nonbinary people and men, while there are other organisations that are better-placed and have a stronger claim to be able to represent their views. We were also mindful to avoid defining the scope through sex as assigned at birth, since doing so in a survey focusing on “women’s health” could inadvertently legitimise an approach of defining people’s gender according to their physical sex characteristics.

Survey distribution and recruitment

Between November 2022 and February 2023, Women’s Health Matters opened the survey for responses. The survey was promoted through our email newsletter, Facebook, Instagram, radio, print media, and the social media accounts and networks of our government and community sector partners. Participants self-selected to be part of the survey, which was hosted on the *SurveyMonkey*[®] platform. As an incentive, participants received a chance to win one of two \$100 gift vouchers.

⁹ Appendix 1, Survey instrument, available at <https://www.womenshealthmatters.org.au/resources/reports/>

Respondents were not required to give their name or identifying details, although if they wished to enter the prize draw, they were required to provide their postcode (to help confirm eligibility) and email address so that we could contact the winners. Email addresses were separated from the survey responses once the survey closed, and deleted after the prizes were awarded. IP addresses were collected in order to prevent people from completing the survey more than once from the same device but deleted after the survey closed.

Survey participation was supported by a [Frequently Asked Questions](#) (FAQ) page, an online copy of the survey instrument in [Word](#) and [RTF](#) formats (for accessibility and so that people could view the survey in advance if they preferred), and a webpage with support options and services (such as telephone helplines and online chat services), to assist people who might find themselves distressed as a result of doing the survey (which included sensitive topics such as violence and pregnancy loss).

Data processing and analysis

After the survey closed, the data was downloaded from *SurveyMonkey*® and deleted from that platform. Data was cleaned to remove incomplete and invalid responses. Following this data cleaning, a set of 1668 complete responses remained, and these responses constitute the dataset used in this report.

The *Stata* statistical package (versions 17 and 18) was used to process and analyse the dataset.

Statistical notation and methods used

This report is mainly descriptive in nature, although some limited suggestions are made about possible relationships between indicators.

Most of the results are presented as proportions, showing the percentage of the responses (or a subset of responses) that gave a particular answer to a given question. In general, answers fewer than 10 responses are not shown, or are shown as aggregated with others where possible.

When reading the data tables, the following notes may be useful:

n= This notation shows the set of responses within which proportions are being compared (i.e. the denominator in the fraction or percentage showing such a proportion). For most tables, n=1668 (i.e. the full survey sample), but for some, it will represent a subset of responses. For example, only the 260 people who reported having endometriosis were asked about their satisfaction with endometriosis healthcare, so n=260 for the set of responses within which different levels of satisfaction were compared.

Freq. (Frequency)

Frequency refers to the number of people who gave a particular response to the question.

Cum. (Cumulative percentage)

Cumulative percentage is a running total adding percentage values, culminating in 100%. Cumulative percentage is shown in this report to indicate where the median (mid-point value) lies for any distribution of answers. The median lies in the category for which cumulative

percentage crosses 50%. In the following (hypothetical) example, the median value lies in the 'Fair' category because, at 55%, this is where the cumulative percentage crosses 50%:

	Per cent (%)	Cum. (%)
Excellent	20	20
Very good	15	35
Good	10	45
Fair	10	55
Poor	45	100

Note that the median is not necessarily in the category with the largest proportion (i.e. the mode - in this example 'Poor').

Limitations of the study and possibilities for future research

Like any study, this one has limitations. These relate mainly to our sampling method and the representativeness of our sample.

As discussed in the Demographics section below, we did not use a random sampling method to conduct our survey. Instead, respondents were recruited through traditional media, social media, email and in-person approaches, and they self-selected to complete the online survey. As a result, while our survey sample is relatively large and broadly representative of the ACT population of women, there are some areas in which the sample differs from the population.

The most notable gaps in our survey are the underrepresentation of younger (under 25 years old) and older (over 54 years old) women, and of women from migrant and refugee backgrounds. The fact that the survey was conducted in written English and through an online format were limitations that would have prevented some people from participating, and redressing these would be a key consideration for any future iteration of the survey.

Another factor that may have influenced results (compared with other surveys such as the ACT General Health Survey) is that Women's Health Matter is embedded in the ACT community in a way that emphasises our advocacy on issues of health equity and our role in helping to make marginalised experiences visible. Our networks and public profile are linked with this role, so it is possible that we tended to recruit people for the survey whose experiences were more likely than average to be marginalised or who were negatively impacted by health inequity.

People responding anonymously through our online survey may also be more likely to give frank comments about negative or sensitive experiences compared to phone surveys or in-person surveys, particularly where the latter are conducted by government or more 'official' agencies compared with our organisation.

Nevertheless, the large sample size of our survey, together with the generally wide representation across different dimensions including disability, location, educational attainment, sexuality, and carer status, means we can be confident that the issues raised by the findings are significant in the ACT community.

As mentioned above, this report is broadly descriptive in nature and does not explore in depth relationships that might exist between different indicators, e.g. the differences across demographic characteristics, or possible associations between different variables (such as experiences of violence and measures of mental health).

While extensive qualitative information (open-ended responses) was provided by respondents, this report does not include systematic qualitative analysis of these answers. Illustrative quotes are provided throughout the report where these are relevant to flesh out the quantitative findings.

Over the coming months and years, Women's Health Matters will conduct further analyses using the dataset and will explore possible collaborations with community partners to interpret, contextualise and ultimately apply the findings.

Findings 1: Demographics

We collected information about key characteristics of the people who responded to the survey, so that we can establish how representative the sample is, and so that we can explore patterns in health experiences and health needs across these characteristics. Our demographic questions included questions about gender, sexuality, Aboriginal and Torres Strait Islander status, cultural, language and migration background, socioeconomic and educational background and housing and location. Data collected about these characteristics are presented in the following sections.

The survey design did not use a random sampling method. Instead, respondents were recruited through traditional media, social media, email and in-person approaches, and they self-selected to complete the online survey. As a result, while our survey sample relatively large and broadly representative of the ACT population of women, there are some areas in which the sample differs from the population as measured by other studies such as the Census. In particular, young and older women, and women from multicultural backgrounds are underrepresented in our sample.

Key demographic features of the sample

1668 eligible people completed the survey (women, femme-identifying people and people who align themselves with this group, who were aged 18+ years and living in the ACT or region).

1.7% of the survey responses were from Aboriginal and/or Torres Strait Islander people (similar to the ABS 2021 Census figures for ACT women aged 18 and over).

28% (the largest proportion) were aged 35-44 (proportionally fewer young women under 25 years old and older women over 54 years old, compared with the 2021 census).

83% were born in Australia (compared with 64% in the ABS census).

14% identified as being from a migrant background, and **2%** as a temporary visa holder.

96% spoke English as their main language at home (compared with 70% in the ABS census).

About **23%** had a disability (similar to the ACT population of women¹⁰).

About **79%** identified as heterosexual.

81% were employed (compared with around 70% in the ABS census).

51% reported at least one indicator of financial stress (higher levels of financial stress than reported by ACT women generally in previous surveys¹¹).

¹⁰ ACT Health (2021) Disability, adults (ACT General Health Survey, 2019 – 2021), <https://health.act.gov.au/about-our-health-system/data-and-publications/healthstats/statistics-and-indicators/disability-2>

¹¹ ACT Government (2021) Open Data Portal dataACT - ACTGHS financial stress, adults, 2019-2021, <https://www.data.act.gov.au/Health/ACTGHS-financial-stress-adults-2019-2021/yb9x-xaa5?referrer=embed>

Aboriginal and Torres Strait Islander people

Around 1.7% (29) of the survey respondents were Aboriginal and/or Torres Strait Islander people. This is similar to the ABS 2021 Census figures for ACT women aged 18 and over.¹²

Respondents were asked to select from 'Aboriginal', 'Torres Strait Islander', 'Aboriginal and Torres Strait Islander', 'Neither', or 'Prefer not to answer'. Because of low numbers, the results for 'Aboriginal', 'Torres Strait Islander', 'Aboriginal and Torres Strait Islander' are reported together, as the single category 'Aboriginal and/or Torres Strait Islander'.

Gender and sexuality

Sound data on self-identified gender, sexuality and sex assigned at birth is lacking in Australian studies, although improvements are being made.¹³ It is therefore difficult to compare our dataset with older datasets for the purpose of assessing representativeness.

Gender

Almost all respondents identified themselves as women or female. Around 1% (16) identified as non-binary, while 12 respondents selected 'Prefer not to answer' or 'Other'.

Sexuality

A total of 304 people, or 18% of the sample of 1668 people, reported they were bisexual, gay, or lesbian, pansexual, queer or another term (described in open-ended responses).

¹² Australian Bureau of Statistics (2022) 2021 Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians – ACT (data collated using TableBuilder), <https://tablebuilder.abs.gov.au/>

¹³ Australian Bureau of Statistics (2021) *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables*, <https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release>; ACON (2023) *Recommended Community Indicators for Research*, <https://www.acon.org.au/what-we-are-here-for/policy-research/#recommended-sexuality-and-gender-indicators>

Table 1: Sexual Orientation

	Freq.	Per cent (%)
Straight - heterosexual	1,311	79
Bisexual	193	12
Gay or lesbian	48	3
Don't know	33	2
Prefer not to answer	20	1
Pansexual	20	1
Queer	18	1
Other	25	1
Total	1,668	100

Sex assigned at birth

Sex assigned at birth differs from gender because it reflects assessments made by medical staff, parents and others about the biological sex of a newborn, based on visible physical characteristics (presence of a vulva or penis). Typically, these assignments are binary in nature, resulting in categories of 'Female' and 'Male'. Gender refers to a person's experience and sense of themselves, with a broader range of possibilities as indicated in the table above, not necessarily reflecting sex assigned at birth.

In our survey, 99% (1651 respondents) said that they were assigned female at birth, while 1% (10) said they had been assigned male. Seven people selected 'Prefer not to answer' or 'Other'.

Intersex

"Intersex" refers to a variation of sex characteristics, such that a person has sex characteristics that do not fit medical and social norms for female or male bodies.¹⁴ As Intersex Human Rights Australia explains, people with these characteristics experience stigma, discrimination and harm as a result, or are at risk of these experiences.

Sex characteristics are physical features relating to sex, including chromosomes, genitals, gonads, hormones, and other reproductive anatomy, and secondary features that emerge from puberty.

We asked survey respondents "Were you born with a variation of sex characteristics (sometimes called 'intersex')?" Around 0.5% (approximately 10 people) reported that they were intersex, while seven said they preferred not to answer.

Age

Our sample was more concentrated around the 35–44-year age group (and to a lesser extent, the 25-43 and 45-54-year-old groups) than the population of women in the ACT as a whole. This means that

¹⁴ Intersex Human Rights Australia (2021) What is intersex? <https://ihra.org.au/18106/what-is-intersex/>

our sample underrepresented people aged 18-24 and those aged over 55, as shown in the following chart.

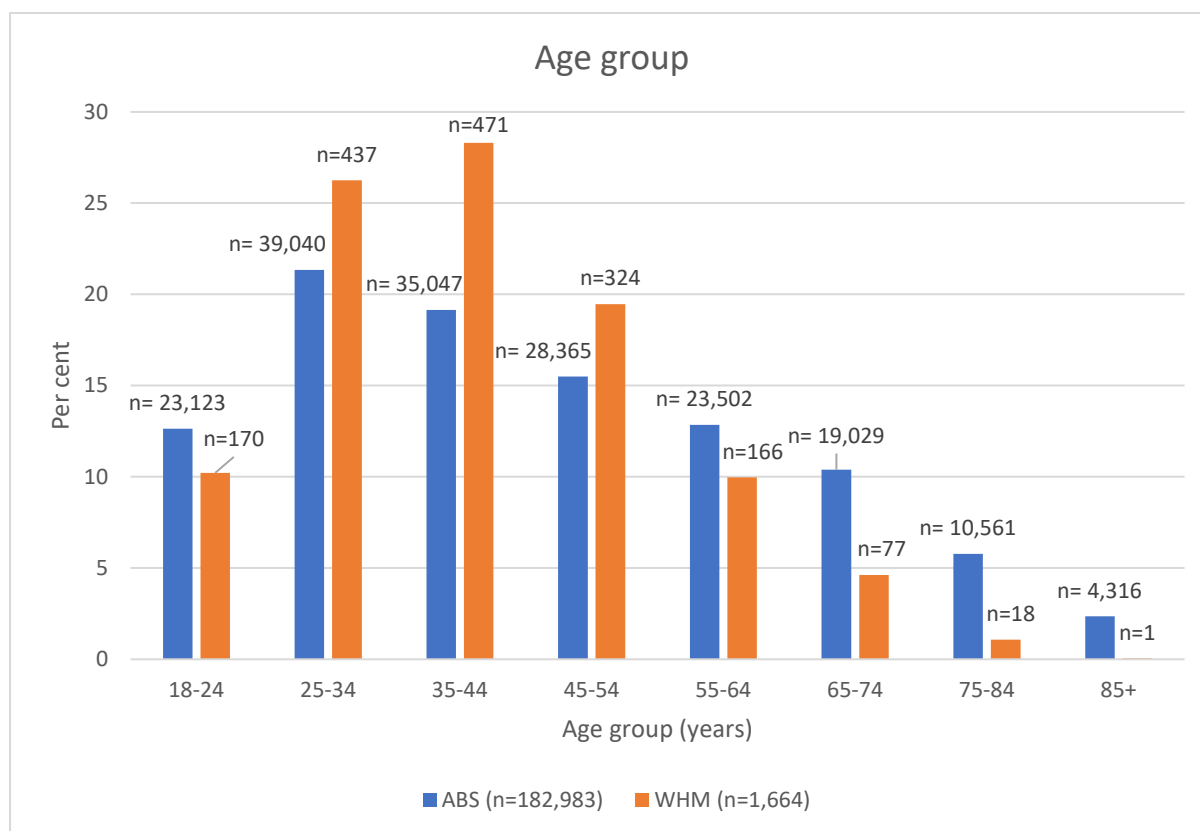


Figure 1: Age Group

Note: Our survey data (WHM) excludes 4 responses from people who selected 'Prefer not to answer'.

Country of birth, language and migration background

Country and region of birth

Around 17% of respondents were born outside of Australia. Of those born outside of Australia, the largest groups were born in England (3.7%), New Zealand (1.7%), India (1.3%) and China (0.8%). In terms of region of birth, the vast majority were born in Oceania (86%), with smaller proportions born in North-Western Europe (5.7%), South and Central Asia (2.3%) and South East Asia (2.2%).

Table 2: Country of Birth

Country of birth	Freq.	Per cent (%)
Australia	1382	82.9
England	61	3.7
New Zealand	29	1.7
India	22	1.3
China	14	0.8
Malaysia	12	0.7
Philippines	10	0.6
Other (fewer than 10 respondents per country) *	124	7.4
Other (unspecified)	14	0.8
Total	1668	

Table 3: Region of Birth

Region of birth	Freq.	Per cent (%)
Oceania and Antarctica	1417	85.7
NW Europe	94	5.7
South and Central Asia	38	2.3
South East Asia	36	2.2%
North East Asia	21	1.3%
Americas	17	1.0%
Sub-Saharan Africa	13	0.8%
South East Europe	10	0.6%
Other (fewer than 10 respondents per region)	8	0.5%
Total*	1654	100%

* Excluding 14 responses where no country was specified for 'Other - specify'

Our survey sample contained a smaller proportion of people born outside Australia (17%) compared with the proportion of the population of ACT women as a whole (aged 18 and over) who were born outside Australia (36%), measured by the 2021 Census.

This difference probably reflects limitations from our recruitment and sampling strategy, specifically that the survey was provided only in written English online and required respondents to self-select for participation. Most likely, the same limitations also impacted on the findings for main language spoken at home and preferred language (presented below).

Length of stay in Australia

For those who answered that they were born outside of Australia (n=286) we asked how long they had lived in Australia. The largest group was those who had lived in Australia for more than 20 years, while the median length of stay in Australia was between 10 and 20 years.

Table 4: How long lived in Australia

	Freq.	Per cent (%)	Cumulative %
Less than 5 years	45	15.7	15.7
Between 5 and 10 years	37	12.9	28.7
Between 10 and 20 years	75	26.2	54.9
More than 20 years	129	45.1	100
Total	286	100	

Main language spoken at home

For all respondents, we asked about the main language they spoke at home. We offered several pre-set options as well as an option to answer 'Other' and specify through open ended response.

The vast majority of respondents (96%) reported that they spoke English as their main language at home.

Table 5: Main Language Spoken at Home

	Freq.	Per cent (%)
English	1,604	96.2
Mandarin	15	0.9
Other (<10 responses)	49	2.9
Total	1,668	100

Preferred language

For all respondents, we asked about the main language they spoke at home. We offered several pre-set options as well as an option to answer 'Other' and specify through free text.

Again, English was reported as the preferred language by almost all respondents (97.6%).

Table 6: Preferred Language

	Freq.	Per cent (%)
English	1,628	97.6%
Mandarin	11	0.7%
Other (<10 responses)	29	1.7%
Total	1,668	100

Migration background and visa status

For all respondents, we asked whether they identified as being from one or more of the following backgrounds: Migrant background, Refugee or asylum seeker background, or Temporary visa holder. Respondents could also indicate 'None of the above' or 'Prefer not to answer'.

Table 7: Migration Background and Visa Status

	Freq.	Per cent (%)
None of the above	1384	83.0%
Migrant background	232	13.9%
Refugee or asylum seeker background	6	0.4%
Temporary visa holder	34	2.0%
Prefer not to answer	20	1.2%

N=1668

By giving the option to select 'Migrant background', this question is designed to allow people who were born in Australia and whose family background involves migration to indicate this background, together with those who migrated themselves.

Of those who identified as being from a migrant background (n=232), 102 people also indicated in a separate question that they were born in Australia. Conversely, 119 respondents told us that they were born outside of Australia but did not identify as being from a migrant background, a refugee or asylum seeker background, or being a temporary visa holder. The largest groups among these were people born in England and New Zealand.

Disability

We asked all respondents whether they were a person with a disability or disabilities, explaining that, for the purposes of our survey, “disability means any impairment, activity limitation or participation restriction that prevents a person's full and equal participation in society. This includes mental illness and/or mental disorders as well as physical or intellectual disabilities.”

Respondents were able to select ‘Yes’, ‘No’, or ‘Unsure’. There were 41 answers of ‘Unsure’, for which respondents were asked to describe, using a free text answer. Following analysis of the open-ended responses against the definition in the question, all but 4 of these responses were recoded to reflect a ‘Yes’ answer.

In total, 382 people (23% of the sample of 1664 people) indicated that they had a disability. This sample excludes four (4) responses where the person gave an open-ended response that was not coded as 'yes' for disability.

The proportion of people with disability in our survey sample was similar to the proportion of women with disability recorded in the ACT General Health Survey (23.1%).¹⁵

Labour, income and education

Being a carer

Providing care is critical for human survival and flourishing. Unfortunately, economic and social structures undervalue caring labour (along with the lives of those who need care). This undervaluing can result in marginalisation and disadvantage for the people who give care as well as the people who receive it (acknowledging that these categories overlap). Caring labour is gendered, with women more likely to spend substantial amounts of time providing unpaid care.¹⁶

We asked all respondents whether they were a carer.

We defined a carer (consistent with the ACT *Carers Recognition Act 2021*) as someone who provides unpaid assistance with the tasks of daily living to another person who has a disability, has a mental disorder or mental illness, has an ongoing medical condition (terminal or chronic illness), is aged and frail, and/or is a child or young person for whom the carer is a kinship carer or a foster carer, and not including being a parent except where a person’s child has one of the other conditions or disabilities listed above.

Just over one-sixth of the 1668 survey respondents (17.5% or n=291) reported that they were carers.

In our survey, proportionally more people who reported being carers also reported having a disability compared with people who are not carers. A total of 32.5% of people who reported being carers also reported having a disability, compared with 21% of people who were not carers reporting having a

¹⁵ ACT Health (2022) *ACT General Health Survey 2020 Statistical Report*, ACT Government, Canberra ACT, <https://health.act.gov.au/sites/default/files/2022-11/2020%20General%20Health%20Survey%20Statistical%20Report%20FINAL%20updated%2020221110.pdf>, p. 12

¹⁶ Australian Bureau of Statistics (2019) *Disability, Ageing and Carers, Australia: Summary of Findings*, 2018, <https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release#carers>

disability. Conversely, proportionally more people who reported having a disability also reported being a carer, compared with people who do not have a disability. A total of 24.6% of people with a disability also reported being carers, compared with the 15% of people who do not have a disability reporting being carers.

People aged 45-54 were most likely to be carers, with 28.4% of people in this age group providing unpaid assistance with the tasks of daily living to someone in the groups listed above, followed by 27.7% of people in the 54-64-year age group.

Looking at employment status, the large proportion of people in the sample who were employed (81%) meant that most people who were carers were also employed (224 people, or 77% of all carers). However, people who were unemployed for 6 months or more contributed more than their share of unpaid care labour, being the group most likely to be carers. Nearly a quarter (24%) of people unemployed for 6 months or more provided unpaid care. This compares with 16.5% of people who were employed and 13% of people unemployed for less than 6 months who reported being carers.

Highest level of education or qualification attained

The majority of respondents (over 70%) had some form of degree qualification. The largest groups overall were those with a Bachelor Degree (27%), followed by those with a Masters Degree (21%). The median qualification reported was Bachelor Degree.

Table 8: Highest Level of Schooling or Qualification

	Freq.	Per cent (%)	Cumulative %
Year 8 or below	1	0.1	0.1
Year 9 or equivalent	7	0.4	0.5
Year 10 or equivalent	20	1.2	1.7
Year 11 or equivalent	12	0.7	2.4
Year 12 or equivalent	156	9.4	11.8
Certificate II	8	0.5	12.3
Certificate III or Trade	44	2.6	14.9
Certificate IV or Post-trade	69	4.2	19.1
Advanced Certificate	7	0.4	19.5
Associate Diploma	11	0.7	20.2
Diploma	93	5.6	25.8
Advanced Diploma	37	2.2	28.0
Associate Degree	6	0.4	28.4
Bachelor Degree	452	27.2	55.6
Bachelor Degree with Honours	109	6.6	62.1
Graduate Certificate	71	4.3	66.4
Graduate Diploma	142	8.5	75.0
Masters Degree	348	21.0	95.9
Doctorate	68	4.1	100
Total	1661	100.0	

Government pensions or allowances

We asked respondents whether they were receiving any kind of government pension or allowance, such as Jobseeker, Carers Allowance, Disability Support Pension, study allowances for students, other pensions and allowances received by people who are aged, disabled, unemployed or sick, carers, families and children, veterans or their families.

Of the 1668 respondents, 86.2% told us that they did not receive such a pension or allowance, while 13.2% did (and 0.6% were unsure).

Employment status

We asked all 1668 respondents about whether they were currently employed, and if not whether they had been unemployed for less than six months or longer. The median status reported was 'Employed', with 81.5% of respondents reporting being employed.

Table 9: Current Employment Status

	Freq.	Per cent (%)	Cumulative %
Unemployed for 6 months or more	241	14.5	14.5
Unemployed for less than 6 months	69	4.1	18.6
Employed	1,358	81.4	100
Total	1,668	100	

Although the definitions used are not identical, this measure can be compared with the ABS Labour Force Status dataset, which is part of the 2021 Census. The ABS Census showed that 68.3% of women in the ACT over 18 years of age were employed (selected either employed full-time, employed part-time or employed but currently away from work), compared with 31.7% who were not employed (selected either unemployed – looking for full-time work, unemployed – looking for part-time work, or not in the labour force).

This result suggests that people who were employed were more likely to take our survey. The relatively higher rates of employment shown in our survey could be related to the age profile of our sample, which has comparatively higher proportions of people who are in the age groups most likely to be employed (25-24 years, 35-44 years, and 45-54 years old), and smaller proportions in the age groups less likely to be employed (18-24 years old and over 54 years old). It might also be related to increasing employment after the restrictions and economic impacts of the early stages of the COVID-19 pandemic.

Wanting to work more hours for pay

Women's underemployment is an established feature of the Australian labour market and contributes to gender inequality in employment and income.¹⁷ Our survey shows a significant proportion (over a fifth, or 20.7%) of people wanting to work more hours for pay than they currently do.

As would be expected, many (34%) of those who want to work more hours for pay are those who are not employed. However, a majority (66%) of those who want to work more hours for pay are already employed. Overall, 17% of people who told us they are employed also indicated they want to work more hours for pay.

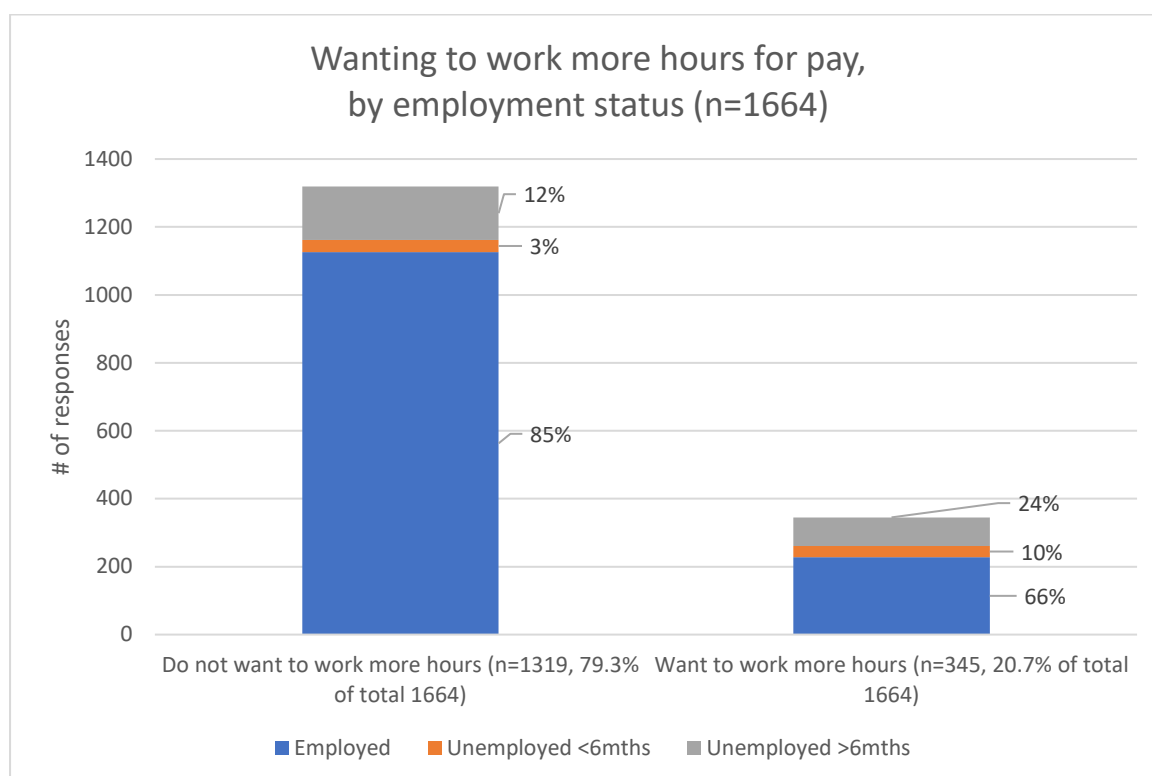


Figure 2: Wanting to work more hours for pay, by employment status

People who have a disability are represented at more than twice the rate (37%) among people who want to work more hours for pay than people without a disability (16%). This is consistent with analysis of answers to the earlier question about government payments, which showed that proportionally more people with disability were relying on government payments or allowances than respondents as a whole, with a quarter (25%) of people with disability in this situation, compared with 13% of the sample overall. Our other research¹⁸ also confirms that women with disability face significant barriers

¹⁷ Ticha, V. (2021) 'Women, underemployment and gender inequality in the labour force', UNSW Newsroom, <https://newsroom.unsw.edu.au/news/business-law/women-underemployment-and-gender-inequality-labour-force>

¹⁸ Women's Health Matters (2022) "I have to ask to be included..." The views of ACT women with disabilities about their health and health needs, access to services, supports and information, and barriers to maintaining health, <https://www.womenshealthmatters.org.au/wp-content/uploads/2022/02/Womens-Health-Matters-Women-with-disability-health-and-wellbeing-report-February-2022.pdf>

in employment and are often prevented from working to their desired level by inaccessible work systems and settings.

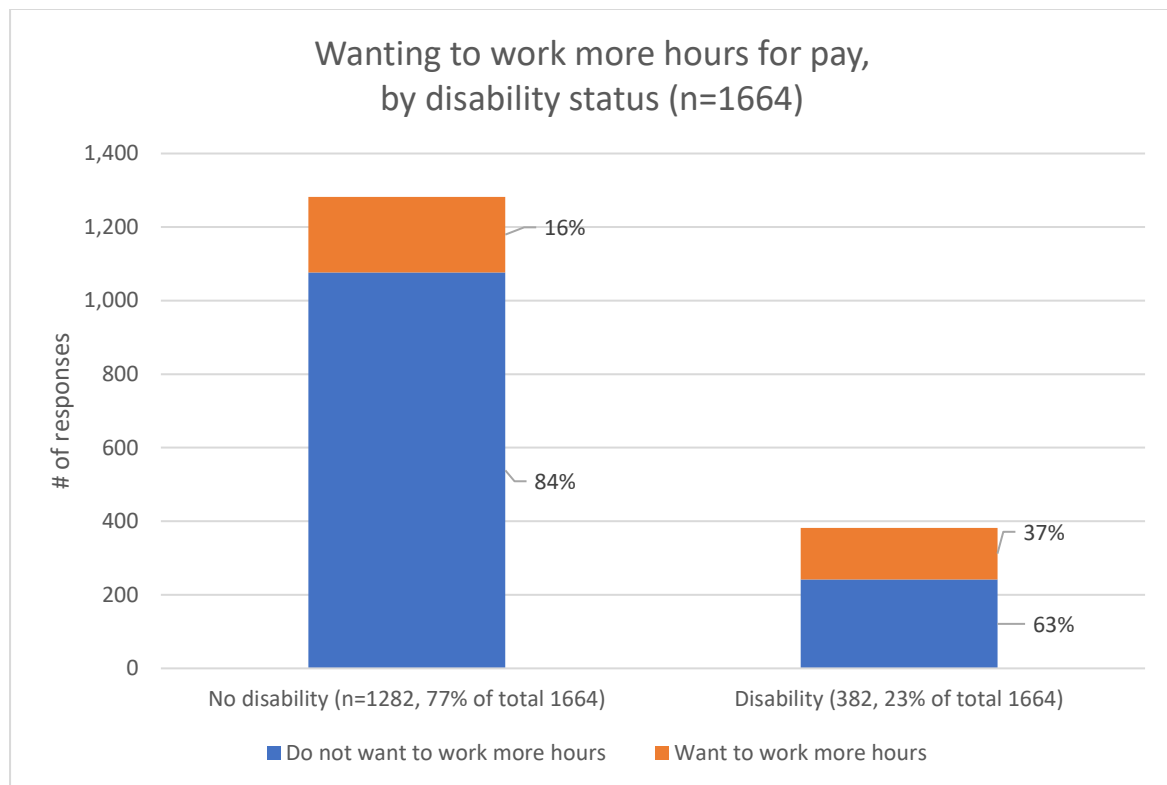


Figure 3: Wanting to work more hours for pay, by disability status

Hours worked for pay in a usual week

The largest proportion (41%) of respondents were working full-time hours (35-44 hours per week), followed by 21.5% working 20-34 hours per week. The median measure for hours worked for pay in a usual week was 35-44 hours per week.

Table 10: In usual week, hours spent in paid work (ranges)

	Freq.	Per cent (%)	Cumulative %
0 hours	286	17.2	17.2
1-19 hours	178	10.7	27.8
20-34 hours	358	21.5	49.3
35-44 hours	686	41.1	90.4
45-59 hours	141	8.5	98.9
60+ hours	19	1.1	100.0
Total	1,668	100	

Hours studying in usual week

Most respondents (69.7%) reported no hours of study in a usual week, while 23.4% reported studying 1-19 hours.

Table 11: Hours spent studying in usual week (ranges)

	Freq.	Per cent (%)	Cumulative %
0 hours	1,163	69.7	69.7
1-19 hours	391	23.4	93.2
20-34 hours	76	4.6	97.7
35-44 hours	27	1.6	99.3
45-59 hours	9	0.5	99.9
60+ hours	2	0.1	100.0
Total	1,668	100	

Financial stress

We asked respondents whether over the last 12 months any of a series of ten scenarios had happened to them because they were short of money.

Consistent with other surveys such as the ACT General Health Survey, the indicator of financial stress reported most commonly was “Delayed or cancelled non-essential purchases”. However, the overall result for each indicator was higher in our survey than in the 2021 ACT General Health Survey (comparing with adults 18 years and over, not disaggregated by gender). This could reflect both the difference in gender profile (which is not disaggregated for the available ACT General Health Survey data) and the difference in economic conditions between 2021 and 2022/23 including factors such as changes to Jobseeker payments and interest rates, as well as differences resulting from our sampling strategy (as discussed above).

Table 12: Indicators of financial stress

	Answered question*	Freq. (Number answered 'yes')	Per cent (%)	ACT General Health Survey 2021
Delay non-essentials	1583	745	47.1%	14.2%
Could not pay utilities	1593	250	15.7%	5.6%
Could not pay housing costs	1596	121	7.6%	1.9%
Could not pay car expenses	1600	191	11.9%	2.9%
Could not make credit card payments	1578	128	8.1%	3.6%
Sold items	1609	219	13.6%	4.8%
Went without meals	1608	177	11.0%	2.2%
Unable to heat or cool home	1598	137	8.6%	1.8%
Sought assistance from family	1613	396	24.6%	7.9%
Sought assistance from community org	1608	109	6.8%	5.8%

* For each question from this set, some of the full sample of people (n=1668) did not answer. Percentages in this table are calculated as a proportion of those who answered each question, excluding those who selected “Don’t know” or “Prefer not to answer”

Housing and location

Housing arrangement

All respondents were asked about their housing arrangement and were directed to select one of seven pre-set options (as listed in table) or to select “Another arrangement” and describe this in an open-ended response.

Upon exploration of the data, two repeatedly mentioned categories emerged from the free text answers. The data was recoded to encompass these two categories (Living with family – 4.4%; and University accommodation – 0.6%), leaving 24 answers in the “Another arrangement” category.

Approximately half of the 1668 survey respondents reported that they owned their home with a mortgage (the most common housing arrangement). Around 28% of respondents were renters, with almost 16% (of the full sample of 1668) renting from real estate agents. Around 15% owned their homes outright.

Table 13: Housing arrangement

	Freq.	Per cent (%)
Owned outright	253	15.2
Owned with mortgage	837	50.2
Rented - ACT Housing	58	3.5
Rented - community housing	19	1.1
Rented - real estate agent	261	15.7
Rented - other landlord	132	7.9
Living with family	74	4.4
University accommodation	10	0.6
Another arrangement (open-ended responses)	24	1.4
Total	1,668	100

Region of ACT

Respondents were asked which area of the ACT and region they resided in. The largest proportion (24%) reported living in Belconnen.

Table 14: Region of ACT

	Freq.	Per cent (%)
Belconnen	400	24.0
Tuggeranong	292	17.5
North Canberra	274	16.4
Gungahlin	224	13.4
Woden Valley	132	7.9
South Canberra	104	6.2
Weston Creek	102	6.1
Rural or regional area outside ACT	100	6.0
Molonglo Valley	40	2.4
Total	1,668	100

Incarceration

Respondents were asked about experiences of incarceration: “Have you ever spent time in a jail, prison, juvenile detention centre, or other correctional facility?” Only a small minority (11 people, or just under 1% of the full survey sample of 1668) reported having ever been incarcerated.

Findings 2: Health & healthcare

Self-rated health

Self-rated health is a standard measure of health used in many surveys including the ACT General Health Survey, the Australian Longitudinal Study of Women's Health and the ABS's National Health Survey. It is administered as a single question about how respondents rated their overall health, using a five-point scale ('Excellent', 'Very good', 'Good', 'Fair' or 'Poor').

Self-rated health is considered a good indication of a person's health at the population level¹⁹, has been shown to have predictive power in relation to mortality, and has the benefit of incorporating social and mental health aspects of health, rather than considering health only as the absence of disease.²⁰

Results of self-rated health surveys are typically presented by comparing two categories: 'Excellent' and 'Very good' (taken together) and 'Fair' and 'Poor' (together), as well as how results are spread across all five of the categories.

Results of our survey show that more respondents rated their health as 'Fair' or 'Poor' (39.8%) than rated their health as 'Very good' or 'Excellent' (27.6%).

Table 15: Self-rated health

	Freq.	Per cent (%)	Cumulative %
Poor	225	13.5	13.5
Fair	436	26.2	39.8
Good	542	32.6	72.4
Very good	366	22.0	94.4
Excellent	93	5.6	100.0
Total*	1,662	100	

* Excluding 6 responses of 'Don't know' or 'Prefer not to answer'

¹⁹ Australian Bureau of Statistics (2019) '4363.0 - National Health Survey: Users' Guide, 2017-18', <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4363.0Main+Features12017-18?OpenDocument>

²⁰ Lorem, G., Cook, S., Leon, D.A., Emaus, N., Schirmer, H. (2020) 'Self-reported health as a predictor of mortality: A cohort study of its relation to other health measurements and observation time' *Scientific Reports* (*nature.com*), 10, 4886 (2020), <https://www.nature.com/articles/s41598-020-61603-0>

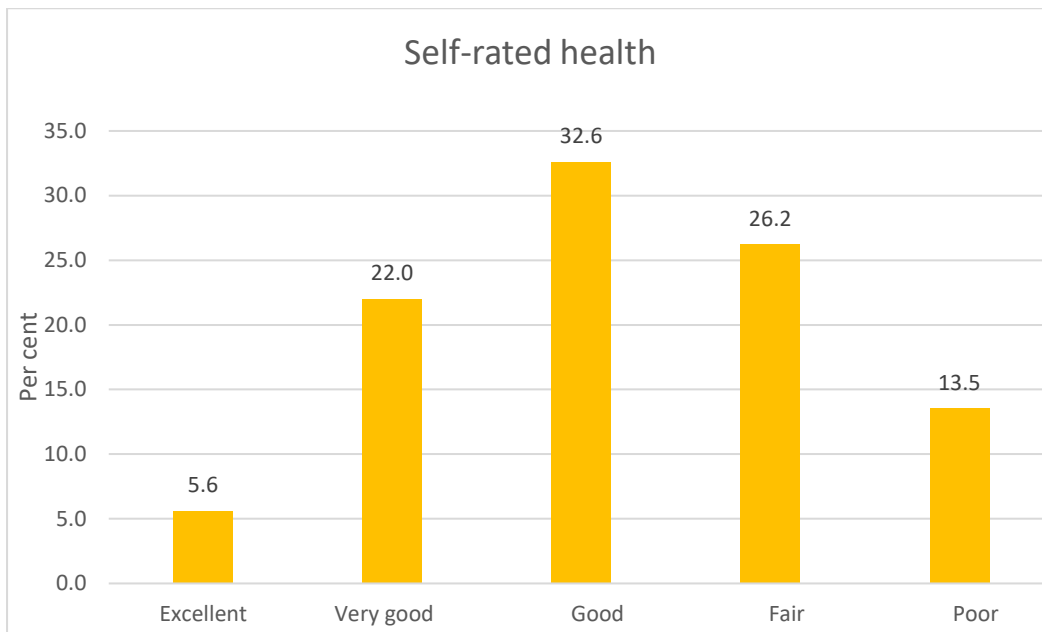


Figure 4: Self-rated health

Comparing our findings with other datasets, we can see that people in our survey overall rated their health more poorly than women over 18 in other surveys conducted previously. The ALSWH, for example, collects data from several cohorts of women across Australia, including assessments of self-rated health. The most recent surveys of relevant cohorts show higher self-rated health overall, compared with our survey, as illustrated in the following chart.

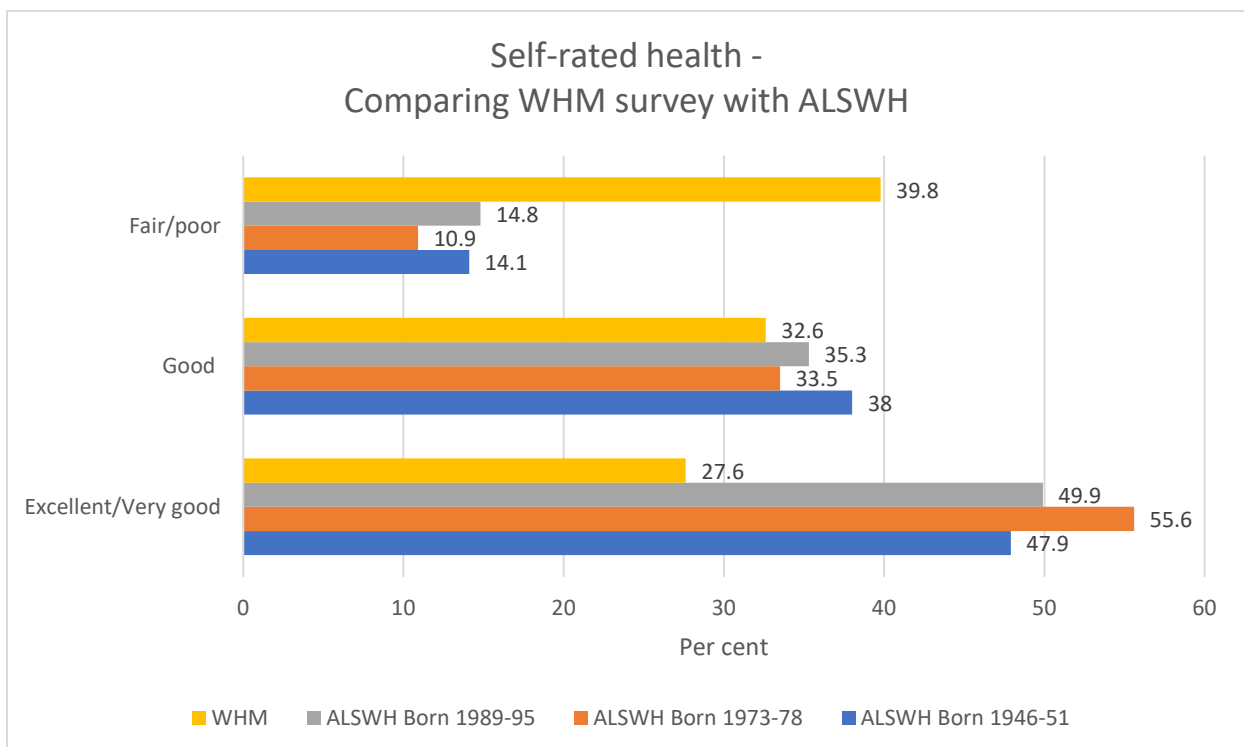


Figure 5: Self-rated health: Comparing WHM survey with ALSWH

Looking at the most recent results from the ACT General Health Survey (2021), we can see that self-rated health among our respondents is lower overall than results for male and for female people in the ACT population of adults as a whole (as measured by the ACT General Health Survey).

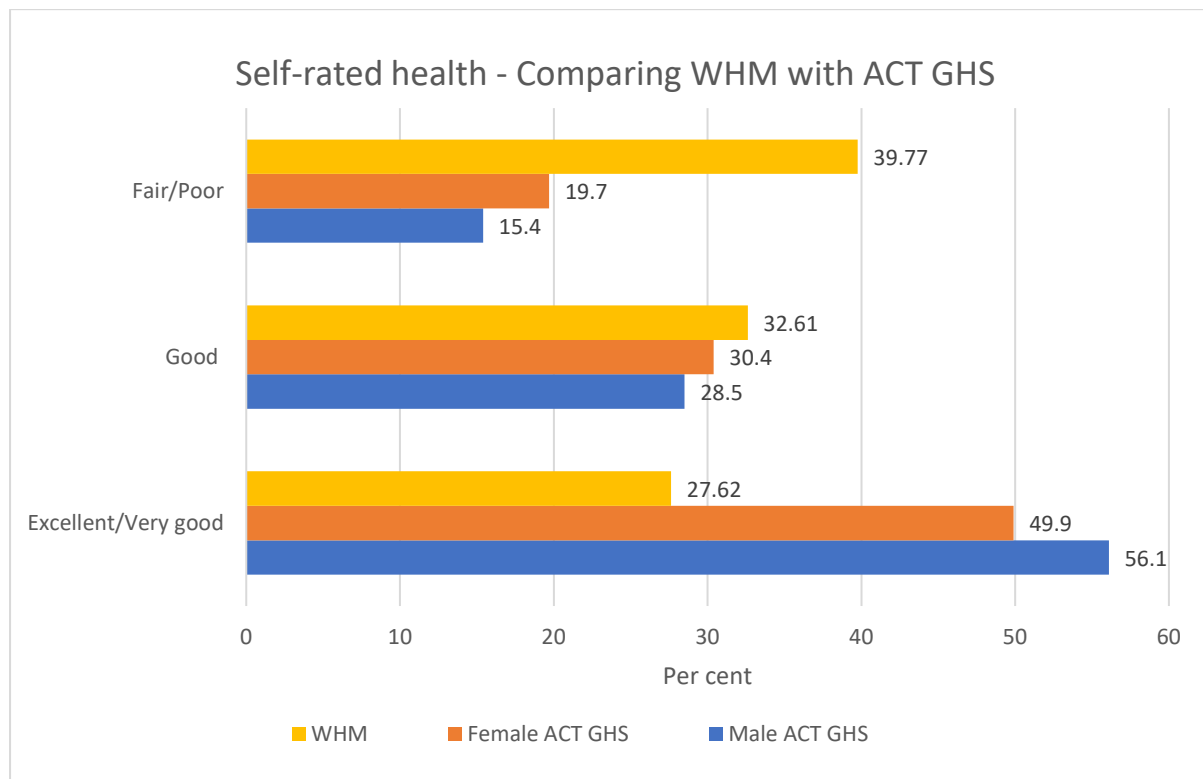


Figure 6: Self-rated health: Comparing WHM with ACT General Health Survey

Although further analysis will be conducted to explore the reasons for and implications of this difference in results, our preliminary assessment is that self-rated health appears poorer in our survey because of differences in sampling strategy (as discussed above, p. 25) and potentially higher representation of groups more likely to experience poor health. It is also possible that the impact of the COVID-19 pandemic and economic factors over recent years and months has influenced results in our survey, compared with surveys conducted two or three years ago.

Health professionals consulted with

We asked respondents to select from a list of services/professionals to indicate which ones they had consulted or used in the last 12 months. All 1668 respondents answered this question.

The results show that by far the most commonly consulted type of service/professional is General Practitioners (GPs) (91.9%), followed by allied health professionals (60.4%). It is also notable that over a third of respondents reported using telehealth at least once in the previous 12 months. Only a very small percentage of people (2.6%) consulted none of the services/professionals listed.

As discussed elsewhere in this report (see below on p. 43), respondents reported high rates of mental distress and mental illness, with around 64% of people reporting that they had been treated for or

diagnosed with a mental health condition and 45% reporting treatment/diagnosis in the last 2 years. In this context, it is notable that only around a third of respondents reported having consulted with a psychologist, counsellor or other mental health worker in the last 12 months.

Table 16: Services used in last 12 months

	Freq.	Per cent (%)
A GP (general practitioner)	1,533	91.9
Allied health professional ²¹	1,007	60.4
Health information on the internet	964	57.8
Dentist	868	52.0
Specialist (such as a cardiologist, gynaecologist or neurologist)	745	44.7
Apps to support your health (e.g. on your phone, watch or tablet)	608	36.5
Telehealth (consultation with a health service by phone/computer)	587	35.2
Psychologist, counsellor, or other mental health worker	569	34.1
Nurse ²²	331	19.8
Emergency department in a hospital	302	18.1
Healthdirect phone service	189	11.3
Consulted an alternative health practitioner ²³	153	9.2
Consulted a midwife	130	7.8
Consulted with none of these services	44	2.6

Rating access to GP

We asked respondents to rate their overall access to a General Practitioner (GP), with specific features of access (such as cost, physical accessibility etc) to be explored in separate questions.

In general, access to a GP was rated positively, with significantly more people (44.7%) rating their access as 'Excellent' or 'Very good', compared with people rating their access as 'Fair' or 'Poor' (26.4%).

²¹ In the survey, the category was listed after 'Psychologist, counsellor or other mental health worker' and worded as 'Another allied health professional (optometrist, physiotherapist, dietitian, chiropractor, osteopath, pharmacist, podiatrist, speech pathologist).

²² In the survey the category was worded as 'Community nurse, practice nurse or nurse practitioner (e.g. walk-in clinic)'.

²³ In the survey the category was listed as 'Alternative health practitioner (naturopath, acupuncturist, herbalist)'.

Table 17: Rating GP Access

	Freq.	Per cent (%)	Cumulative %
Poor	134	8.0	8
Fair	306	18.4	26.4
Good	482	28.9	55.3
Very good	486	29.1	84.4
Excellent	260	15.6	100.0
Total	1,668	100	

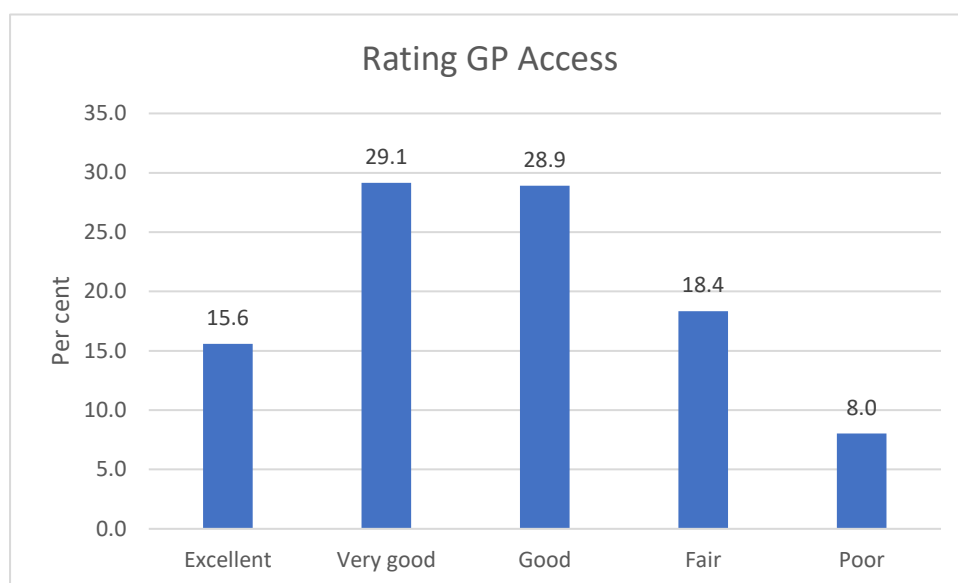


Figure 7: Rating GP access

Looking by area of residence, it appears that residents of North Canberra rate their GP access more poorly than residents of other areas. However, across each area including North Canberra, there was a larger proportion of people rating access as 'Excellent/Very good' than rating access as 'Fair/Poor'. It is likely that in Canberra access to a GP is more strongly related to factors such as cost and availability, rather than area of residence.

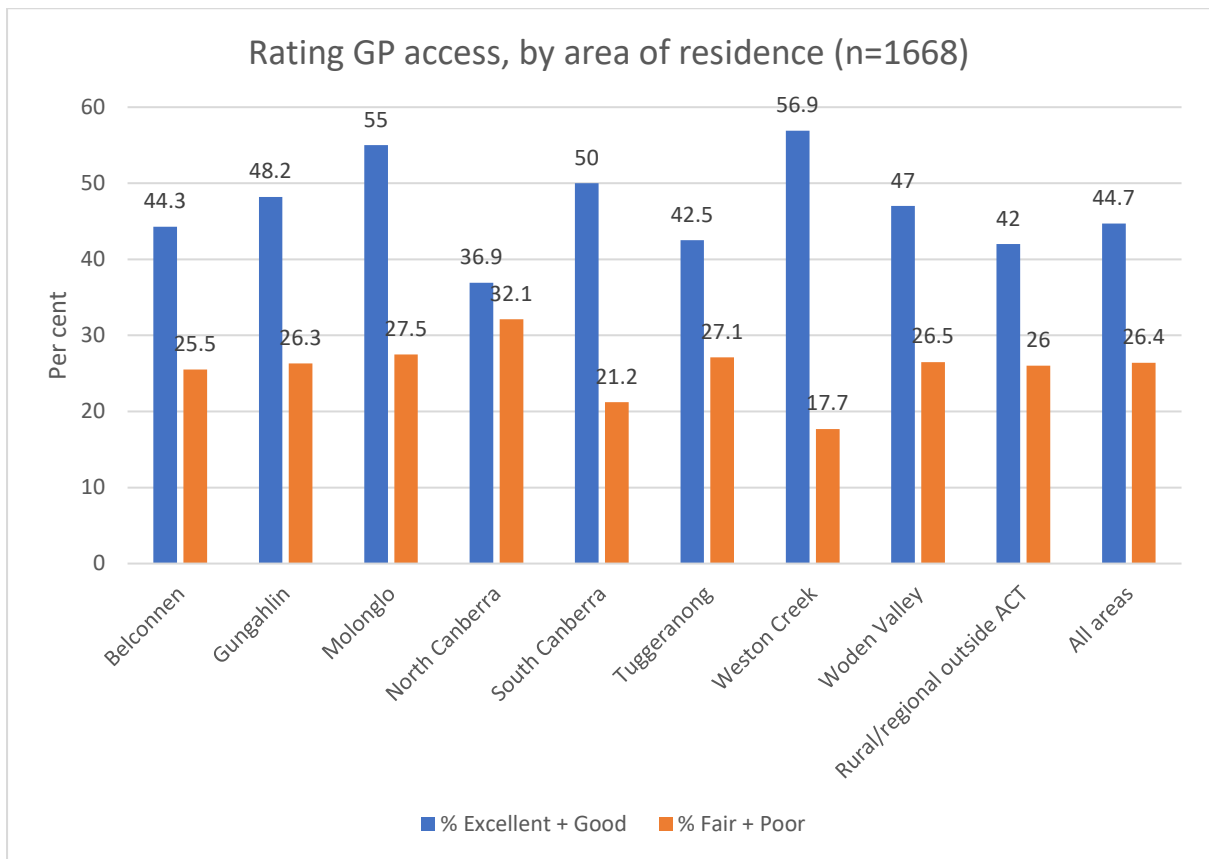


Figure 8: Rating GP access, by area of residence

Low socioeconomic status as measured by indicators such as financial stress, has been established as a contributing factor in ill health and a barrier to accessing resources, services, activities and social connections that support wellbeing.²⁴ We compared how well people rated their access to a GP depending on how many indicators of financial stress they reported, and there does appear to be a relationship between financial stress and access to a GP, as shown in the table below.

People who reported more experiences of financial stress also rated their access more poorly, compared with respondents as a whole, while people who reported no experiences of financial stress rated their access more highly.

²⁴ Australian Institute of Health and Welfare (2022) 'Health across socioeconomic groups' AIHW Web Article, <https://www.aihw.gov.au/reports/australias-health/health-across-socioeconomic-groups>

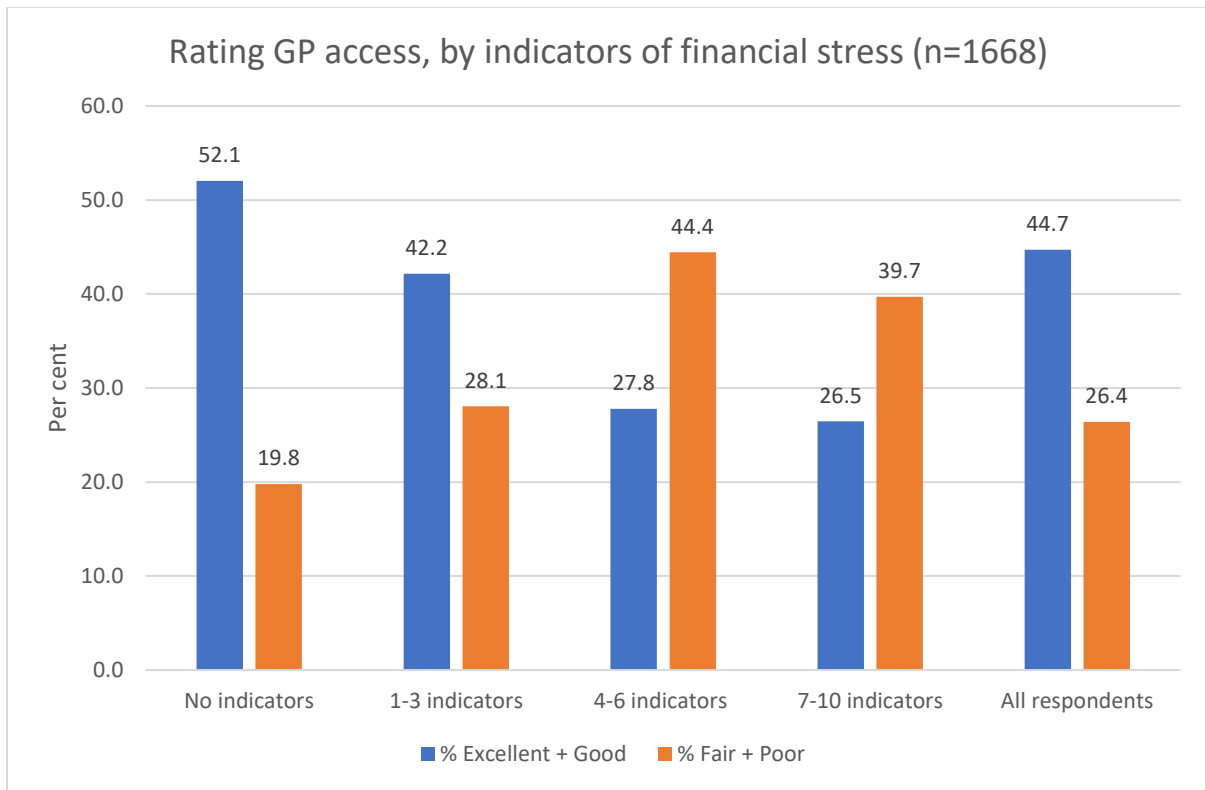


Figure 9: Rating GP access, by indicators of financial stress

Main reason for rating GP access as 'Fair' or 'Poor'

For those people who rated their access to a GP as only 'Fair' or 'Poor' (n=440) we asked people to select the main factor making it difficult (one selection only). The key factors most commonly reported were difficulty getting an appointment (61%) and problems with it being too expensive (24%).

Table 18: Main reason for rating GP access as fair or poor

	Freq.	Per cent (%)
Difficulty getting an appointment	268	60.9
Too expensive	104	23.6
Not enough time personally to see a GP	12	2.7
Difficult to travel to see a GP	3	0.7
Other	53	12.05
Total	440	100

Quotes from the 'Other' option included the following:

“Difficult to find doctor who fits and has availability, constantly get new GPs”

“I have to book in advance to see my own Dr. It’s also very expensive at around \$90 for a 15 minute consultation. She only bulk billed during Covid although did again when I wasn’t working.”

Different aspects of access to GP

We asked all respondents: “thinking about consulting a GP for your own health care, how would you rate the following now: access to bulk-billing, access to a female GP if wanted, and access to preferred GP each time.” These responses are presented together below, and in following tables separately (to show standard error and confidence intervals).

Results show that respondents rated access to bulk-billing particularly poorly, with over three-quarters (79%, 1140) of the people who answered the question (n=1443) saying their access to bulk-billing was only ‘Fair’ or ‘Poor’. It should be noted, though, that a significant number of people (n=225 or 13.5% of the full sample of n=1668 people) answered that they did not know or that the question was not applicable. Presumably, this portion contained many people who did not need and/or had not considered attempting to access bulk-billing, possibly in part because it is widely known to be rare in the ACT.

A significant portion of people (45%) also answered that their access to their preferred GP each time was only ‘Fair’ or ‘Poor’. This is notable as it provides further evidence of the need to consider carefully how incentives and access to telehealth are linked to access to a regular or preferred GP, suggesting that it is not patient choice that is a determining factor in a regular relationship with a GP.²⁵

²⁵ See recent efforts to address these issues: Commonwealth of Australia (2023), Budget 2023-24 Budget Measures, Budget Paper No. 2, https://budget.gov.au/content/bp2/download/bp2_2023-24.pdf, p.149

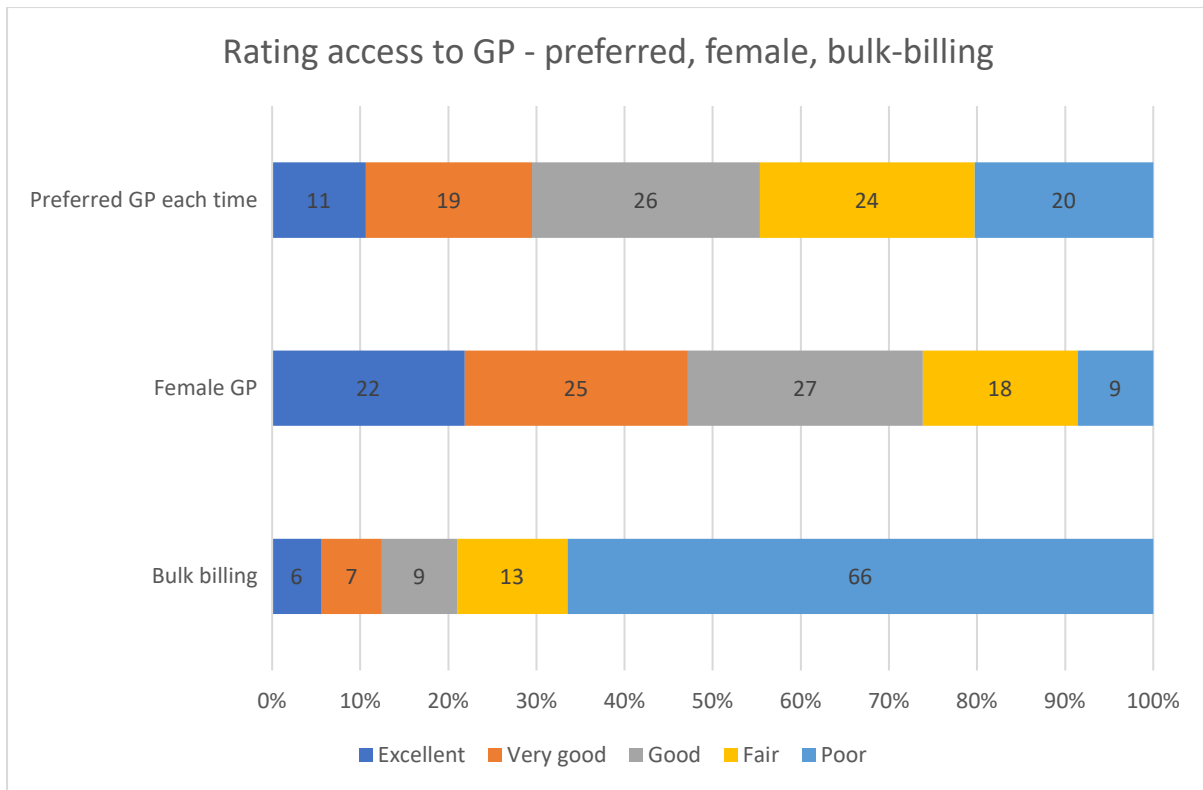


Figure 10: Rating access to GP - Preferred, female, bulk-billing
 Note: Totals sum to different numbers depending on the number of respondents who answered (and did not select "don't know" or "not applicable"): n=1,637 for the question about preferred GP each time; n=1,602 for female GP; n=1,443 for bulk billing.

Rating GP consultations

Acknowledging the key role of GPs, we asked further questions about how well respondents rated several aspects of their experience ("Thinking about consulting a GP for your own health care, how would you rate the following now"). Respondents were asked to answer this question for each of the following:

- Cost
- Accessible facilities
- How long waited to get an appointment
- Time waited in waiting room
- Time spent with doctor
- The doctor's explanation of your problem and treatment
- How well the doctor listened to you explain your problem or concerns
- How well the doctor treated you with dignity and respect
- How well the doctor respected your culture, identity, beliefs and choices
- The technical skills of the doctor.

The results show that the cost of seeing a GP is rated poorly, with almost 70% of respondents rating this aspect as only 'Fair' or 'Poor'. Time spent waiting for an appointment and time spent waiting in the waiting room also had more respondents rating these aspects as 'Fair' or 'Poor', compared with the proportion rating them 'Excellent' or 'Very good'; however, the margin was smaller and overall rating was better than for cost.

Respondents rated the quality of doctors' skills, their explanations, opportunities to ask questions, how well the doctor listened and their respect for patients' dignity and different backgrounds, and the accessibility of facilities fairly well overall.

The findings from this set of questions suggests that, in relation to GPs at least, problems with cost and availability may have been more significant for our survey respondents than issues with the quality or appropriateness of care.

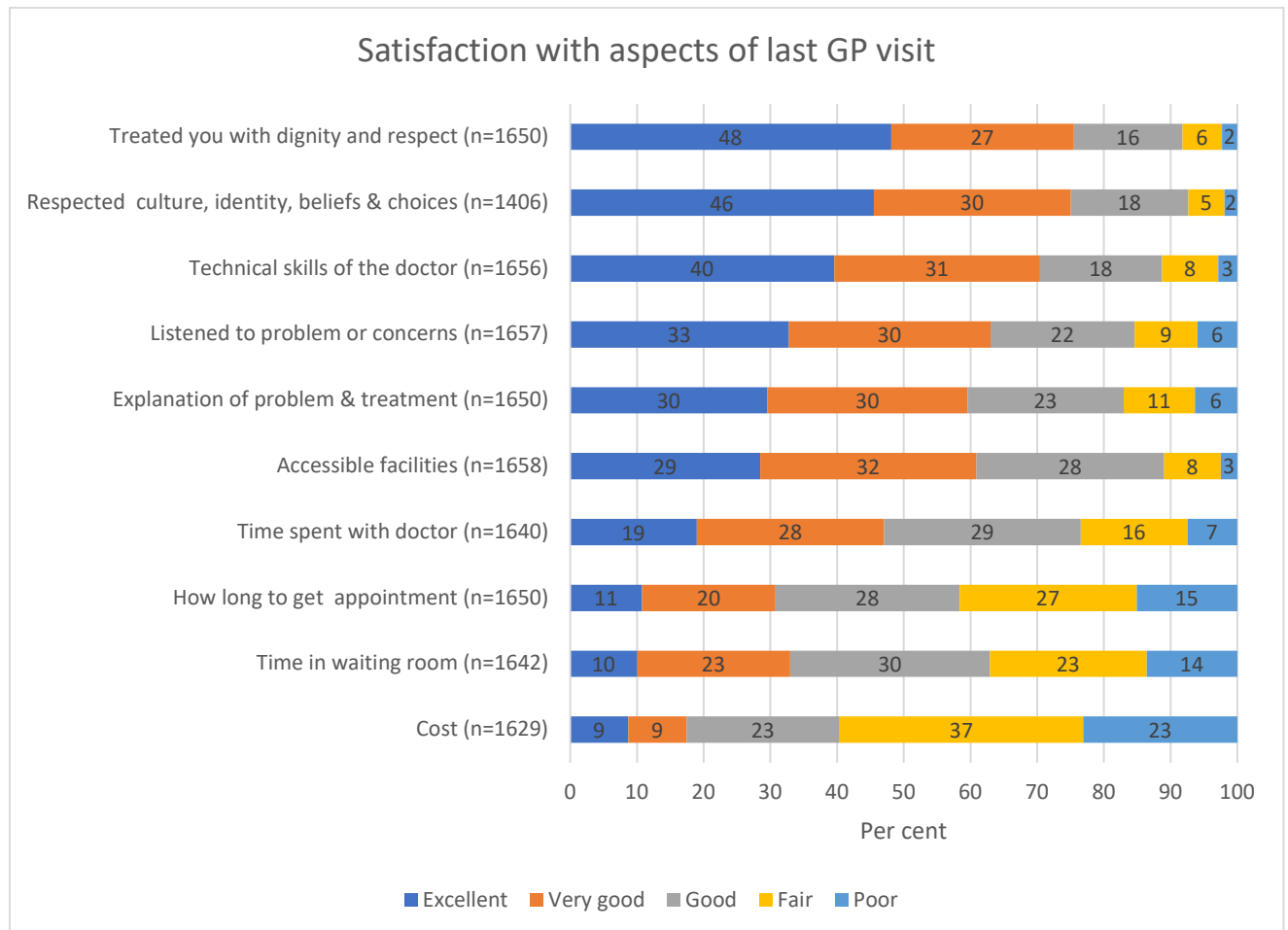


Figure 11: Satisfaction with aspects of last GP visit

Note: Totals sum to different numbers depending on the number of respondents who answered (and did not select "don't know" or "not applicable"). See "n=" figures in brackets beside the question in the graph.

Access to different kinds of health care

We asked respondents to rate their access to different kinds of medical care as ‘Excellent’, ‘Very good’, ‘Good’, ‘Fair’ or ‘Poor’. The kinds of care we asked about were:

- Telehealth
- Family planning or sexual health services
- Medical care in an emergency
- Medical specialists if you need them
- Medical care on short notice
- After-hours medical care
- Mental health services (counselling, psychology) if you need it

The kinds of care rated most poorly for access were mental health services, specialists, medical care at short notice and medical care after hours. For every type of care (except Telehealth) more people rated their access as fair or poor than rated it as excellent/very good.

It should be noted that some of the kinds of care listed had significant numbers of people answering ‘Don’t know’ or ‘Not applicable’. For example, 402 people answered ‘Don’t know’ or ‘Not applicable’ in relation to access to mental health services, while 760 answered ‘Don’t know’ or ‘Not applicable’ in relation to sexual health and family planning services.

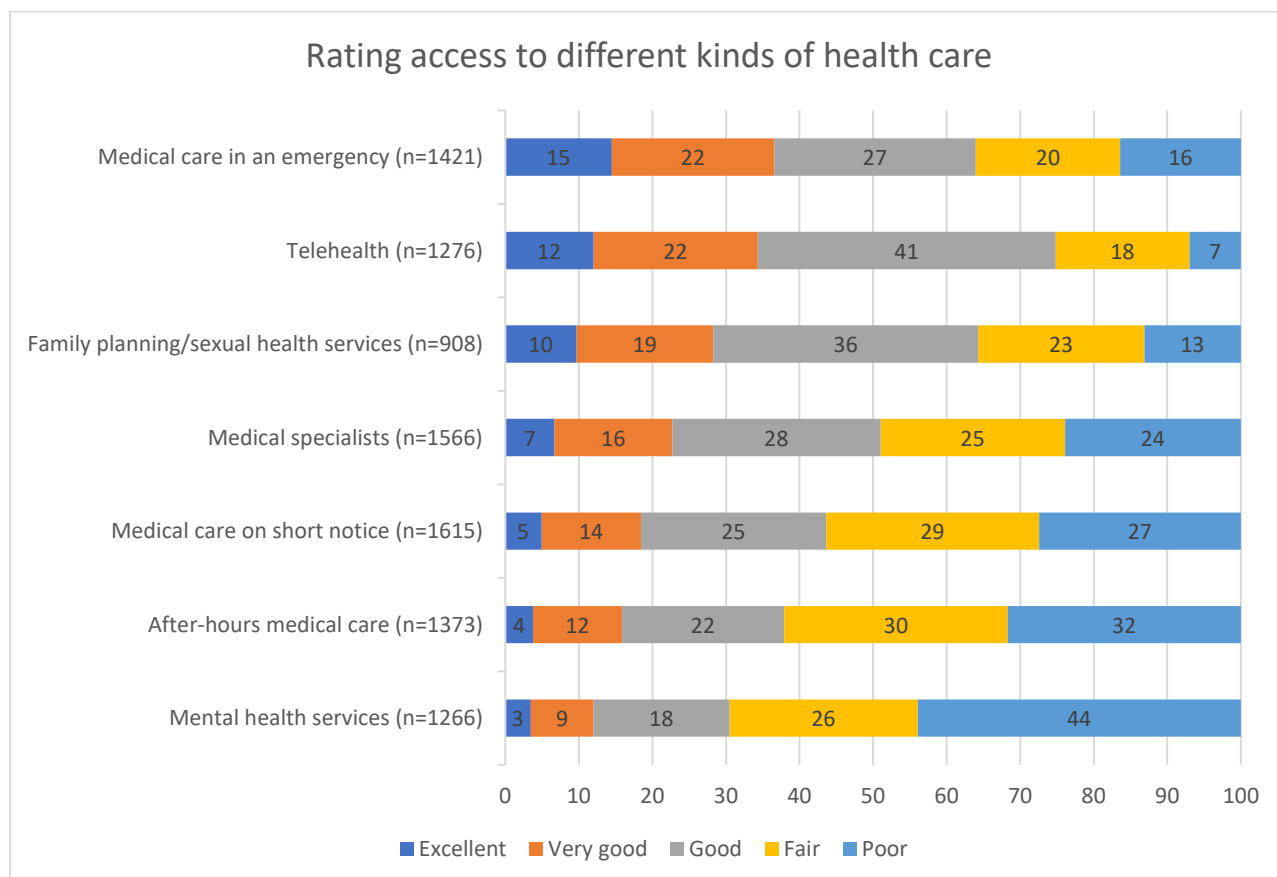


Figure 12: Rating access to different kinds of health care

Note: Totals sum to different numbers depending on the number of respondents who answered (and did not select “don’t know” or “not applicable”). See “n=” figures in brackets beside the question in the graph.

The following quotes are from an open-ended question asked after the questions on access to different types of health care, “Please tell us more about your access to different health services if you wish”:

“I have easy access to a hospital ED and walk-in clinics, and I know where to go for sexual health services if I needed it, but not having a GP means I can’t access telehealth and I don’t know what the wait lists would be like for mental health.”

“I really need access to psychological support more than the ten sessions. I have history of mental health and physical health issues. I gave birth with complications and subsequent postnatal depression and anxiety. Wait times were too long to update plan. There was a barrier by waiting to get into see my GP and appointments available.”

Trust in doctors, whether taken seriously and willingness to seek healthcare

People’s willingness to seek help for health issues, their experiences of being taken seriously and their trust in health professionals are all key factors in the ability of the health care system to meet the needs of the population. Growing evidence of the systemic discrimination against and dismissal of women and girls by the health care system has led the new Australian National Women’s Health Advisory Council to be tasked with addressing “medical misogyny.”²⁶

To help explore these issues in the ACT, we asked a series of questions about people’s experiences of receiving care and their inclination to seek help from a doctor. We asked all 1668 respondents to indicate the extent to which they agreed with four statements:

- The care I have received from doctors in the last few years has been good
- If you wait long enough, you can get over almost any disease without seeing a doctor
- I avoid seeing a doctor whenever possible
- I only go to a doctor if there is no other option

The results show overall positive assessment of the care received from doctors, with over three quarters agreeing or strongly agreeing that the care they had received in the last few years had been good. However, there were some concerning findings about people’s inclinations to seek health care, with over

²⁶ Kearney, G., MP, Assistant Minister for Health and Aged Care (2023) Women’s health experts appointed to tackle ‘medical misogyny’ (media release), <https://www.health.gov.au/ministers/the-hon-ged-kearney-mp/media/womens-health-experts-appointed-to-tackle-medical-misogyny>

a third agreeing or strongly agreeing that they only go to the doctor if there is no other option, and a quarter of respondents agreeing or strongly agreeing that they avoid seeing a doctor wherever possible.

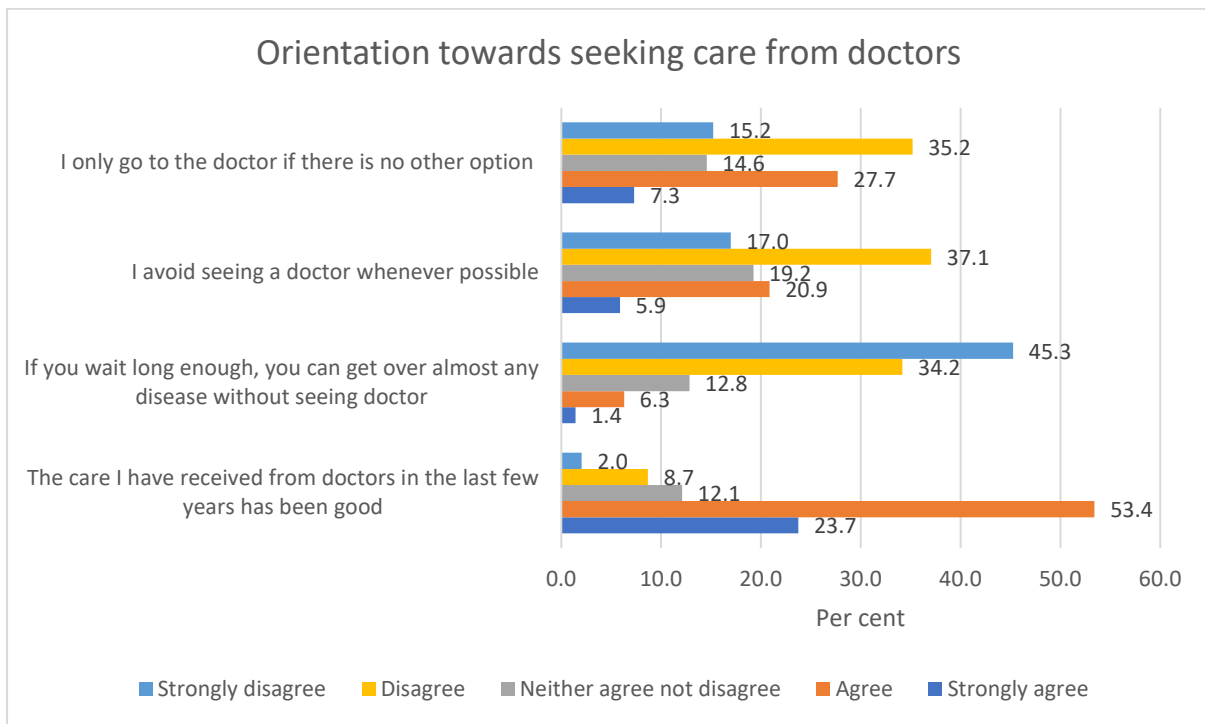


Figure 13: Orientation towards seeking care from doctors
N=1668

In a separate question, we asked, “Thinking about the last few years, please rate the extent to which you feel you have been taken seriously by doctors when explaining symptoms or health concerns?”

It is concerning that over a third of respondents felt that doctors were taking them only somewhat seriously or not at all seriously.

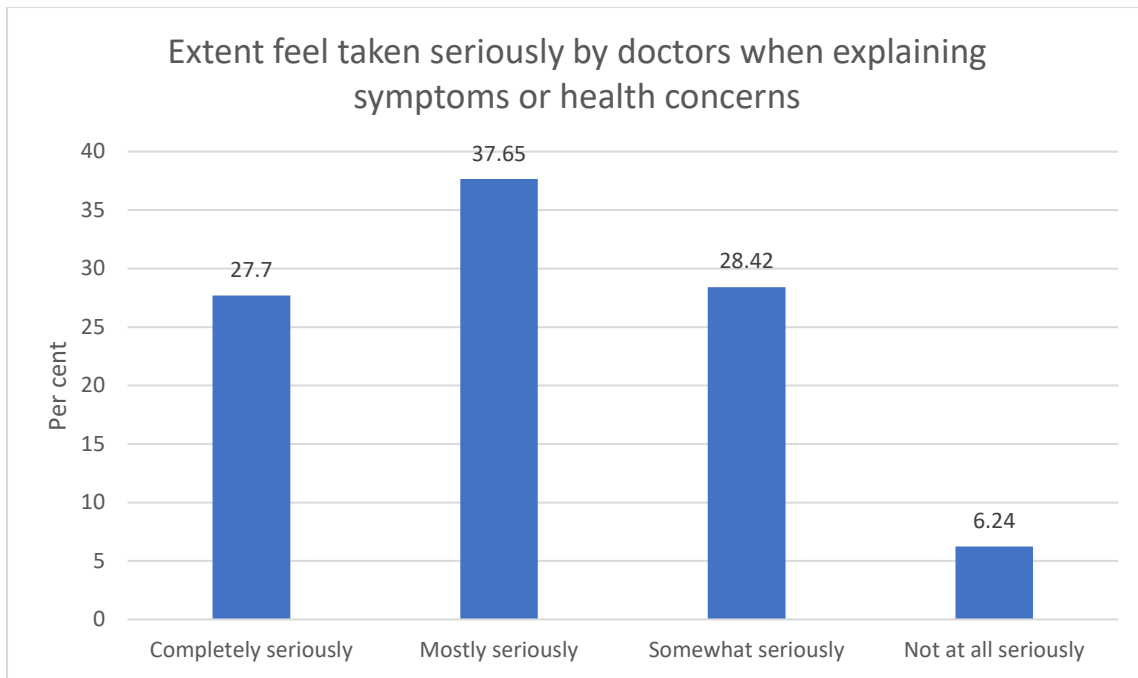


Figure 14: Perception of being taken seriously by doctors (n=1668)

Findings 3: Health information

Access to information about health is crucial for people’s ability to keep themselves and their dependants well. For women, this is particularly important, given the historical (and in many cases continuing) lack of information and stigma surrounding aspects of sexual and reproductive health.

Online sources of information provide the potential for greater availability of health information, but this information is not always reliable and accessible for people of different backgrounds. In situations where healthcare is sometimes costly or where there are other barriers to seeing a health professional, access to health information from diverse informal and ‘official’ sources can be a useful adjunct to individual healthcare consultations. Again, however, policy-makers need to be careful about using people’s access to health information as a way to encourage self-management, in a context where not all information is high-quality, and where there is unequal access to suitable individual healthcare consultations with medical professionals.

Online sources of health information

Our survey found that almost all respondents (93%) get some of their health information from online sources, with 92% using the internet (webpages), and around 28% using social media.

Table 19: Use of online sources of health information

	Freq.	Per cent (%)
Do not use online information	114	6.8
Use online	1,554	93.2
<i>Use internet (webpages)</i>	<i>1,535</i>	<i>92</i>
<i>Use social media</i>	<i>474</i>	<i>28.4</i>
Total	1,668	100

We asked respondents to indicate which online sources they have used to try to get health information, allowing them to select all that applied. The most commonly used online sources were government websites (78% used), *Healthdirect* (62%) and *Facebook* (21%).

Table 20: Types of online health information sought

	Freq.	Per cent (%)
Government websites	1294	77.6%
Healthdirect	1032	61.9%
Facebook	357	21.4%
Health on the Net (HON) certified sources	309	18.5%
Instagram	231	13.9%
TikTok	140	8.4%
Twitter	57	3.4%
Other health app	412	24.7%
Other social or messaging app	55	3.3%
Other online sources (free text)	449	38.4%

Note: Percentages in this table are expressed as a proportion of the full survey sample (n=1668). Other online sources listed in free text answers included Google, Mayo Clinic, WebMD and others.

For the 1554 people who indicated that they used online sources for health information, we asked about their reasons for using these online sources, allowing them to select multiple options from pre-set answers and/or provide a an open-ended ‘Other’ response. The most common responses were “To improve my understanding of symptoms/health condition after seeing a health practitioner or receiving a diagnosis” (83%) and “To decide whether or not to see a health practitioner about my symptoms/health condition” (71%). Even though it was the least commonly cited reason, a significant minority (44% or nearly 700 people) reported using online health information instead of seeing a health practitioner. This is concerning in the context of other results indicating that cost and availability of appointments are barriers to access, and that a significant proportion of people had experiences of doctors not taking their concerns seriously.

Reasons for using online sources

Table 21: Reasons for using online sources

	Freq.	Per cent (%)
To decide whether or not to see a health practitioner about my symptoms/ health condition	1098	70.7%
To prepare myself to see a health practitioner about my symptoms/ health condition	888	57.1%
To improve my understanding of symptoms/ health condition after seeing a health practitioner or receiving a diagnosis	1288	82.9%
To get information about my symptoms/ health conditions instead of seeing a health practitioner	677	43.6%
To better understand public health information or directions	759	48.8%
Other (free text answer)	83	5.3%

N=1554

The following quotes are taken from open-ended responses about 'Other' reasons for using online health information:

“Because I like to know things, I take social media info with a grain of salt and consider info from other sources depending on their information (whether gov website, health, peer reviewed etc)”

“I have complex health needs and if I didn’t educate myself about my disease and the health system, I wouldn’t be able to advocate for myself when the health system starts to treat you like a disease and not a person”

Non-online sources of health information

We asked all respondents (n=1668) “Where do you get information about your health?” (referring to non-online sources).²⁷ We offered a range of pre-defined options as well as the opportunity to give open-ended ‘Other’ responses.

The most common sources of health information were doctors (80%), family members (46%) and friends (44%).

Table 22: Non-online sources of health information

	Freq.	Per cent (%)
Doctor	1341	80.4%
Family	760	45.6%
Friends	729	43.7%
Other professional	706	42.3%
Nurse	619	37.1%
Literature	560	33.6%
Media	283	17.0%
Community organisation	222	13.3%
Education settings	218	13.1%
Family planning / sexual health service	188	11.3%
Posters	164	9.8%
Other (open-ended response)	52	3.1%

N=1668

The following is a quote from the ‘Other’ open-ended responses:

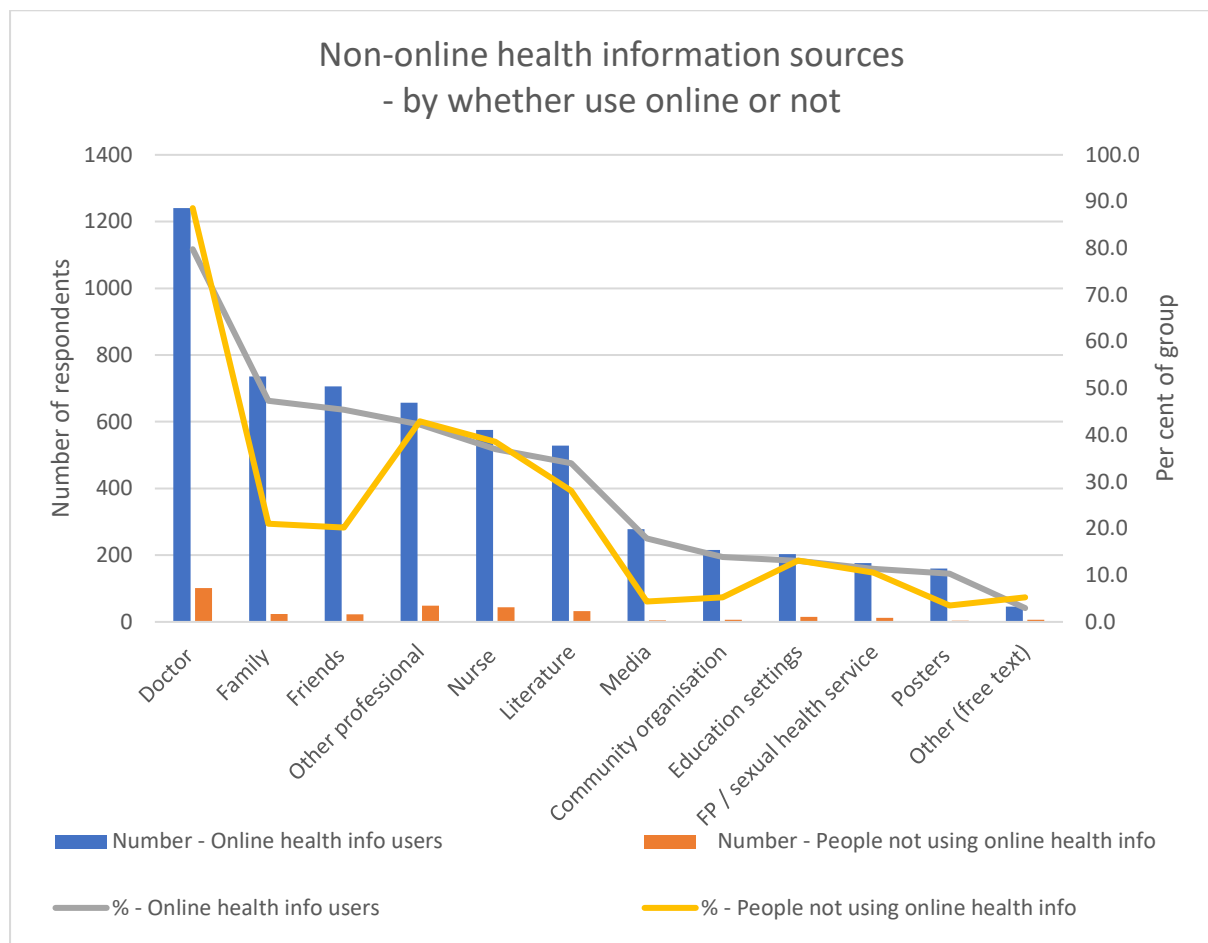
“I’m in a support group for a health issue that I have and it’s nice to see their outcomes and tips and tricks they have whilst going through it”

The fact that family and friends rank so highly as sources of health information adds further evidence to the importance of community-wide health literacy and understanding of the health system.

²⁷ For those who had previously indicated that they used online sources, this question was asked in the form “Apart from online sources, where do you get information about your health? (select all that apply)”, For those who had indicated that they did not use online sources, the question was asked as “Where do you get information about your health? (select all that apply)”.

One interesting result that warrants further investigation is that proportionally fewer people who did not use online sources of information (compared with people who did use online health information) reported getting information from friends (20% vs 45%) or family (21% vs 47%) – as shown by the yellow line in the chart below. One implication of this is a proportionally greater reliance on health professionals (doctors and nurses) for health information by people who do not use online sources.

It is possible that difference reflects social isolation together with lack of access to digital information sources. Further analysis is required to investigate what other demographic factors (such as age or language background) might contribute to these trends.



Findings 4: Mental health

Psychological distress (K6)

The Kessler Psychological Distress scale (K6) is a measure of psychological distress developed by Kessler et al (2002).²⁸ The K6 is delivered as set of six questions asking how often in the past 4 weeks respondents:

- felt nervous
- felt hopeless
- felt restless or fidgety
- felt that everything was an effort
- felt that nothing could cheer them up
- felt that they were worthless.

We scored 'none of the time' as 1, 'a little of the time' = 2, 'some of the time' = 3, 'most of the time' = 4, and 'all the time' = 5. People with total scores equalling 6-18 are considered unlikely to have a serious mental illness. Scores of 19-30 indicate probable serious mental illness.

For the purposes of scoring, if a respondent did not answer one of the six questions, the value was supplied by the mean of the five scores of the questions they did answer. Responses missing more than one answer were excluded.²⁹

Our survey found that around 19% of respondents had a K6 score indicating probable serious mental illness (of the sample of n=1649³⁰). By comparison, the 2021 ACT General Health Survey found that 5.6% of female people had a K6 score indicating probable serious mental illness.³¹

While further analysis will help to explore the reasons for this discrepancy, it is likely that these reasons include our sampling strategy and the resulting differences between our sample and the characteristics of the ACT population as a whole. It is also likely that the result is impacted by the ongoing COVID-19 pandemic and related financial insecurity (which is also higher in our survey), given that financial insecurity contributes to psychological distress.³² An Australia-wide study found a significant increase in

²⁸ Kessler R.C., Andrews G., Colpe L.J., Hiripi E., Mroczek D.K., Normand S.L., Walters E.E., Zaslavsky A.M. (2002) 'Short screening scales to monitor population prevalences and trends in non-specific psychological distress' *Psychological Medicine*, 32, 959–976, <https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=2d15ecd85e49592797084a960d6b7e003ca5bd85>

²⁹ Follows the same procedure as the ACT General Health Survey. See ACT Health (2021) *2019 ACT General Health Survey Summary of Results* (Health Series Report No. 67), <https://www.health.act.gov.au/sites/default/files/2021-12/2019%20General%20Health%20Survey%20Summary%20of%20Results%20FINAL%20version.pdf>

³⁰ The figure of 1649 is equal to the full respondent sample of 1668 minus 19 people who answered "Prefer not to answer" or "Don't know" to more than one of the 6 questions, leading their other answers to be excluded.

³¹ ACT Health (2021) Psychological distress, adults (ACT General Health Survey, 2011 – 2021), <https://health.act.gov.au/about-our-health-system/data-and-publications/healthstats/statistics-and-indicators/psychological-0>

³² See for example Australian Institute of Health and Welfare (2023) 'Suicide and self-harm monitoring: Social and economic factors and deaths by suicide', <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/social-factors-suicide>

levels of likely mental illness from 6.3% pre-pandemic, to 17.7% in early July 2020, using the K6 in combination with another single-item measure.³³

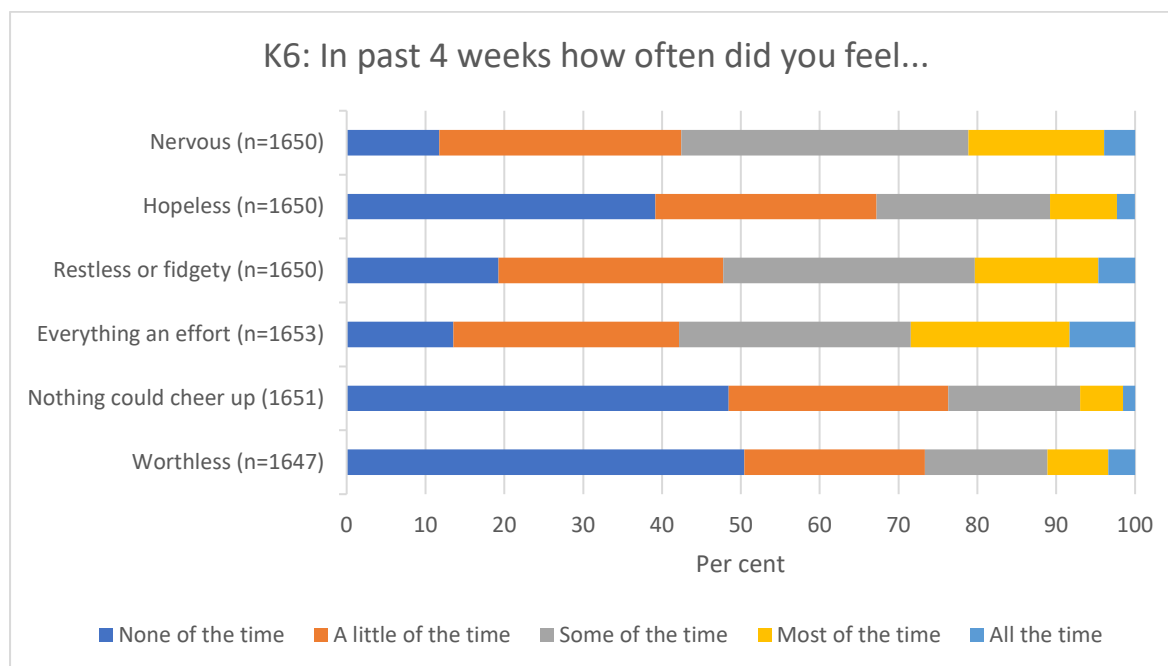


Figure 15: Psychological distress scale (K6) - In the past 4 weeks how often did you feel...

Note: Totals do not equal the full sample size (n=1668) because some respondents chose not to answer one or more of the K6 questions.

The median score was between 7 and 13, with half of all respondents having scores falling within that range.

Table 23: Psychological distress (K6) rating frequencies

K6 score	Freq.	Per cent (%)	Cumulative %
6	54	3.3	3.3
7-13	823	49.9	53.2
14-18	452	27.4	80.6
19-24	256	15.5	96.1
25-30	64	3.9	100.0
Total*	1649	100	

Note: 19 people answered "Prefer not to answer" or "Don't know" to more than one of the 6 questions and their other answers were excluded. Ranges are defined according to the strata developed by Kessler et al 2010 and documented by the ABS.³⁴

³³ Botha F., Butterworth P., Wilkins R. (2022) 'Evaluating How Mental Health Changed in Australia through the COVID-19 Pandemic: Findings from the 'Taking the Pulse of the Nation' (TTPN) Survey' International Journal of Environmental Research and Public Health, 4, 19(1): 558, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8744652/>

³⁴ Australian Bureau of Statistics (2012) '4817.0.55.001 - Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2007-08', <https://www.abs.gov.au/ausstats/abs@.nsf/lookup/4817.0.55.001chapter92007-08>

Ever diagnosed or treated for mental health conditions

We asked respondents whether they had ever been diagnosed or treated for a range of mental illnesses, using a list of pre-defined options together with the option to specify an 'Other' condition using an open-ended response. This is similar to the ACT General Health Survey question about whether respondents had been diagnosed with mental health conditions.

After analysis of the open-ended responses, several answers were recoded into the pre-defined categories. Three new categories were added (obsessive compulsive disorder, postnatal depression and autism spectrum), representing conditions that appeared multiple (10+) times in the open-ended responses.

Only just over a third reported never having been diagnosed or treated for a mental illness. Around 46% of respondents reported having been diagnosed or treated for anxiety, and a similar proportion reported having been diagnosed or treated for depression. Anxiety and depression were the most commonly reported mental illnesses.

Noting the slightly different questions, this appears to be a higher prevalence of mental health conditions than the most recent ACT General Health Survey data. In 2021 the ACT GHS found 36.1% of female respondents reported having been diagnosed for any mental health condition.³⁵

Table 24: Ever diagnosed or treated for mental health conditions

	Freq.	Per cent (%)
Never diagnosed or treated	575	34.5
Anxiety	774	46.4
Depression	768	46.0
Post traumatic stress disorder (PTSD)	220	13.2
Complex post traumatic stress disorder (C-PTSD)	103	6.2
Other eating disorder	75	4.5
Anorexia	52	3.1
Bulimia	46	2.8
Bipolar	31	1.9
Borderline personality disorder (BPD)	30	1.8
Obsessive compulsive disorder (OCD)	16	1.0
Postnatal depression	15	0.9
Autism spectrum disorder (ASD)	13	0.8
Other (<10 reported for each)	66	4.0
Prefer not to answer	30	1.8

N=1668

³⁵ ACT Health (2021) Any mental health condition, adults (ACT General Health Survey, 2011 – 2021), <https://health.act.gov.au/about-our-health-system/data-and-publications/healthstats/statistics-and-indicators/any-mental-2>

Diagnosed with or treated for mental health conditions in last two years

We asked respondents whether they had been diagnosed or treated for a range of mental illnesses in the last two years, using the same list of pre-defined options as in the previous question, together with the option to specify an 'Other' condition using an open-ended response.

After analysis of the free text responses, several answers were recoded into pre-defined categories. One new category was added (attention deficit hyperactivity disorder), representing a condition that appeared multiple (10+) times in the open-ended responses.

As with the previous question, anxiety and depression were the two most commonly reported conditions. Around 45% of all respondents had been diagnosed with or treated for a mental health condition in the last two years.

Table 25: Diagnosed with or treated for mental health conditions in last two years

	Freq.	Per cent (%)
Not diagnosed or treated last 2 years	874	52.4
Anxiety	562	33.7
Depression	495	29.7
Post traumatic stress disorder (PTSD)	118	7.1
Complex post traumatic stress disorder (C-PTSD)	79	4.7
Attention deficit hyperactivity disorder (ADHD)	42	2.5
Other eating disorder	26	1.6
Borderline personality disorder (BPD)	20	1.2
Bipolar	19	1.1
Anorexia	13	0.8
Other (<10 reported)	72	4.3
Prefer not to answer	30	1.8

N=1668

Findings 5: Sexual and reproductive health

Access to high-quality sexual and reproductive healthcare and information is important for wellbeing across the lifespan. This chapter examines people’s experiences with several aspects of sexual and reproductive health, highlighting the need for continuing efforts to improve access, reduce stigma and support people to speak about and ask for help with their sexual and reproductive health.

Sexual activity

Most respondents (69%) had engaged in physical sexual activity with another person in the last 6 months, although a substantial proportion had not (27%).

Table 26: Sexual activity within last 6 months

	Freq.	Per cent (%)
Had sex in last 6 months	1158	69.4
Did not have sex in last 6 months	450	27
Prefer not to answer	60	3.6
Total	1668	100

Contraception

Data collection and analysis – contraception

We asked all people who had sex in the last 6 months about their contraceptive use. We showed a list of types of contraceptive and asked respondents to select all they had used during this period, as well as provide an open-ended answer about any other method not listed that they had used.

We acknowledge that not all contraceptive use is for the purpose of preventing pregnancy and may instead be used to treat other conditions or manage aspects of sexual and reproductive health. In potential future iterations of the survey we will consider structuring the questions about sex and contraception differently, to encompass people who had not had sex, but had used contraceptives.

Those who answered that they did not use any contraceptive were invited to answer an optional open-ended question about why they did not use contraception. Most of these answers indicated that people did not need contraception because of menopause, hysterectomy, partner having a vasectomy or being in same-sex or queer sexual relationships.

Analysis of the way contraceptive data is presented in other studies (e.g., ALSWH) shows that most studies exclude people who could not have gotten pregnant anyway (e.g., because they have gone through menopause, had a hysterectomy, partner had vasectomy, or did not have penis in vagina sex). Contraceptive use data is then generated for the group of respondents who are considered ‘at risk’ of pregnancy.

Our study did not have a question specifically to identify people ‘at risk’ of pregnancy. In order to create comparable data, responses in our survey were recoded to identify the subset of respondents who were in scope according to the ‘having sex that could result in pregnancy’ definition above (‘at risk’). This included answers about tubal ligation and not having penis in vagina sex, which were given as pre-defined options, as well as some answers that were provided in open-ended ‘Other’ responses (including menopause, hysterectomy, and partner vasectomy).

In any future iterations of the survey, we will consider changing the structure to show more clearly the different situations of people in relation to sex and contraception, including identifying where people are, and are not, ‘at risk’ of getting pregnant.

Our findings – contraceptive use

Of the 1158 people who had sex in the last 6 months, there were 714 people whose answers indicated they could have gotten pregnant from the sex they had and did not want to get pregnant (i.e., considered ‘at risk’ of pregnancy in other studies). This figure sets aside answers from people who had no penis in vagina sex, had gone through menopause, who had a hysterectomy or tubal ligation, whose partner had a vasectomy, or who were pregnant or trying to get pregnant.

As shown in the table below, in our study condoms were the most common contraceptive method (39%) followed by progestogen only IUDs such as Mirena (25%), the combined pill (19%) and withdrawal method (18%). This is a higher level of progestogen only IUD use and a lower level of combined pill use compared with previous Australian studies. For example, the 2015 HILDA survey showed oral contraception (all forms) (28%) and condoms (24%) as the most used forms of contraception, with IUDs (both copper and hormonal) making up only 4.5% of usage.³⁶

Taken together, 39% of respondents in our survey used some form of Long Acting Reversible Contraceptive (LARC), which in our study we defined as including progestogen IUDs, implants, copper IUDs, injections and vaginal rings. Again, this is a significantly higher level of LARC use than has been recorded in previous national level studies. For example, the ALSWH found that in 2018 around 23% of women in the 24-29 age group and 24% of women aged 40-45 years were using LARCs.³⁷ Earlier studies

³⁶ Family Planning NSW (2020) *Contraception in Australia 2005-2018* Ashfield, Sydney, https://www.fpnsw.org.au/sites/default/files/assets/Contraception-in-Australia_2005-2018_v20200716.pdf pp. 19-20

³⁷ Australian Longitudinal Study on Women’s Health (2021) *Contraception, Conception, and Change of Life: Highlights from the ALSWH Reproductive Health Report*, <https://alswh.org.au/shorthand/reproductive-health-report/#group-section-LARC-ahQKRN3dZW>. The ALSWH study defined LARC methods as combining hormonal IUD, copper IUD, implant, injection and vaginal ring for the 1973-78 cohort, and as combining implant and hormonal IUD methods for the 1989-1995 cohort. See Loxton D., Byles J., Tooth L., Barnes I., Byrnes E., Cavenagh D., Chung H.-F., Egan N., Forder P., Harris M., Hockey R., Moss K., Townsend N., Mishra G.D (2021) *Reproductive health: Contraception, conception, and change of life – Findings from the Australian Longitudinal Study on Women’s Health*, Report prepared for the Australian Government Department of Health, https://alswh.org.au/wp-content/uploads/2023/01/ALSWH_2021-Major-Report-Reproductive-health_Final_May-17.pdf, p21

found around 12% of women (all age groups) who were using contraception were using LARC methods (in 2016).³⁸ Another study estimated that in 2018, 10.8% of women aged 15-44 were using a LARC.³⁹

Table 27: Contraceptive use

	Freq.	Per cent (%)
Condoms	280	39.2
Progestogen IUD	181	25.4
Combined pill	134	18.8
Withdrawal	127	17.8
Implant	64	9.0
Fertility awareness	50	7.0
Did not use contraception	43	6.0
Progestogen only pill	41	5.7
Emergency contraception	41	5.7
Copper IUD	21	2.9
Breastfeeding	20	2.8
No penis in vagina sex	19	2.7
Pill - type unknown	15	2.1
Injection	11	1.5
Other (<10 responses each)	10	1.4

Note: N=714 (people considered 'at risk' of pregnancy as per definition above)

Younger people aged 18-24 and 25-34 were more likely than respondents in general to use condoms (53% and 43% respectively, compared with 39% overall). People aged 18-24 were also more likely to use the combined contraceptive pill (31% compared with 19%). People aged 18-24 and 25-34 were less likely to use the progestogen only IUD (18% and 19% compared with 25% generally).

Satisfaction with contraception

Most people (56%) were either 'Extremely satisfied' or 'Very satisfied' with their current form of contraception, while 13% were either 'Dissatisfied' or 'Very dissatisfied'. The largest proportion (32%) reported being 'Quite satisfied', while the median response was 'Very satisfied'.

³⁸ Family Planning NSW (2020) Contraceptive use in Australia: LARCs slowly on the rise (media release), <https://www.fpnsw.org.au/media-news/media-releases/contraceptive-use-australia-larcs-slowly-rise>

³⁹ Grzeskowiak, L.E., Calabretto, H., Amos, N., Mazza, D., Ilomaki, J. (2021) 'Changes in use of hormonal long-acting reversible contraceptive methods in Australia between 2006 and 2018: A population-based study' *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 61: 128-134, <https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/ajog.13257>

Table 28: Satisfaction with contraception

	Freq.	Per cent (%)	Cumulative %
Very dissatisfied	12	1.8	1.8
Dissatisfied	75	11.2	13.0
Quite satisfied	211	31.5	44.4
Very satisfied	183	27.3	71.7
Extremely satisfied	190	28.3	100
Total	671	100	

Note: n=671 people were 'at risk' of pregnancy and used a form of contraception during the last 6 months.

Reasons preventing person from changing form of contraception

We asked the 87 people who were 'Dissatisfied' or 'Very dissatisfied' with their contraceptive method what was preventing them from changing their contraception.

Table 29: Reasons preventing person from changing form of contraception

	Freq.	Per cent (%)
Cost	20	23.0
Doctor has advised	20	23.0
Preferences or dynamics in relationship	14	16.1
Do not have time	13	14.9*
Not sure of options	10	11.5*
Other (open-ended response)	49	56.3

Note: N=87; * Relative Standard Error (RSE) was between 25% and 50% for these estimates - use with caution

Among the open-ended answers given about 'Other' reasons preventing respondents from changing their form of contraception, themes included the lack of desired options, health and mood impacts of hormonal contraceptives, and concerns about pain from IUDs. The following are quotes from the open-ended 'other' responses:

"Pill doesn't work well (mood wise). I would like to get an IUD but the process of putting one in sounds traumatic (stories from friends)"

*“I have been told I have to be on the pill to treat my PCOS
[polycystic ovary syndrome]”*

Infertility

We asked respondents to describe their experiences of fertility/infertility, asking “If you have ever intended or tried to become pregnant/have a baby, which of the following descriptions of fertility apply to you?” followed by a list of options from which people could select all that applied.

Table 30: Experiences of fertility/infertility

	Freq.	Per cent (%)
No difficulty conceiving, or have not intended or tried to conceive	1176	70.5
I had/have difficulty conceiving for medical reasons (now or in the past)	300	18
My partner had/has difficulty having children for medical reasons (now or in the past)	54	3.2
I cannot/could not conceive without assistance because I am/was single	45	2.7
Partner and I cannot/were not able to conceive together because we are same sex/gender diverse	19	1.1
Other (open-ended response)	134	8
Prefer not to answer	58	3.5

Note: n=1668 but columns sum to more than 1668 or 100% because respondents could select more than one option for type of challenge experienced.

The results show a significant proportion of people (434 or 26%) have had some form of difficulty with getting pregnant or having children.⁴⁰

Women’s Health Matters’ 2022 report on access to Assisted Reproductive Technology contains a detailed exploration of experiences of infertility in the ACT, including the results of a survey of 175 people who have had difficulty getting pregnant or becoming a parent in the ACT, as well as interviews and a focus group.⁴¹

⁴⁰ This figure was calculated as the number of those who answered the question (1668) minus the number who gave no answer indicating a difficulty conceiving or trying to have children i.e. those who answered ‘No difficulty’ or ‘Prefer not to answer’.

⁴¹ Women’s Health Matters (2022) *Assisted Reproductive Technology in the ACT: Experiences of trying to get pregnant or become a parent*, <https://www.womenshealthmatters.org.au/wp-content/uploads/2022/06/Womens-Health-Matters-ART-report-FINAL.pdf>

Endometriosis

Endometriosis is a condition that can cause severe pain in the pelvic area, as well as infertility. It involves tissue similar to the lining of the uterus growing outside the uterus. The symptoms of endometriosis can be treated with medication or surgery, but it often takes a long time and a great deal of effort to get a diagnosis and/or treatment for endometriosis. Many people suffer pain and distress from the condition for years before obtaining relief (if at all).

We asked survey respondents whether they had every been diagnosed with or treated for endometriosis. Of the full sample of survey respondents, 15.6% or 260 people answered that they had been diagnosed with or treated for endometriosis.

For those who told us they had been diagnosed with or treated for endometriosis (n=260), we asked people when their endometriosis was first diagnosed or treated, and used the dates given to calculate number of years since diagnosis/first treatment. The smallest time elapsed was 0 years (i.e., diagnosis/first treatment in the same year as completing the survey), and the largest time elapsed since first diagnosis/treatment was 47 years. The mean number of years since diagnosis/first treatment was 11.5 years (95% CI: lower 10.2 years, upper 12.9 years).

There were overall low levels of satisfaction with endometriosis healthcare, with over 50% of people who had endometriosis saying they were 'Dissatisfied' or 'Very dissatisfied' with their healthcare for the condition.

A number of people told us that they have adenomyosis, which is different from endometriosis. In any future iteration of the survey, we will consider asking separately about adenomyosis.

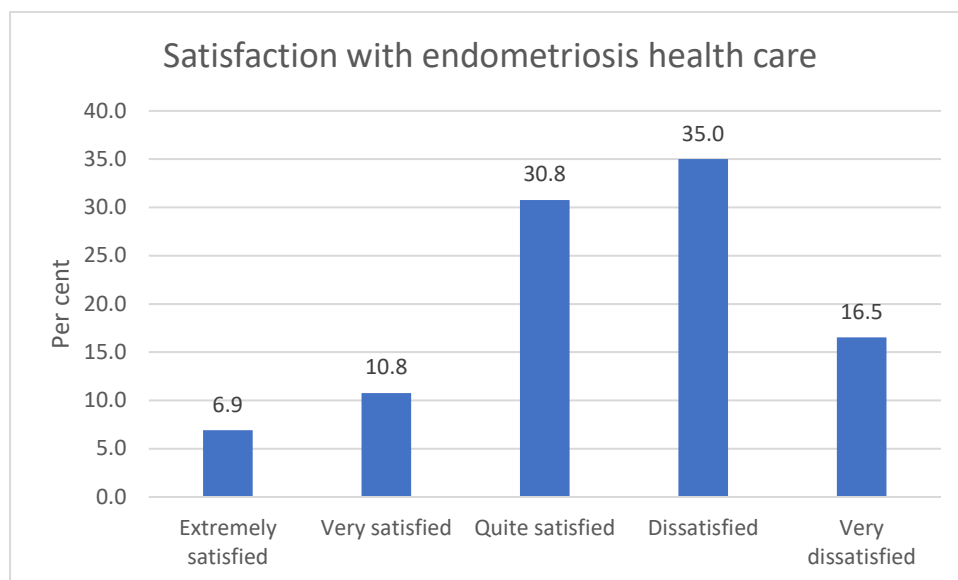


Figure 16: Satisfaction with endometriosis health care

The following quotes are from a separate optional open-ended question asking all participants "Is there anything else you would like to tell us about your experience in relation to endometriosis?":⁴²

"After 7 years of speaking to GPs about concerns with pain and menstruation I was referred to the endo service. I had a Telehealth consult with the endo nurse, and needed to schedule my follow up due to illness, and never heard from them again. They placed me on the wait list to see the gynaecologist, and over two years later I received a call to advise I was still not at the top of the list. I was referred to a private gynaecologist 5 years ago, but could not afford the fee as I was a full time uni student. Now after a decade, I've seen a private specialist who believes it's endometriosis and has discussed the risks and benefits of seeking confirmatory surgery and discussed management options."

"Despite incredible pain, visiting multiple GPs and emergency several times my concerns were ignored. By the time a doctor took my complaints seriously I had gone into premature ovarian failure."

"I have had 4 surgeries to treat my endometriosis, as well as birth control to manage symptoms. Each time I had to convince my specialists it was there, I HAD been diagnosed before, and I knew it was back due to severity of symptoms."

⁴² This question was asked of all 1668 participants rather than only those who had indicated they had been diagnosed with or treated for endometriosis, in recognition of the fact that some people are likely to be trying to get a diagnosis, or managing possible endometriosis, without having been formally diagnosed with or treated for the condition.

Polycystic ovary syndrome (PCOS)

Polycystic ovary syndrome (PCOS) is a complex hormonal condition often involving irregular or absent periods, acne, excess facial or body hair growth, scalp hair loss or high levels of androgens (testosterone and similar hormones) in the blood, and/or polycystic ovaries (many immature follicles on the ovaries) visible on an ultrasound.⁴³ People with PCOS also often have reduced fertility.

We asked survey respondents (n=1668) whether they had every been diagnosed with or treated for PCOS.

Around 14% (or 229) of the respondents had been diagnosed with or treated for PCOS.

We asked people when their PCOS was first diagnosed or treated, and used the dates given to calculate number of years since diagnosis/first treatment. The smallest time elapsed was 0 years (diagnosis/first treatment in the same year as completing the survey), and the longest ago was 52 years ago. The mean number of years since diagnosis/first treatment was 12.6 years (95% CI: lower 11.3 years, upper 14 years).

There were overall low levels of satisfaction with endometriosis healthcare, with around 54% of people who had PCOS saying they were dissatisfied or very dissatisfied with their healthcare for the condition.

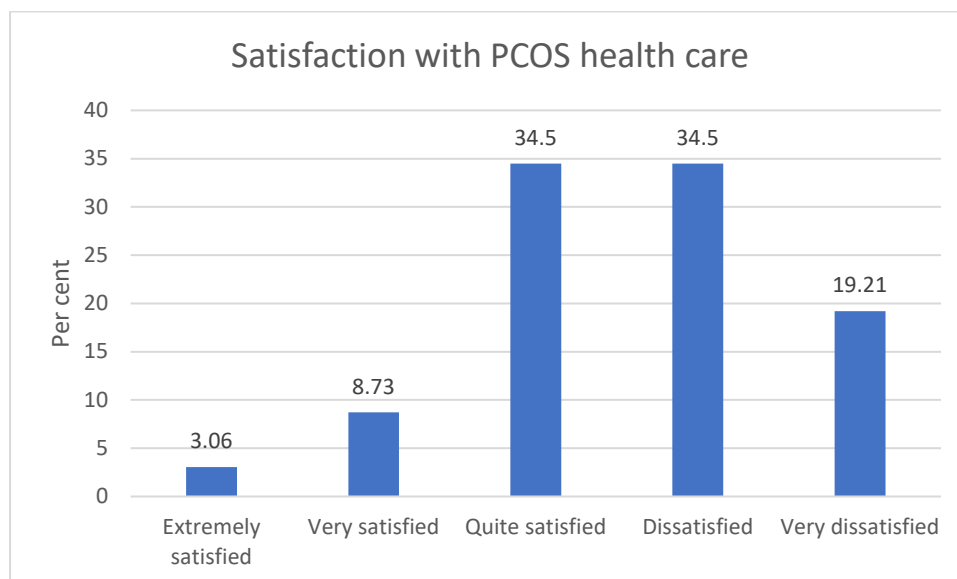


Figure 17: Satisfaction with PCOS health care

⁴³ Healthdirect (2023) Polycystic ovarian syndrome (PCOS), <https://www.healthdirect.gov.au/polycystic-ovarian-syndrome-pcos>

The following quotes are from a separate optional open-ended question asking all participants "Is there anything else you would like to tell us about your experience in relation to polycystic ovary syndrome (PCOS)?":⁴⁴

"Diagnosed in context of infertility, specialist indicated should have been diagnosed/managed much earlier. My specialist was great but earlier diagnosis would have impacted how long it took to get on top of it."

"Doctors need to stop using the line if you just lose weight it will go away, not only is it extremely disrespectful it's incorrect and uneducated. Also not every woman with PCOS wants children so not everything is fertility related. More help to cover the huge costs for ultrasounds etc need to be looked at."

In general, the open-ended responses to the question about experiences with PCOS suggested that there is low health literacy regarding PCOS among people in the community and health professionals.

For both endometriosis and PCOS, open-ended responses indicated that it is often overwhelming for people to be diagnosed with a condition that affects fertility and has significant implications for their lives, and that as a result there was not always good understanding about what that means in practice, what treatment or management options are available or needed, or what these options would entail.

Further analysis of open-ended responses will be useful for understanding the health needs and barriers facing people who may be experiencing these conditions.

Persistent pelvic pain (PPP)

We asked respondents whether, in the last 12 months, they had experienced persistent pelvic pain, defined as pain below your belly button and above your legs that is present on most days (or more than 2 days of your period, for people who have periods) for six months or more. People who experience persistent pelvic pain include those who have endometriosis.

Of the full sample of 1668 respondents, 26% (of 428) had experienced persistent pelvic pain (PPP). Of these 428, 79% (or 340) had sought treatment from a healthcare professional for this pain.

We asked people when their PPP started, and used the dates given to calculate number of years since diagnosis/first treatment. The most recent start was 1 year ago and the longest was 45 years ago. The

⁴⁴ This question was asked of all 1668 participants rather than only those who had indicated they had been diagnosed with or treated for PCOS, in recognition of the fact that some people are likely to be trying to get a diagnosis, or managing possible PCOS, without having been formally diagnosed with or treated for the condition.

mean number of years since diagnosis/first treatment was 10.6 years (95% CI: lower 9.6 years, upper 11.5 years).

Satisfaction with treatment for PPP was in general low, with nearly 60% of the respondents who had sought treatment reporting they were either 'Dissatisfied' or 'Very dissatisfied', while only 12% were either 'Extremely satisfied' or 'Very satisfied'.

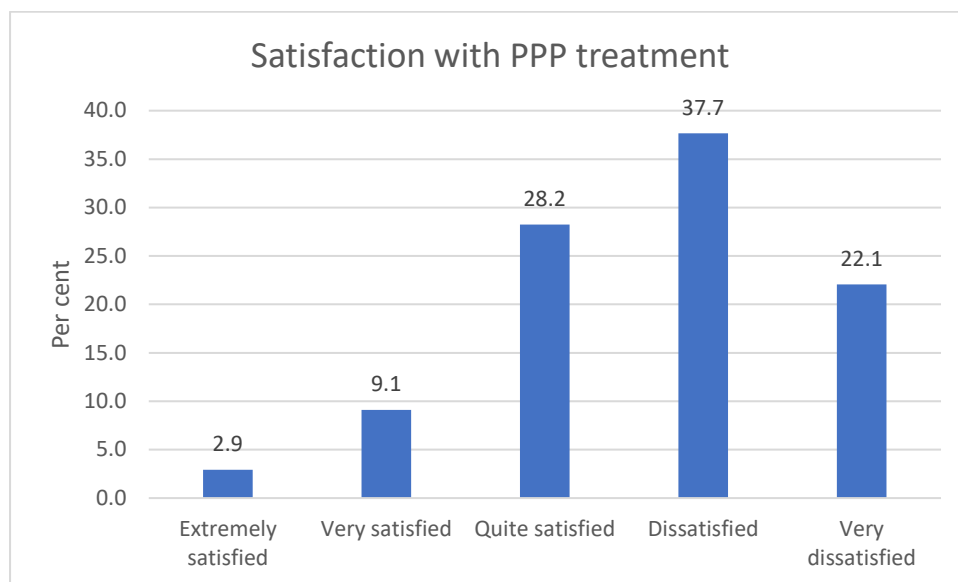


Figure 18: Satisfaction with PPP treatment
N=340

Table 31: Missed work or study due to PPP

	Freq.	Per cent (%)
No	137	32.0
Yes	280	65.4
Prefer not to answer	11	2.6
Total	428	100

Of those who had experienced PPP (n=428), around two thirds (or 280) had missed work/study as a result in the last 12 months. This represents 17% of the survey sample as a whole (n=1668), indicating the significant impact of PPP, and the importance of measures such as reproductive health leave, as well as providing further evidence of the need for strategic and coordinated approaches to sexual and reproductive health overall.

We asked the 428 people who had experienced PPP and optional open-ended question, "Is there anything else you would like to tell us about your experience in relation to persistent pelvic pain?". The following quotes are from responses to that question:

“As my persistent pelvic pain occurs with menstruation it is assumed that I can simply take panadol and carry on with my normal activities, this is not the case and I often have to prepare in the weeks ahead to make sure life is as simple as possible so I can focus on managing my pain instead”

“I am unable to sit or stand for long. Pelvic pain has stolen my life. It seems too complex for most health professionals and a multidisciplinary approach is necessary”

“I was referred to one specialised practitioner in Canberra, who is absolutely excellent and has been instrumental in my condition improving. However, I do not know if any other specialists are available in Canberra, or if people are even aware that they exist to treat this condition. I only learned about the existence of this specialisation because of a referral from an excellent physiotherapist. I believe that better public education on persistent pelvic pain is necessary.”

Abortion

Important steps to improve access to abortion are under way in the ACT, with the establishment of a free access program provide medical and surgical abortion at no cost for women in the ACT,⁴⁵ as well as a Legislative Assembly Inquiry into Abortion and Reproductive Choice.⁴⁶ At the national level, a Senate committee reported on an Inquiry into the Universal Access to Reproductive Healthcare.⁴⁷

⁴⁵ Berry, Y., Deputy Chief Minister and Minister for Women, and Stephen-Smith, R., Minister for Health (2023) No cost abortions now available in the ACT (media release), https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/yvette-berry-mla-media-releases/2023/no-cost-abortion-now-available-in-the-act

⁴⁶ Legislative Assembly for the ACT, Standing Committee on Health and Community Wellbeing (2023) *Inquiry into Abortion and Reproductive Choice in the ACT* (report), https://www.parliament.act.gov.au/_data/assets/pdf_file/0008/2208554/Report-10-Inquiry-into-abortion-and-reproductive-choice-in-the-ACT.pdf

⁴⁷ Parliament of Australia, Senate Standing Committee on Community Affairs (2023) *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia* (report of the Inquiry into the universal access to reproductive healthcare),

To support these initiatives, Women’s Health Matters recently conducted research on people’s experiences of accessing abortion in the ACT and region, including a survey with 102 responses from people who had accessed or tried to access an abortion.

The data report on this research⁴⁸, and the submissions using the data⁴⁹ contain in-depth analysis of access and barriers to abortion healthcare in the ACT. The information presented in the current report is of a much more general nature and does not explore the issues in as much depth.

In this survey, for all people who indicated they had ever been pregnant (n=1109), we asked how many abortions they had ever had. Results showed 23.5% of this group had ever had one or more abortions.

Considering the 261 people who reported that they had ever had an abortion, when we compare the sample as a whole (n=1668), we can see that 16% of our respondents overall reported ever having had one or more abortions. Considering people of reproductive age only (aged 18-44 years, n=1078), results show 24% had one or more abortion.

These proportions are broadly consistent with other Australian datasets.⁵⁰

Table 32: Number of abortions (people who had ever been pregnant)

	Freq.	Per cent (%)
0	838	75.6
1	197	17.8
2	46	4.2
3+	18	1.6
Prefer not to answer	10	0.9
Total	1,109	100

N=1109 (had ever been pregnant)

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ReproductiveHealthcare/Report; Women’s Health Matters (2022) Submission to the Senate inquiry into universal access to reproductive healthcare, <https://www.womenshealthmatters.org.au/wp-content/uploads/2023/05/FINAL-WHM-Submission-to-Senate-inquiry-into-universal-access-to-reproductive-healthcare-1.pdf>

⁴⁸ Women’s Health Matters (2022) *Data report – Survey on access to abortion in the ACT and surrounding regions*, <https://www.womenshealthmatters.org.au/wp-content/uploads/2023/01/WHM-Data-report-Survey-on-abortion-access-2022.pdf>

⁴⁹ Women’s Health Matters (2022) Submission to the Inquiry into abortion and reproductive choice in the ACT, <https://www.womenshealthmatters.org.au/wp-content/uploads/2022/10/WHM-Submission-Inquiry-into-abortion-and-reproductive-choice.pdf>

⁵⁰ Direct comparisons are not straightforward, as measures differ (e.g. abortions per 1,000 women aged 15-44 years, rate of abortion over lifetime for women of different ages). See for example: Children by Choice (no date) *Abortion Rates in Australia*, <https://www.childrenbychoice.org.au/organisational-information/papers-reports/abortion-rates-in-australia/>; Wright, S. M., Bateson, D., McGeechan, K. (2021) *Induced abortion in Australia: 2000-2020*, Family Planning NSW: Ashfield, Australia, https://www.fpnsw.org.au/sites/default/files/assets/Induced-Abortion-in-Australia_2000-2020.pdf

Of the 261 people who indicated that they had one or more abortions in their lifetime, we asked how many were in the ACT. Just over half indicated that one or more of their abortions had been in the ACT. However, results from a further question show that fewer than 10 of the people who had ever had an abortion in the ACT had an abortion in the ACT in the last year.

Table 33: Had had an abortion in the ACT

	Freq.	Per cent (%)
0	125	47.9
1	119	45.6
2	17	6.5
Total	261	100

For the 136 people who had ever had an abortion in the ACT we asked, “Thinking about your most recent (or only) experience of having an abortion or termination in the ACT/region, how satisfied were you with your ability to access the procedure?”

The majority (56%) were either ‘Extremely satisfied’ or ‘Very satisfied’, while 14% were ‘Dissatisfied’ or ‘Very dissatisfied’. We did not ask how long-ago people’s experience was (except for asking whether it was in the last year, as noted above: n=6 indicated that it was). In any future iterations of the survey, we will consider including a question to provide information about how long ago people accessed abortion services.

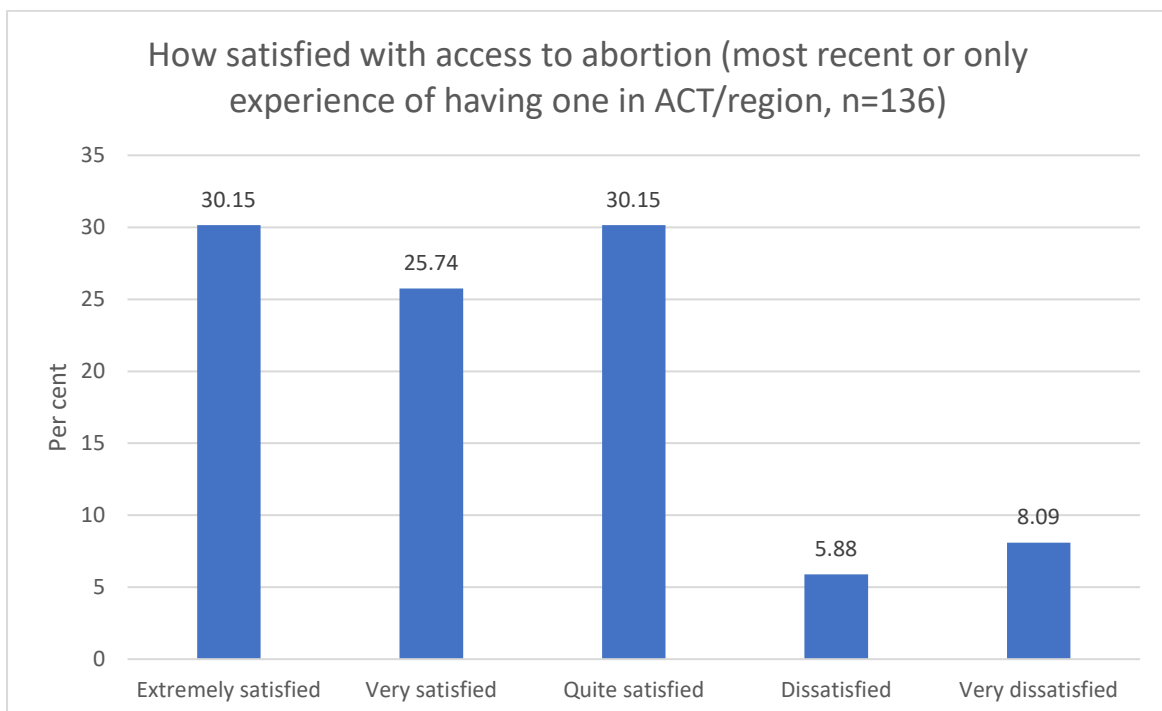


Figure 19: Satisfaction with access to abortion (most recent or only experience of having one in ACT/Region)

Menopause

We asked respondents whether they had reached menopause, defined as, for people with uteruses, the time when menstruation stops (when people stop having periods altogether).

Just over a fifth of all respondents indicated they had reached menopause.

Table 34: Reached menopause

	Freq.	Per cent (%)
No	1,178	70.6
Yes	361	21.6
Unsure	92	5.5
Not applicable	28	1.7
Prefer not to answer	9	0.5
Total	1,668	100

For those who indicated they had reached menopause (n=361), we asked what age they were when their periods completely stopped. As expected, the majority (over 60%) experienced menopause between 45 and 55 years of age.

Table 35: Age when periods stopped

	Freq.	Per cent (%)	Cum. %
Before 40 years of age	40	11.1	11.1
Between 40 and 45 years	52	14.4	25.5
Between 45 and 55 years	223	61.8	87.3
Over 55	46	12.7	100.0
Total	361	100	

“You suffer in silence and you’re discriminated against at work if you mention menopause. It labels you as ‘too old.’”⁵¹

⁵¹ Quote in response to optional open-ended question asked of all 1668 participants, “Is there anything else you would like to tell us about experiencing (or not experiencing) menopause?”

We asked people who had experienced menopause how satisfied they were with their access to support services in relation to menopause. The results show significant levels of dissatisfaction, with over 40% of people reporting they were ‘Dissatisfied’ or ‘Very dissatisfied’, compared with only 23% reporting they were ‘Extremely’ or ‘Very satisfied’.

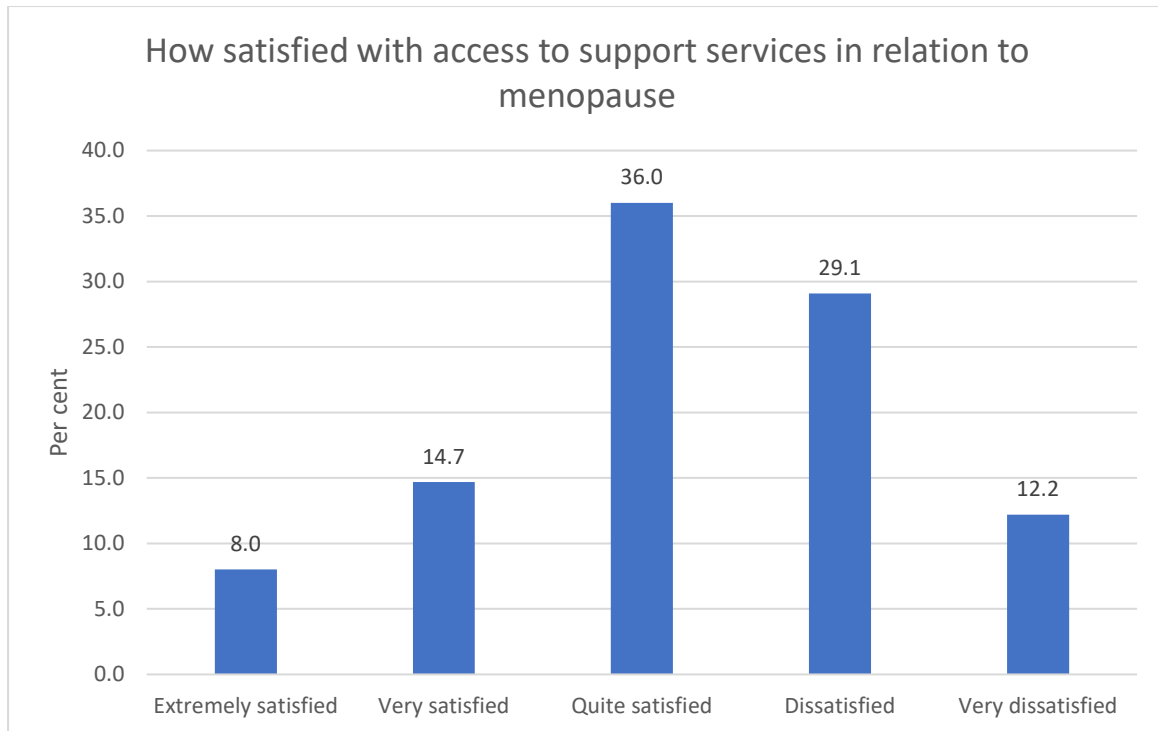


Figure 20: Satisfaction with access to support services in relation to menopause

“Access to services for menopause is poor and relies on word of mouth. Trying to get any help with menopause is hard work and you're mostly told that's what happens with menopause.”⁵²

⁵² Quote in response to optional open-ended question asked of all 1668 participants, “Is there anything else you would like to tell us about experiencing (or not experiencing) menopause?”

Findings 6: Pregnancy & parenting

Experiences of having children or not having children are among the most significant faced across the lifetime. Social norms attribute greater responsibility to women for processes associated with reproduction, parenting and child-rearing, while people of diverse genders and sexualities are often excluded or their desires and experiences about parenting disregarded because they do not fit expected models.

In our survey, we asked respondents about their parenting status. The majority (58%) have a biological child or children only (including adult children), while a significant portion (39%) do not have children. A small number (3%) have people in their care who are not their biological children (in some cases together with their own biological child).

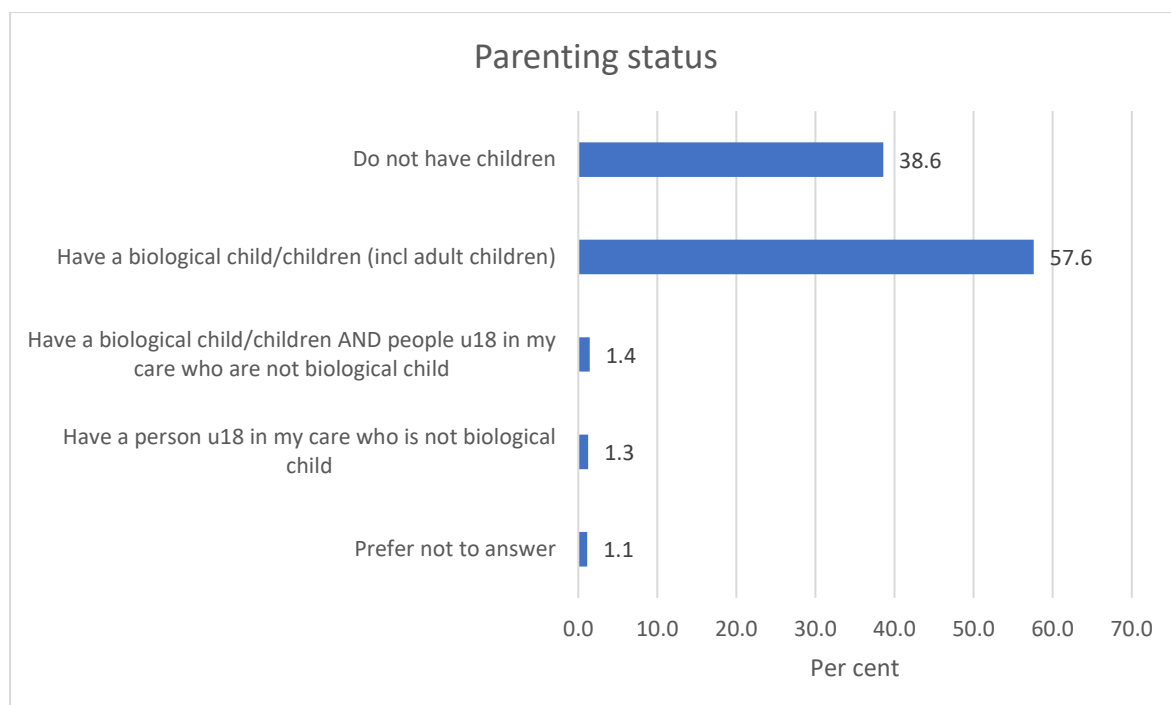


Figure 21: Indication of parenting status
N=1668

Parenting intentions

We also asked people about their parenting intentions (regardless of their parenting status). Nearly two thirds (62%) said they were not currently trying to get pregnant or have a baby and did not plan to in the future.

It should be noted that this includes people who have gone through menopause and people who have children and might already have as many children as they want.

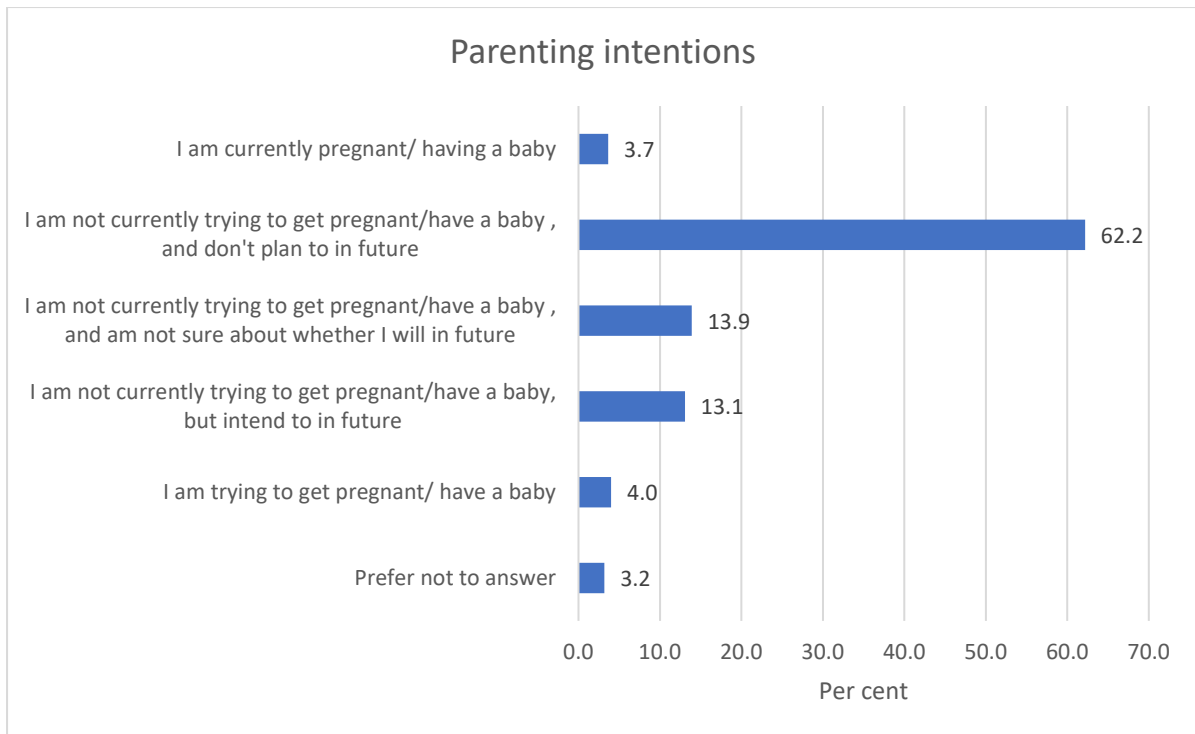


Figure 22: Parenting intentions
N=1668

Looking closer at the parenting intentions of people who do not have children (n=643), we can see that a smaller but still substantial proportion of this group (42%) do not plan to have children.

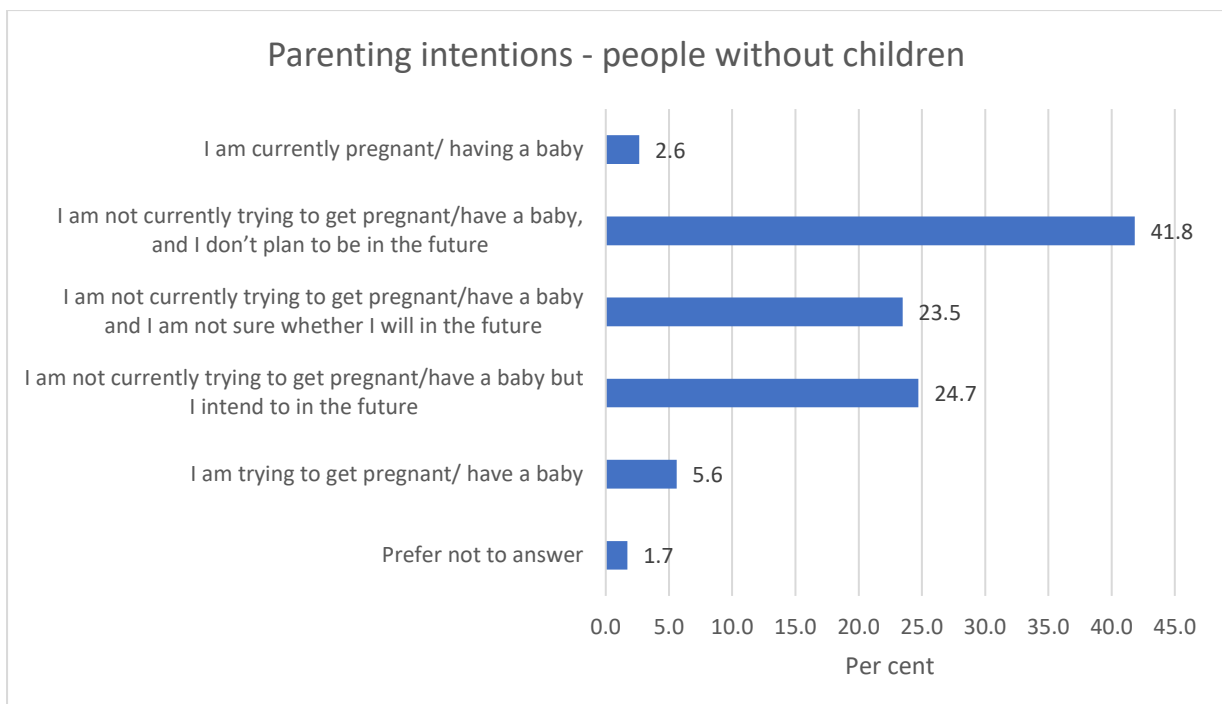


Figure 23: Parenting intentions - people without children
N=643

Factors influencing parenting intentions

We asked all respondents (n=1668) to tell us which factors influence their current parenting intentions, offering a list of pre-defined options as well as the chance to select 'Other' and provide an open-ended response.

'Age' and 'personal choice' were the factors most commonly selected, with substantial numbers also indicating 'finances', being 'happy with family size' and 'fertility' as important in decisions about parenting.

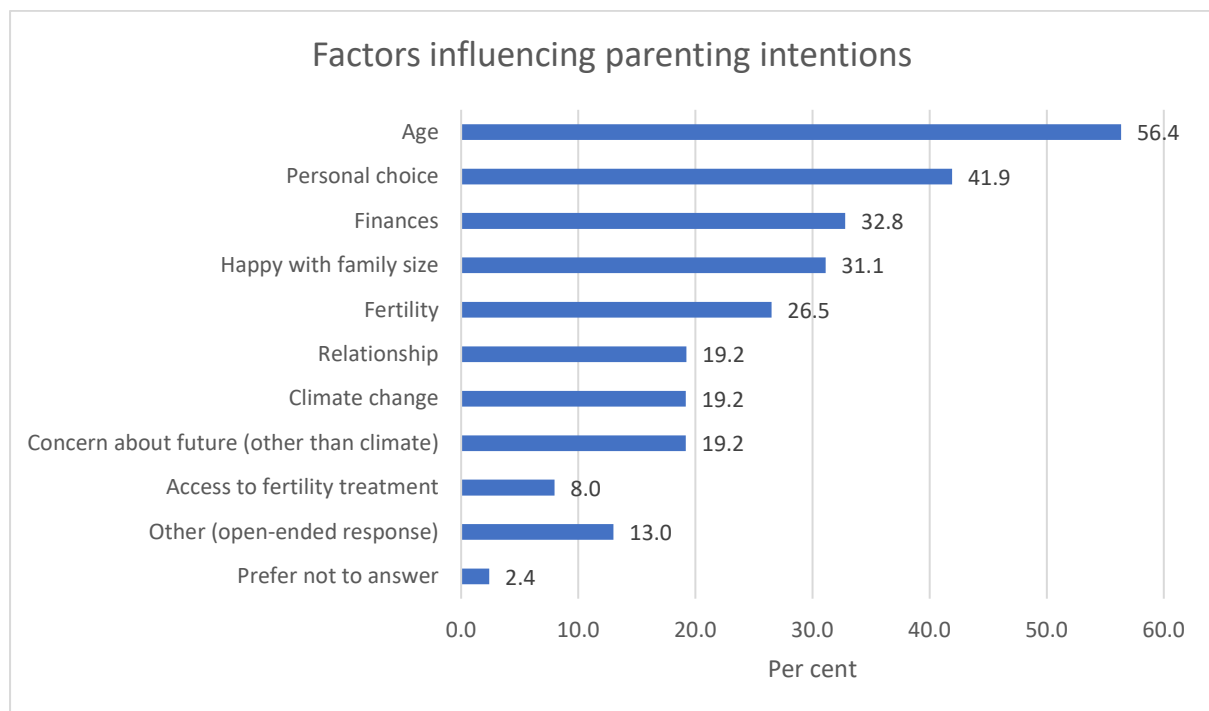


Figure 24: Factors influencing parenting intentions
N=1668

The following are quotes from the open-ended responses to the 'Other' option:

"Lol I'm too young to ruin my life like that, got fun stuff I wanna do first"

"I'm queer – this is going to make the process expensive and lengthy and difficult"

"First baby did not sleep through the night for two and a half years. I could not go through that again."

How many times pregnant

We asked all respondents (n=1668) how many times they had been pregnant, to the best of their knowledge, including current pregnancies, miscarriages, stillbirths and abortions as well as pregnancies carried through to childbirth.

Two thirds of respondents (n=1109) reported that they had been pregnant one or more times in their lives, while one third (n=540) had never been pregnant. (Nineteen respondents selected “Prefer not to answer.”)

Looking more closely at the number of times pregnant, the most commonly reported (and the median) number of pregnancies was 2, with just over a fifth of all respondents reporting they had been pregnant twice.

Table 36: How many times pregnant

	Freq.	Per cent (%)	Cum. (%)
0	540	32.4	32.4
1	222	13.3	45.7
2	367	22.0	67.7
3	250	15.0	82.7
4	132	7.9	90.6
5	66	4.0	94.5
6	36	2.2	96.7
7	14	0.8	97.5
8	12	0.7	98.3
9+	10	0.6	98.9
Prefer not to answer	19	1.1	100.0
Total	1,668	100	

Pregnancy loss

We asked a series of questions about pregnancy loss. Of those who had ever been pregnant (n=1109), 33 people (3%) had had a stillbirth.

Among the people in our survey who had experienced stillbirth, satisfaction with access to support services in relation to stillbirth was low, with half (50%) of all people who had experienced a stillbirth reporting they were dissatisfied or very dissatisfied with their access to support services.⁵³

Of the 1109 people who had ever been pregnant, 432 people (39%) had had a miscarriage. While most people who had experienced a miscarriage reported having just one, almost 15% of the 1109 people who had ever been pregnant reported having had two or more miscarriages.

⁵³ The detailed breakdown of data is not reported in full for this question because some results are small (<10), and the results should be used with caution for this reason.

Table 37: Number of miscarriages

	Freq.	Per cent (%)	Cum. (%)
0	664	59.9	59.9
1	267	24.1	84.0
2	87	7.8	91.8
3	30	2.7	94.5
4+	48	4.3	98.8
Prefer not to answer	13	1.2	100.0
Total	1,109	100	

We asked separately about how many ectopic pregnancies respondents had experienced, finding that 29 people (or 3% of the 1109 people who had ever been pregnant) had had one or more ectopic pregnancies (with most respondents reporting just one, and small numbers reporting two or three).

Births

For people who had ever been pregnant (n=1109), we asked how many times they had ever given birth to a living baby.

Note that we did not ask how recent these experiences were. For any future iterations of the survey, we will consider adding a question to provide this information, which will help to contextualise and interpret findings about models of care, birth experiences and satisfaction with maternity services.

In the discussions below, we briefly outline some differences in the results by age of respondent. While the age comparisons are not equivalent to and cannot replace data about how recent respondents' experiences were, they suggest the kinds of patterns that might be found at the population level when births that occurred many years ago are compared with births that were more recent. For example, people aged 25-34 are relatively more likely to have given birth less than five years ago, compared with people aged 45-54 years.

The most commonly reported and median number of times that respondents had given birth to living babies was two (43%).

Table 38: Number of births to a living baby (people who had ever been pregnant)

	Freq.	Per cent (%)	Cum. (%)
0	125	11.3	11.3
1	283	25.5	36.8
2	476	42.9	79.7
3	176	15.9	95.6
4+	47	4.2	99.8
Prefer not to answer	2	0.2	100.0
Total	1,109	100	

Maternity model of care

For all people who had given birth to a living baby (n=982), we asked what type of maternity care they had for the most recent time they gave birth.

The most commonly reported type of maternity care was private obstetrician (28%) followed by continuity of midwifery care (21%). Proportionally fewer people in younger age groups had used private obstetricians for their most recent birth, while proportionally more people in younger age groups had continuity of midwifery care and (to a lesser extent) GP shared care or maternity care team arrangements.

Table 39: Maternity model of care (people who had ever given birth to a living baby)

	Freq.	Per cent (%)
Private obstetrician	279	28.4
Continuity of midwifery care	210	21.4
GP shared care	148	15.1
Maternity care team	107	10.9
Private midwifery-led care	6	0.6
Not sure	37	3.8
Most recent birth was not in the ACT	195	19.9
Total	982	100

Satisfaction with maternity care

For all people who had given birth to a living baby (n=982), we asked how satisfied they were with their maternity care. As noted above, these results need to be used with caution, as they do not provide information about when the experience of maternity care occurred. The responses show overall high levels of satisfaction with maternity care, as 59% of respondents were extremely or very satisfied with their care, compared with around 12% of respondents dissatisfied or very dissatisfied.

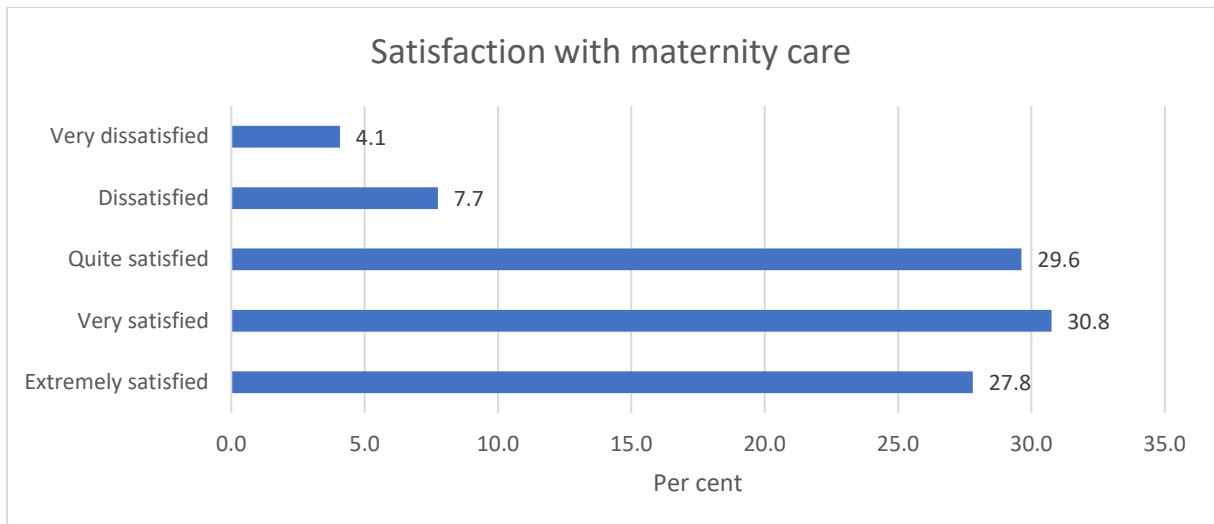


Figure 25: Satisfaction with maternity care (respondents who had given birth to a living baby)

There were no significant differences in satisfaction with maternity care between people of different age groups. That is, looking across different age groups, levels of satisfaction were similar.

Homebirth

Homebirth remains rare according to our survey, with only 1.5% of the 982 people who had ever given birth to a living baby reporting they had a homebirth at some point. Due to small numbers of people who had homebirths, comparisons should be used with caution. However, it does appear that similar (very low) proportions of people had homebirths across all different age groups.

Caesarean section births

Over a third of people in our study who had given birth to a living baby had had a caesarean. This is consistent with other studies of caesarean rates in Australia, such as the AIHW's National Core Maternity Indicators, which report a rate of 33.7 caesareans per 100 live births.⁵⁴ Consistent with other studies showing increases in caesarean rates over time, our data shows that respondents from younger age groups had proportionally higher incidence of caesarean birth than older age groups.

Conditions during pregnancy and after birth

We asked people who had given birth to a living baby (n=982) whether they had been diagnosed or treated for a range of conditions in relation to their most recent pregnancy.

The results show that postnatal depression affected one in six people in our study, while significant numbers experienced gestational diabetes, hypertension and/or postnatal anxiety.

⁵⁴ Australian Institute of Health and Welfare (2023) *National Core Maternity Indicators, Caesarean section* (web report), <https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators-1/contents/labour-and-birth-indicators/caesarean-section>

Table 40: Conditions during pregnancy and after birth (respondents who had given birth to a living baby)

	Freq.	Per cent (%)
Postnatal depression	174	17.7
Gestational diabetes	133	13.5
Hypertension	124	12.6
Postnatal anxiety	123	12.5
Antenatal anxiety	79	8.0
Antenatal depression	58	5.9
Pre-eclampsia	58	5.9

Traumatic birth experiences

Following the approach taken by Australian Longitudinal Study on Women’s Health, we have collected information on the prevalence of traumatic birth experiences, as risk factors for poor perinatal mental health and as significant negative healthcare experiences in and of themselves. As defined by ALSWH⁵⁵, we asked about experiences of caesarean section after labour started, labour lasting longer than 36 hours, and emotional distress during labour (pregnancy loss is addressed elsewhere in this report).

We found high levels of these experiences, with almost a quarter of respondents who had given birth to a living baby (n=982) reporting emotional distress during labour, and over a fifth reporting caesarean section after labour started. Almost 14% reported labour lasting longer than 36 hours.

Overall, 45% of people who had given birth to a living baby reported some form of traumatic birth. Although not directly comparable with the Australia-wide ALSWH data (which sought information about experiences with first births only), our results are broadly similar. ALSHW found that 45.6% of women born 1989-95 and 36.9% of women born 1973-78 had experienced a traumatic birth (as measured by the indicators below, plus incidence of stillbirth).

Incidence of traumatic birth experiences do not appear to greatly differ by age group (noting that in some cases numbers are small, making comparisons potentially unreliable).

⁵⁵ Loxton D., et al (2021) *Reproductive health*, https://alswh.org.au/wp-content/uploads/2023/01/ALSWH_2021-Major-Report-Reproductive-health_Final_May-17.pdf

Table 41: Traumatic birth experiences (people who had given birth to living baby)

	Freq.	Per cent (%)
None	540	55.0
Caesarean section after labour started	215	21.9
Labour lasting longer than 36 hours	136	13.9
Emotional distress during labour	240	24.4

Percentages calculated as proportion of n=982 people who gave birth to a living baby

Findings 7: Discrimination, safety & violence

Experiences of discrimination and violence are key contributors to ill health, through direct and indirect impacts.⁵⁶ These include physical, emotional, social, economic and psychological effects.

Our survey gathered information about whether (and how recently) respondents had experienced different kinds of discrimination and violence, as well as how safe they felt in certain settings.

Further analysis will be needed to understand the relationships between these results and other aspects of our findings, as well as to contextualise the results in terms of other research and implications for policy and practice.

Please note that reading about experiences of violence and abuse can be distressing. The following sections contain information that readers may find difficult.

When administering the survey, we provided links in multiple places to a separate webpage with support options for respondents.⁵⁷ For the questions on safety and violence (excluding the questions on discrimination) we gave respondents the choice to opt out of the full set of questions.

Of the whole sample of 1668, there were 1412 people who chose to proceed with the questions on safety and violence. We cannot know people's reasons for choosing not to proceed with those questions, but it is likely that some did so because of experiences of violence or abuse.

Discrimination

We asked respondents (n=1668) whether, in the last 12 months, they had been discriminated against or treated unfairly. Just under a third (32% or 528) reported that they had.

We asked the 528 people who reported having been discriminated against "Thinking about the last time you experienced discrimination or were treated unfairly, which of the following factors do you believe it was related to?" We asked respondents to select all factors that applied from a pre-defined list as well as giving the option to write other open-ended responses.

Almost two thirds (63%) reported that gender was a factor, while 40% indicated age and 30% appearance as factors in the discrimination. One in five reported having been discriminated against on the basis of disability.

It should be noted that our survey sample overall under-represented people from migrant and refugee backgrounds and from language backgrounds other than English, so it is likely that our findings in relation to discrimination also under-estimate the prevalence of discrimination on the basis of cultural

⁵⁶ Townsend et al (2022) *A life course approach to determining the prevalence and impact of sexual violence in Australia*; Lum On, M., Ayre, J., Webster, K., Moon, L. (2016) *Examination of the health outcomes of intimate partner violence against women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited (ANROWS), https://anrowsdev.wpenginepowered.com/wp-content/uploads/2019/01/160324_1.7-Burden-of-Disease-FINAL_0.pdf; Davis, B.A. (2020) 'Discrimination: A Social Determinant Of Health Inequities' *Health Affairs Forefront*, 25 February, <https://www.healthaffairs.org/content/forefront/discrimination-social-determinant-health-inequities>

⁵⁷ The page with support options can be found here: <https://www.womenshealthmatters.org.au/support-options-survey-of-womens-health-in-the-act/>

and language background. Indeed, the 2019 ACT General Health Survey reported discrimination on the basis of nationality (41.7%), skin colour (25%) and language (15.1%) at higher levels than indicated in the results of our survey (note, however, that the ACT General Health Survey data is not disaggregated by gender).⁵⁸

Table 42: Factors in experiences of discrimination in last 12 months

	Freq.	Per cent (%)
Gender	331	62.7
Age	209	39.6
Appearance	158	29.9
Disability	121	22.9
Race	58	11.0
Sexuality	50	9.5
Language	19	3.6
Religion	17	3.2
Other (<10 responses)	6	1.1
Other (open-ended responses)	110	20.8

N=528

Other (open-ended) answers included descriptions of discrimination on the basis of health issues, especially mental illness, weight, parenting or family arrangements. Future analysis might include recoding of 'Other' responses and response categories.

People who reported experiencing discrimination were asked an optional open-ended question, "Is there anything that you would like to tell us about your experience(s) of discrimination or unfair treatment?" The following quotes are from those open-ended responses:

"As an older woman I get ignored or treated as unimportant in medical settings. It's just so common it's expected."

"Being in a fat body sees me frequently discriminated against. It causes me to hesitate seeing a doctor for fear of judgement or mistreatment. My experience having an IUD put in was horrible and they refused to provide anaesthetic because of my weight. Also the gowns are always too small which takes away privacy and dignity."

⁵⁸ ACT Government (2021) Open Data Portal dataACT - ACTGHS reason for discrimination, adults, 2019, <https://www.data.act.gov.au/Health/ACT-GHS-reason-for-discrimination-adults-2019/2fq5-bbez?referrer=embed>

“I gave birth in April, I faced discrimination throughout my pregnancy because I was disabled. There were also many times I didn’t have access to an accessible bathroom at a medical facility or to a height adjustable bed.”

Safety in public places

We asked respondents who agreed to answer questions about safety and violence (n=1412) two sets of questions about their feelings of safety in public places: one about using public transport alone after dark; and one about walking alone after dark in their area. For each of these scenarios, we explored how safe they felt and their main reason for not using these spaces or facilities (if they reported that they did not use them).

Using public transport alone after dark

Two out of every five people (40% or 565 people) reported that they had used public transport alone after dark in the ACT in the last 12 months (n=1412 who answered).

For those who answered that they had used public transport alone after dark in the last 12 months (n=565), we asked whether they felt safe *waiting for public transport* alone after dark, and whether they felt safe *using public transport* alone after dark.

The majority (59% or 332) of those who had used public transport alone after dark reported that they did not feel safe waiting for public transport.

Responses for using (as opposed to waiting for) public transport indicated higher levels of perceived safety, with a small majority (54% or 306 people) reporting that they felt safe while using public transport alone after dark. These findings indicate the importance of frequent nighttime services for women’s feelings of safety.

For those who answered that they did not use public transport alone after dark (n=847), we asked why not (asking respondents to select the reason that best applies). Two thirds answered that they had no need to do so, while a quarter said it was because they did not feel safe.

‘Other’ (free text) answers included reasons to do with the lack of public transport services, accessibility issues in relation to disability and explanations of reasons in which issues of safety are combined with other factors.

Table 43: Reasons for not using public transport alone after dark

	Freq.	Per cent (%)
No need	558	65.9
Did not feel safe	214	25.3
Other (free text)	75	8.9
Total	847	100

Taken together, over 558 people in our survey either do not use public transport alone after dark because they do not feel safe, or do use public transport alone after dark it but feel unsafe while waiting for or using it. This represents at least 40% of people in our survey (as a proportion of the 1412 who answered the questions on violence and safety) whose ability to participate in activities and public life at night is impacted by safety concerns relating to public transport.

“Public transport is too few and far in between so wait times are often long late at night. I feel the least safe when waiting for public transport. As soon as I get on I can sit near the driver.”⁵⁹

Walking alone in local area after dark

Turning to answers about walking alone in one’s area after dark, 725 people or just over 50% (of the 1412 people who answered questions on violence and safety) reported that they had done so in the last year.

For those who answered that they had walked alone in their area after dark in the last 12 months (n=725), we asked whether they felt safe while doing so. A small majority, 416 people or 57% of 725, reported that they did feel safe in that situation.

For those who answered that they had not walk alone in their area after dark in the last year (n=687), we asked why not (the reason that best applies).

A small majority (382 or 56%) reported that the main reason for not walking alone in their area after dark was because they did not feel safe.

Other (open-ended) answers (n=30) included reasons to do with disability, poor lighting, previous experiences of sexual harassment or violence, and reasons in which issues of safety are combined with other factors.

⁵⁹ This is a quote from an open-ended optional question “Is there anything you would like to tell us about your feelings of safety (or lack of safety) in public spaces or on public transport in the ACT?”

The following are quotes from an open-ended optional question “Is there anything you would like to tell us about your feelings of safety (or lack of safety) in public spaces or on public transport in the ACT?”:

“I wouldn't feel safe being alone after dark in ACT”

“Last time I walked I was called names by men, so I prefer to walk with my husband.”

“Street lighting in Canberra makes walking alone at night impossible in multiple ways!”

“I feel safe in my suburb, but would avoid city centre in the late hours.”

Reproductive coercion

Reproductive coercion is behaviour intended to limit another person’s ability to make reproductive choices and have autonomy over the reproductive functions of their body. It is a type of gender-based violence that is often, but not always, perpetrated against women. Reproductive coercion intersects with other forms of violence and control, and is reinforced by settings in which laws, rules and social norms work to stigmatise and control sexuality and bodily autonomy of women and gender diverse people.

Research on reproductive coercion in Australia includes the major paper by MSI Australia, *Hidden Forces* (2020),⁶⁰ which sets out key definitions and recommendations, and builds on other research by Children by Choice (2018).⁶¹ Datasets are limited but developing within scholarship and sexual and reproductive health settings.⁶²

In our survey we asked a set of questions about experiences that could indicate possible reproductive coercion. These questions were based on questions suggested by Children by Choice for practitioners screening for reproductive coercion⁶³. However, it is important to note that the data generated by these questions in an online survey format, without other exploration and contextualisation, is not capable of definitively establishing whether a respondent has or has not experienced reproductive coercion. At

⁶⁰ Marie Stopes Australia (2020) *Hidden forces: A white paper on reproductive coercion in contexts of family and domestic violence* (Second edition), <https://www.msiaustralia.org.au/wp-content/uploads/Hidden-Forces-Second-Edition-.pdf>

⁶¹ Children by Choice (2018) *Screening to Safety Project: Final project report*, https://www.childrenbychoice.org.au/wp-content/uploads/2022/01/screening_to_safety_project_final_report.pdf

⁶² Sheeran, N., Vallury, K., Sharman, L.S., Corbin, B., Douglas, H., Bernardino, B., Hach, M., Coombe, L., Keramidopoulos, S., Torres-Quiazon, R., Tarzia, L. (2022) ‘Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions’ *Reproductive Health* 19, 170, <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-022-01479-7>

⁶³ Children by Choice, Screening tool (no longer published online)

best, our survey can establish the presence or absence of experiences that *could* indicate *possible* reproductive coercion.

Because of the sensitivity of questions about reproductive coercion, we provided an additional opportunity for respondents to opt out of these questions. Following this opt-out/opt-in question, 1052 respondents remained in the survey and answered questions about reproductive coercion. These respondents were still given options to select 'Prefer not to answer' for any of the individual questions in the set.

We found that 124 people, or around 12% of the 1052 respondents who agreed to answer questions about reproductive coercion, reported experiencing one or more of the indicators. Most of these (85 people) reported having experienced only one of the indicators, while 39 people reported experiencing more than one. Proportions are given in the table below, but considering the relatively small numbers of people, comparisons between them should be used with caution.

Table 44: Experiences of behaviours indicating possible reproductive coercion

	Number answered yes or no to question*	Freq. (Number answered yes)	Per cent (%)*
Do not feel OK talking to partner about pregnancy	858	20	2.3
Been coerced about not agreeing to pregnancy	1043	35	3.4
Sexual partner tried to interfere with birth control	1051	40	3.8
Needed to hide contraception	1049	15	1.4
Anyone coerced you to end pregnancy	1044	50	4.8
Anyone coerced you to continue pregnancy	1049	22	2.1

* Percentages are calculated as a proportion of total answered 'yes' or 'no' to question, excluding answers of 'prefer not to answer' and (in the case of the first question) 'do not have partner'.

The following quotes are from responses to an optional open-ended question: "Is there anything else you'd like to add about becoming pregnant / having a baby and experiences of violence or coercion?":

"I've been forced to take the morning after pill in addition to regular contraception such as the pill because the male did not want me to fall pregnant. He also refused to wear condoms or would take it off during sex."

“He put holes in the condom. I now have a wonderful son, but he used the pregnancy and my sons to be in my life and to hurt me for years”

Sexual violence

In our survey we defined sexual violence for respondents in the following terms: “Sexual violence is when someone forces, pressures or tricks another person into doing sexual things, or having sexual things done to them. Sexual violence can include sexual harassment, unwanted sexual touch, stalking, having images taken or distributed without consent, indecent assault and rape.”

Following this definition, we posed the question as “Have you ever been forced to take part in unwanted sexual activity?” in order to make the question consistent with ALSWH indicators.

Of the 1412 people who agreed to answer the set of questions about violence, 44% indicated that they had experienced some form of sexual violence. This is higher than the prevalence estimated by the ABS’s Personal Safety Survey (2021), which found that 22% of women had experienced sexual violence since the age of 15.⁶⁴ This may be due to differences in the framing of the question (lifetime including vs excluding childhood), our sampling strategy and/or representativeness of the sample in relation to the population.

Recent research by ALSWH has found higher Australia-wide lifetime prevalence of sexual violence, in a range to which our results is closer: 51% of women in their twenties; 34% of women in their forties; and 26% of women aged 68 to 73.⁶⁵ As the authors of that study note, “The differences in prevalence by age may reflect generational differences in understanding, personal feelings about disclosing sexual violence and the time since the violence occurred”.⁶⁶

Table 45: Experiences of sexual violence

	Freq.	Per cent (%)
No	757	53.6
Yes	620	43.9
Prefer not to answer	35	2.5
Total	1,412	100

For people who answered that they had experienced sexual violence (n=620), we asked whether they had experienced sexual violence in the last year, or if the sexual violence they had experienced was

⁶⁴ Australian Bureau of Statistics (2023) Personal Safety, Australia, 2021-22 financial year, <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release>

⁶⁵ Townsend et al (2022) *A life course approach to determining the prevalence and impact of sexual violence in Australia*

⁶⁶ Townsend et al (2022) *A life course approach to determining the prevalence and impact of sexual violence in Australia*, p.8

more than 12 months ago. As expected, the large majority of sexual violence experienced had occurred more than a year ago, with 6% of those who had experienced this form of violence reporting it in the last year.

Taken as a proportion of all those who agreed to answer the set of questions about violence (n=1412), our survey found 2.7% of respondents had experienced sexual violence in the last year. This is slightly higher than the 2021 Personal Safety Survey, which reported 1.9% of women had experienced sexual violence in the last year.

Table 46: Experiences of sexual violence - how long ago (people who indicated they had experienced sexual violence)

	Freq.	Per cent (%)
More than 12 months ago	579	93.4
In last year	38	6.1
Prefer not to answer	3	0.5
Total	620	100

Domestic violence

In our survey we defined domestic violence for respondents in the following terms: “Domestic violence is when someone uses force or manipulation to maintain power and control over their partner or spouse. It can involve controlling behaviour, physical violence, sexual violence, stalking, using technology to control or threaten, financial abuse, intimidation, and emotional and verbal abuse such as insults. For the purposes of this question, we are talking about situations where you have been subjected to this kind of behaviour.”

Following the definition, we posed the question as “Have you ever been in a violent relationship with a spouse/partner?” in order to make the question consistent with ALSWH indicators.

Of the 1412 people who agreed to answer the set of questions about violence, 28% indicated that they had experienced some form of domestic violence. This is similar to the prevalence estimated by the ABS’s Personal Safety Survey (2021), which found that 27% of women had experienced some form of violence or abuse by a cohabiting partner since the age of 15.⁶⁷

⁶⁷ Noting that the definition differs somewhat in that the PSS specifies cohabitation whereas our question does not. Australian Bureau of Statistics (2023) Personal Safety, Australia, 2021-22 financial year, <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release>

Table 47: Experiences of domestic violence

	Freq.	Per cent (%)
No	992	70.3
Yes	396	28.1
Prefer not to answer	24	1.7
Total	1,412	100

For people who answered that they had experienced domestic violence (n=396), we asked whether they had experienced domestic violence in the last year, or if the domestic violence they had experienced was more than 12 months ago. As expected, the majority of domestic violence experienced had occurred more than a year ago, with 12% of those who had experienced this form of violence reporting it in the last year.

Taken as a proportion of all those who agreed to answer the set of questions about violence (n=1412), our survey found 3.3% of respondents overall had experienced domestic violence in the last year. For comparison, the 2021 Personal Safety Survey found that 0.9% of women had experienced physical or sexual violence from a cohabiting partner in the last year, while 3.9% had experienced cohabiting partner emotional abuse in the last year (these figures are not aggregated to a single measure of domestic violence in the PSS).⁶⁸

Table 48: Experiences of domestic violence - how long ago (people who have experienced domestic violence)

	Freq.	Per cent (%)
More than 12 months ago	347	87.6
In last year	46	11.6
Prefer not to answer	3	0.8
Total	396	100

Family violence

In our survey we defined domestic violence for respondents in the following terms: “Family violence is when someone uses force or manipulation to maintain power and control over another person in their family (other than their partner or spouse). It can involve controlling behaviour, physical violence, sexual violence, stalking, using technology to control or threaten, financial abuse, intimidation, and emotional and verbal abuse such as insults. Family violence includes violence by an adult against a child or young

⁶⁸ Australian Bureau of Statistics (2023) Personal Safety, Australia, 2021-22 financial year, <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release>

person, by a young person against an adult, and by one adult against another (for example, between in-laws).”

Following this definition, we posed the question as “Have you ever experienced violence from another family member (not a partner or spouse)?”

Of the 1412 people who agreed to answer the set of questions about violence, 31% indicated that they had experienced some form of family violence. The ABS’s Personal Safety Survey (2021) measures “violence by a family member since the age of 15”, showing that 8.1% of women had experienced this.⁶⁹ However, these measures are not directly comparable since the ABS measure excludes violence by a family member experienced when younger than 15 years old, whereas our measure includes it.

Table 49: Experiences of family violence

	Freq.	Per cent (%)
No	948	67.1
Yes	430	30.5
Prefer not to answer	34	2.4
Total	1,412	100

For people who answered that they had experienced family violence (n=430), we asked whether they had experienced family violence in the last year, or if the family violence they had experienced was more than 12 months ago. As expected, the majority of family violence experienced had occurred more than a year ago, with 15% of those who had experienced this form of violence reporting it in the last year.

Taken as a proportion of all those who agreed to answer the set of questions about violence (n=1412), our survey found 4.6% of respondents overall had experienced family violence in the last year.

Table 50: Experiences of family violence - how long ago (people who have experienced family violence)

	Freq.	Per cent (%)
More than 12 months ago	361	84.0
In last year	65	15.1
Prefer not to answer	4	0.9
Total	430	100

⁶⁹ Noting that the definition differs somewhat in that the PSS specifies cohabitation whereas our question does not. Australian Bureau of Statistics (2023) Personal Safety, Australia, 2021-22 financial year, <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release>

Workplace sexual harassment

Workplace sexual harassment is a subset of sexual violence. We chose to ask about it specifically in our survey because data focused on sexual harassment in the workplace setting is less available than data about sexual harassment generally, and local, recent data would be useful to complement other studies such as the Australian Human Rights Commission's (AHRC's) national surveys, the last of which was in 2022.⁷⁰

In our survey we defined workplace sexual harassment for respondents in the following terms: "Sexual harassment is any unwelcome sexual behaviour that would reasonably be expected to cause the targeted person to be offended, humiliated or intimidated. Workplace sexual harassment is sexual harassment that occurs at work, at a work-related event or while looking for work, including any place where a worker goes, or is likely to be, while working, such as remote working at home or in online environments."

Following the definition, we posed the question as "Have you ever experienced sexual harassment at work, at a work-related event or while looking for work?" (consistent with the AHRC survey).

Of the 1412 people who agreed to answer the set of questions about violence, 40% indicated that they had experienced workplace sexual harassment at some time in their lives. The AHRC did not collect information about lifetime workplace sexual harassment, but noted that 89% of women had experienced some form of sexual harassment in their lives since the age of 15 (including but not limited to workplace sexual harassment).

Table 51: Experiences of workplace sexual harassment

	Freq.	Per cent (%)
No	843	59.7
Yes	558	39.5
Prefer not to answer	11	0.8
Total	1,412	100

For people who answered that they had experienced workplace sexual harassment (n=558), we asked whether they had experienced workplace sexual harassment in the last year, or if the workplace sexual harassment they had experienced was more than 12 months ago. As expected, the majority of workplace sexual harassment had occurred more than a year ago, with 9.7% of those who had experienced this form of violence reporting it in the last year.

Taken as a proportion of all those who agreed to answer the set of questions about violence (n=1412), our survey found 3.8% of respondents overall had experienced workplace sexual harassment in the last

⁷⁰ Australian Human Rights Commission (2022) Time for respect: Fifth national survey on sexual harassment in Australian workplaces, <https://humanrights.gov.au/time-for-respect-2022>

year. This appears to be a lower prevalence than Australia-wide data collected by the AHRC, which found 19% of people (all genders) had been sexually harassed at work in the previous 12 months.⁷¹

Table 52: Experiences of workplace sexual harassment - how long ago (people who had experienced workplace sexual harassment)

	Freq.	Per cent (%)
More than 12 months ago	501	89.8
In last year	54	9.7
Prefer not to answer	3	0.5
Total	558	100

To make our study comparable with the AHRC survey, we additionally asked people who said they had experienced workplace sexual harassment in their lifetime whether they had experienced workplace sexual harassment in the last 5 years. Of the 1412 people who agreed to answer questions about violence, 212 or 15% said they had been sexually harassed at work in the last 5 years. This is lower than the rate reported by the AHRC survey (2022), which found 41% of women had been sexually harassed at work in the last 5 years.⁷²

Further analysis will be needed to understand the differences between the Australia-wide AHRC findings and our survey findings. It is possible that these differences relate to the different occupational structure of the of the ACT workforce and potentially the under-representation of young people aged 18-24 in our sample.

Institutional violence

Institutional violence is a structural form of violence that occurs not only at an individual level but at the level of facilities and organisations, and involving the people who staff them. People who are subjected to multiple forms of marginalisation and discrimination are particularly likely to experience this form of violence. Institutional violence can be a form of gender-based violence, in which harm is perpetrated in ways intimately linked to a person’s gender, often in addition to other aspects of a person’s identity.

Questions about institutional violence are not often included in studies of gender-based violence or violence against women. These studies often focus on violence occurring in personal, family or sexual relationships, and less on the social and institutional context in which violence occurs. We believe it is important to represent experiences of gender-based violence (and other violence) that do not fit neatly into the usual categories of domestic, sexual and family violence, and which may be experienced at higher rates by people who are particularly marginalised.

⁷¹ Australian Human Rights Commission (2022) Time for respect: Fifth national survey on sexual harassment in Australian workplaces, <https://humanrights.gov.au/time-for-respect-2022>

⁷² Australian Human Rights Commission (2022) Time for respect: Fifth national survey on sexual harassment in Australian workplaces, <https://humanrights.gov.au/time-for-respect-2022>

In our survey, we defined institutional violence in the following terms: “Institutional violence is when a facility or organisation inflicts harm on a person, or controls them in harmful ways. This can happen in different settings such as hospitals, prisons, schools, group homes, or nursing homes.

Examples include being forcibly restrained, forced to take medicine, or denied the ability to make your own choices. It can also include sexual violence, physical violence or emotional abuse by workers, or by others in those settings.”

Following this definition, we posed the question as: “Have you ever experienced institutional violence?”

Because of the additional sensitivities with this topic, we made the question optional. Only 426 people chose to answer this question, possibly because it is a complex concept and not a familiar term, or because it may be too distressing to recall such experiences of violence. Of those who chose to answer, 69 people (16.2%) said that they had experienced institutional violence.

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