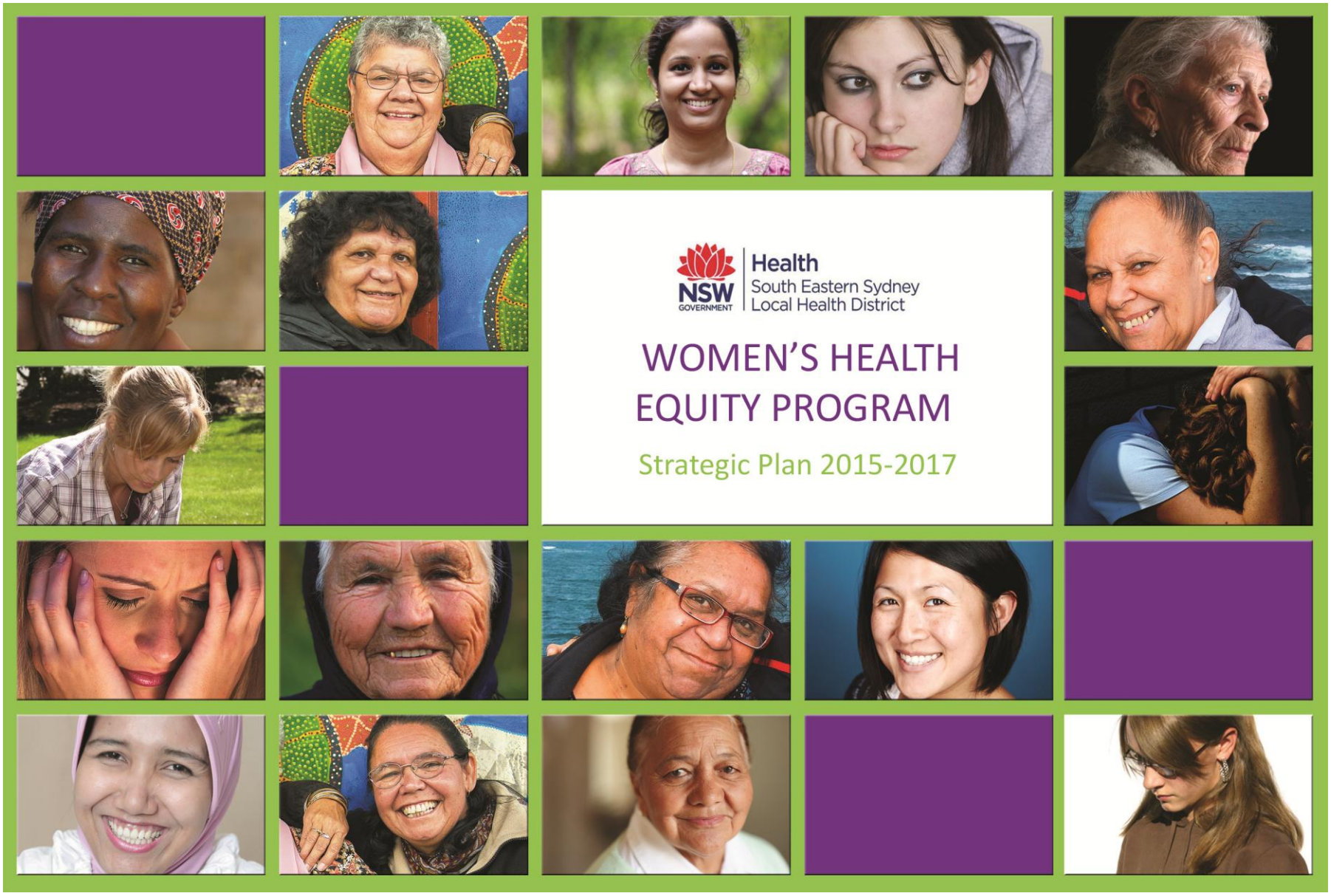


NSW GOVERNMENT Health
South Eastern Sydney
Local Health District

WOMEN'S HEALTH EQUITY PROGRAM

Strategic Plan 2015-2017

"Addressing women's health is a necessary and effective approach to strengthening health systems overall – action that will benefit everyone. Improving women's health matters to women, to their families, communities and societies at large. Improve women's health – improve the world."

- From the WORLD HEALTH ORGANIZATION (2014) "Women and Health – Today's evidence, tomorrow's agenda"[1]

Women's Health Equity Program Strategic Plan 2015-2017

Prepared by the Ambulatory and Primary Health Care Directorate, South Eastern Sydney Local Health District

February 2015

CONTENTS

Abbreviations and language used in this document

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CNC	Clinical Nurse Consultant
FTE	Full-time equivalent
HIV	Human Immunodeficiency Virus
HSM	Health Service Manager
LGA	Local Government Area
LHD	Local Health District
NGO	Non-Government Organisation
NSW	New South Wales
SESLHD	South Eastern Sydney Local Health District
STI	Sexually transmitted infection
The National Policy	*National Women's Health Policy 2010*[2]
The NSW Framework	*NSW Health Framework for Women's Health 2013*[3]
The Reform Package	*It Stops Here - the NSW Government's Domestic and Family Violence Framework for Reform*[4]
WHO	World Health Organization

The terms "domestic violence" and "family violence" refer to any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour[4]. The term "family violence" is often used in Aboriginal communities in particular.

The term "Aboriginal" is used throughout this document to include Aboriginal and Torres Strait Islander peoples, in accordance with NSW Health policy[5]. No disrespect is intended towards our Torres Strait Islander staff, patients or communities.

The term "culturally and linguistically diverse" is sometimes abbreviated to "CALD". However as some people find this offensive, that acronym is not used in this document. It should also be noted that people from culturally and linguistically diverse backgrounds are not exclusively born overseas. Many Australian-born people (including babies born to recently-arrived migrants) also have a strong cultural background that is important to acknowledge. The term "migrant" is only used in this document where it specifically refers to a person born overseas.

EXECUTIVE SUMMARY

The South Eastern Sydney Local Health District has a wide range of plans, services and programs that aim to improve the health of women. From specific clinical services such as those provided by the Royal Hospital for Women, to population health programs delivered across our communities, we aim to address both the immediate clinical needs of women as well as proactively addressing the determinants of their health.

The proposed new *SESLHD Women's Health Equity Program* sits within this broader strategic context. It is funded in recognition of the fact that despite a system-wide commitment to the health of all women, additional focussed strategies are warranted to address inequities. **The program goal is to improve the health and wellbeing of women living in the SESLHD, particularly those who experience health inequities.** Many of these women have barriers to accessing and/or benefiting from health services and programs, and therefore their inequities are compounded. This program aims to address this from both a service improvement perspective and through directly targeted interventions to support these women.

There are many priorities for action within the scope of women's health. In alignment with the *National Women's Health Policy 2010*, the *SESLHD Women's Health Equity Program* will focus on four priority areas: **the prevention of chronic diseases and control of risk factors, mental health and wellbeing, sexual and reproductive health and healthy ageing**. In addition, there is specific focus on **domestic and family violence**, in support of local implementation of *It Stops Here - the NSW Government's Domestic and Family Violence Framework for Reform*.

The program focuses on two groups of women in particular:

- **Aboriginal women**, who continue to experience some of the most significant disadvantages of health and wellbeing in Australia, and
- **Women from culturally and linguistically diverse backgrounds**, particularly those born in non-English speaking countries, who may face many barriers to accessing and benefiting from our services and programs.

Whilst attention to these two groups does not preclude attention to the needs of other women, it provides clear priorities for actions within the resources of this program.

Delivered through the Ambulatory and Primary Health Care Directorate, the *SESLHD Women's Health Equity Program* has three clear objectives:

1. Provide strategic leadership and advocacy for women's health across SESLHD, with a particular focus on equity.
2. Deliver targeted short-term clinical services for women who experience disadvantage, and support engagement with, and development of, mainstream services for their ongoing care.
3. Support implementation of the NSW Government's domestic and family violence reforms.

This plan describes a rationale and clear basis for action to achieve these objectives, to improve the health and wellbeing of women in SESLHD.

THE STRATEGIC CONTEXT

Women's health

What do we mean when we talk about women's health? Maternity services, pap tests and mammograms come quickly to mind. Whilst these are undeniably important issues, the scope of women's health is far greater.

In 2009, the World Health Organization (WHO) published a report titled *Women and health: today's evidence, tomorrow's agenda*[1] which described evidence and issues over the life course of girls and women. It included the familiar issues noted above, but also considered broader concerns such as chronic disease, injury, violence and mental health. It highlighted the interplay of biological and social determinants of women's health, and the impact of gender inequities upon increased risk, reduced access to health care and information, and reduced health outcomes.

In Australia, similar strategic directions for women's health are outlined in the *National Women's Health Policy 2010*[2] ("The National Policy") which also adopts a broader scope to address the health and wellbeing of women. The National Policy recognises that there is no "typical" or "average" Australian woman – that each has her own life demands, family circumstances and health needs. But there are a number of key issues that are recognised as the highest priorities for action, and which represent the major challenges associated with death and burden of disease for women in the next 20 years. These priority areas are described in Box 1.

BOX 1: **Priorities from the *National Women's Health Policy 2010*[2].**

1. Prevention of chronic diseases through the control of risk factors targeting chronic disease such as cardiovascular disease, diabetes and cancer, as well as risk factors such as obesity, nutrition, physical inactivity, alcohol and tobacco consumption. The policy also encourages a clearer understanding of the context of women's lives, including the barriers that prevent women taking up healthier lifestyle behaviours.

2. Mental health and wellbeing targeting anxiety, depression and suicide.

3. Sexual and reproductive health targeting access to information and services relating to sexual health, reproductive health, safe sex practices, screening and maternal health. The health of mothers prior to conception, during pregnancy and in the post-natal period can have a profound and long term effect on their own health and that of their children.

4. Healthy ageing targeting musculoskeletal conditions, disability and dementia. The policy highlights that the social, economic and environmental conditions under which women live and age can affect their experience of ageing.

These priorities for action are also consistent with the *NSW Health Framework for Women's Health 2013*[3] ("The NSW Framework") from which this plan flows. The NSW Framework places strong emphasis on the needs of our health services to improve the way we recognise, acknowledge and respond to women's issues. In particular, it draws attention to the impact of social determinants of health. Socioeconomic disadvantage is closely linked to health status. Factors such as lower levels of income, education and employment are frequently related to poorer measures of health including disease and disability, injury, lower life expectancy, and higher service needs[6, 7]. Such issues are particularly relevant to the many women who experience inequities in pay and superannuation savings, both of which are major contributors to women's relatively poor economic security[2].

Financial security is also influenced by the role that many women provide as carers in our society and their subsequently reduced capacity for economic independence[8]. As well as being the primary caregivers of children, women provide the majority of long-term, unpaid care for family members or friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged[2, 9]. Women as carers often report poorer physical, mental and emotional health and wellbeing themselves. This can be associated with disturbed sleep, physical injuries while providing care, and the constant pressure of caring[2]. Just over one-third of primary carers have a disability themselves[8], and over half of female carers report being depressed for six months or more since they started caring[2].

Such complexities are common when considering the health of women. The differences between men and women go well beyond biology. Women often have less power and status at work and home, and greater experiences of harassment, violence and discrimination[2]. These things impact upon their health and wellbeing. For example, women who have experienced violence (either domestically or otherwise) are at high risk of mental health issues[2]. But research has also shown other associations with ill health, from increased risk behaviours (such as tobacco and alcohol use and HIV risk behaviours) to subsequent poor chronic disease outcomes[10].

These complexities warrant careful consideration. Whilst it is important to identify specific priority health issues, such as those listed here – chronic disease and risk factors, mental health and wellbeing, sexual and reproductive health, and healthy ageing – health issues are rarely so easily compartmentalised in practice. Understanding the links between these issues and the many complex determinants of health that underpin them is important to help us design and deliver more appropriate, responsible health services that will better meet the needs of women.

"Women's health experiences and the delivery of health services and programs designed for them are different to those affecting men…. (we need) to design and deliver programs and services which are relevant to women's physical, mental and social needs, and to improve engagement with women consumers of health and other services."

– Hon Jillian Skinner MP, NSW Minister for Health, Minister for Medical Research.
From the *NSW Health Framework for Women's Health 2013*[3]

Additional information describing women's health issues has been collated in separate documents to support this plan. This includes an overview of the leading causes of death in Australian women, the role of women as carers and the complexities of women's health.

Women's health in SESLHD

The health of women is a priority across SESLHD services, and reflects our commitment to working together to improve the health and wellbeing of our community[11]. In addition to our wide range of clinical, community and population health services, we have specialist women's health services that provide care in breast health, gynaecology, maternity services, maternal foetal medicine, menopausal care, newborn intensive care and reproductive medicine.

To support the implementation of women's health initiatives at the local level, funding from the National Women's Health Program is distributed by the NSW Ministry of Health to local health districts across NSW (LHDs). LHDs determine how these funds are allocated according to local needs, through a variety of models from traditional clinical nursing positions to teams that take a broader strategic and/or population health approach. SESLHD previously directed this funding to the *Well Women's Health* Program, which has provided services to local women for almost 20 years. It primarily targeted women who experience disadvantage and other vulnerabilities, provided them with a women's health clinical service, and attempted to facilitate their future transition into mainstream care. This was supplemented by community development work.

A review of the program conducted in 2014 identified the core principles of the program that should be maintained, along with new strategic and practical directions for the future[12]. With respect to the important foundations that were built by the former program, this new *Women's Health Equity Program* has been designed to provide a stronger foundation for strategic, District-wide service influence and improvement, to better clarify the scope and targeted reach of clinical interventions specifically provided through the program, to coordinate all actions more strategically, and to be implemented under a more effective management structure. This plan is the product of a strategic planning process that has included input from the current team, management, and wider consultation across the District.

The primary goal of the new *SESLHD Women's Health Equity Program* is to improve the health and wellbeing of women living in the SESLHD, particularly those who experience health inequities. In particular, this includes Aboriginal women, who continue to experience some of the most significant disadvantages of health and wellbeing in Australia, and women from culturally and linguistically diverse backgrounds, particularly from non-English speaking countries, who may face many barriers to accessing and benefiting from our services and programs. Whilst attention to these two groups does not preclude attention to the needs of other women, it provides clear priorities for actions within the resources of this program.

The priorities for action align with those of the National Policy: the prevention of chronic diseases and control of risk factors, mental health and wellbeing, sexual and reproductive health and healthy ageing. In addition, there is specific focus on domestic and family violence, in support of local implementation of *It Stops Here - the NSW Government's Domestic and Family Violence Framework for Reform*.

Figure 1 draws together the program's goal, objectives, priority areas and priority populations. These are then explored in the following pages.

The SESLHD Women's Health Equity Program

Figure 1: The plan at a glance

Chronic disease and risk factors

The *National Women's Health Policy 2010*[2] calls for prioritisation of chronic disease management and prevention including:

- Cardiovascular disease (the biggest killer of Australian women[13])
- Cancer (the leading cause of cancer deaths in Australian women is lung cancer, followed by breast and colorectal cancers[13])
- Respiratory disease
- Diabetes

Common risk factors for chronic disease include:

- Tobacco use
- Overweight and obesity
- Poor nutrition
- Physical inactivity
- Excessive alcohol consumption

The policy also encourages a clearer understanding of the context of women's lives, including the barriers that prevent women from embracing healthier lifestyle behaviours. There are complex connections between these and other health priority areas.

In SESLHD:

- Nearly 2,000 women die and over 20,000 are hospitalised each year due to cardiovascular disease, cancer, respiratory disease and diabetes[14].
- Despite the wide availability and promotion of screening, only 52% of eligible women were appropriately screened within the last 2 years for breast cancer and around 60% were appropriately screened for cervical cancer[14].
- At the population level, the prevalence of risk factors (for both genders, aged 16+)[14] is:
  - 14% currently smoke
  - 28% are overweight or obese
  - 47% are not adequately physically active
  - 25% consume alcohol at levels posing lifetime risk.

Additional data and examples of local plans, services and programs addressing each of the priority health areas are available in a separate document.

Mental health and wellbeing

The National Policy highlights the importance of strategies to address the mental health of women. Anxiety and depression are the leading burden of mental health-related disease for women[2], with women being more likely than men to report very high levels of distress[15].

Notably, higher rates of mental health conditions are reported for middle aged Aboriginal women than non-Aboriginal women, with higher rates of related hospitalisation and mortality[3].

Mental health issues are complex, and the experiences of many women in relation to financial insecurity, power imbalances at work and in the home, carer responsibilities and experiences of violence and other trauma must be considered. These can all have strong influences on mental health. Women are more likely than men to be responsible for a sole-parent household when young, to care for others during their middle age, and to live alone when elderly[2].

Understanding some specific differences between men and women is also essential when considering issues such as suicide and intentional self-harm. Males have higher rates of suicide, yet females have higher rates of hospitalisation due to intentional self-harm[16]. Mechanisms for self-harm (the methods used) are also distinctly different. Services and programs can only be effective if such differences are considered.

In SESLHD:

- In 2010-11, mental and behavioural disorders accounted for 209 female deaths. This is more than double that of males (101) and on par with female deaths from respiratory disease (220)[14].
- In 2012-13, 9,067 females were hospitalised due to mental disorders, again at a rate higher than for males (6,236)[14].
- In 2011-12, there were 503 female hospitalisations due to self-harm, almost double that recorded for males (263)[14].

Sexual and reproductive health

The more "typical" issues of women's health such as sexual and reproductive health are, of course, important considerations. This includes access to information and services relating to sexual health, reproductive health, safe sex practices, screening and maternal health.

Maternal health is an essential consideration of any women's health program. The importance of the health of mothers prior to conception, during pregnancy and in the post-natal period can have a profound and long term effect on their own health and that of their children[2].

- Average maternal age has increased over the last decade, which is associated with a range of maternal and infant risks[2].
- Conversely but of equal importance are the needs of young mothers, who are often from groups who experience significant disadvantage[2].
- Whilst 3.5% of non-Aboriginal SESLHD mothers smoked during pregnancy in 2012, that rate was almost ten times higher in SESLHD Aboriginal mothers (32.9%)[17].

Almost half of the total NSW HIV positive population and about a quarter of Australia's HIV positive population live in SESLHD[11]. A particularly vulnerable group is women from culturally diverse backgrounds, with 59% of new notifications over the past five years coming from a person from a high HIV prevalence country, or a person whose sexual partner was from a high prevalence country[2].

- There were 150 new cases of HIV in SESLHD in 2012, the highest of any LHD[14].

Chlamydia is the most notified sexually transmitted infection within Australia, with rates doubling between 2003 and 2008. Untreated chlamydia in women may lead to infections of the cervix, uterus and pelvis. Complications may result in pelvic pain, infertility and ectopic pregnancy[2].

- In SESLHD, notifications of chlamydia are described by local public health officials as "high and increasing"[17], and are most common for women in the 20-29 years age group[17]. Around 44% of total chlamydia notifications in 2012-13 were for women[14].

Healthy ageing

Women are fortunate to have a longer life expectancy than men[13]. A strong focus on healthy ageing is therefore prioritised in both the National Policy and the NSW Framework, to maximise the quality of these years.

- Physical changes are brought about by menopause and ageing generally[3].
- The impact of behaviours such as smoking and poor nutrition can become established chronic disease in older years[3, 15].
- Many of the chronic disease statistics described earlier have their most significant impact in older age. For example, the population prevalence of diabetes almost doubles between 45-54 and 55-64, and continues to increase with age[2].
- The proportion of Australian women in the population living with disability increases with age, reaching around half of the female population by the age 70-74 and over 80% people aged 85 and over[2].

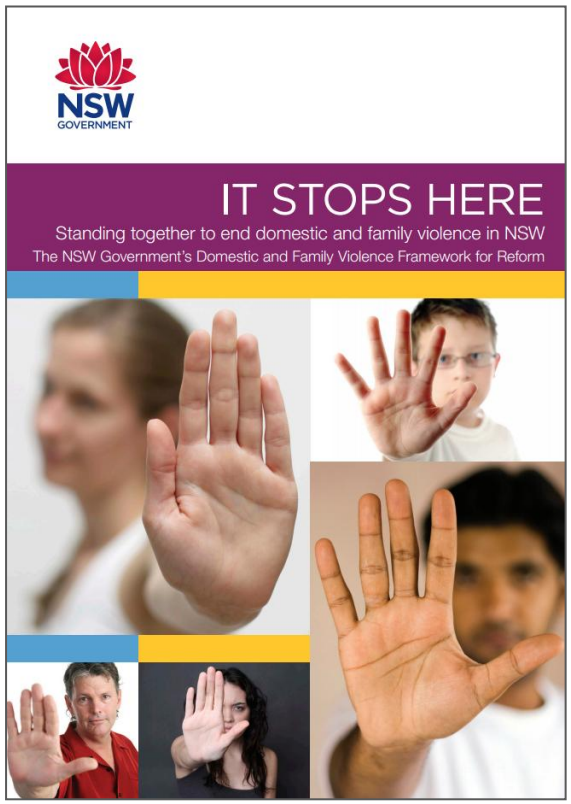
New risks emerge in older age, such as osteoporosis and injury from falls. No other injury cause (including road trauma) has a greater impact on the health system, and falls are also a leading cause of premature admission to residential aged care[18]. Even a fear of falling is in itself a risk factor for future falls, and can significantly affect how older people go about their daily lives[19].

- Older women accounted for two-thirds of all fall-related hospitalisations in SESLHD in 2010-11 (3,029 females / 1,518 males)[14].
- Falls are the most frequently identified incidents within the NSW public health system itself, and equal-third highest cause of death in that context[20]. There have been 25 deaths and 239 serious injuries due to falls in SESLHD facilities in the last 5 years[21].

Across a population that is ageing, dementia and Alzheimer's disease are already the third leading cause of female death across all ages (behind coronary heart disease and stroke, and ahead of all cancers)[24]. Female death rates due to dementia and Alzheimer disease increased sixfold between 1979 and 2009[22].

- Over 10,600 SESLHD residents are affected by dementia now, and over 19,200 will be affected by 2031[17].

Domestic and family violence



It Stops Here - the NSW Government's Domestic and Family Violence Framework for Reform[4] ("the reform package") sets a new direction for addressing domestic and family violence in NSW. This includes any behaviours that control or dominate a person, causing them to fear for their own (or someone else's) safety. It includes physical, sexual, verbal, psychological, mental, and emotional abuse, stalking, harassment, financial abuse and manipulation, denial of freedom and choice, and control of access to family and friends.

No matter the circumstances, experiencing violence at the hands of a partner, family member or relative can have devastating effects on an individual's physical, mental and emotional wellbeing[4].

- In 2012, there were 29,900 domestic violence-related assaults recorded by the NSW Police Force[22].
- Approximately 125,000 incidents are reported to the NSW Police Force annually, while 300,000 additional incidents are estimated to go unreported each year[22].
- Aboriginal women are six times more likely to be victims of domestic and family violence than non-Aboriginal women[22].
- Women from culturally and linguistically diverse backgrounds are more likely than other women to have trouble accessing services for domestic violence[3].
- In addition to the immediate impact of violence, longer-term health outcomes for women experiencing violence at the hands of their partner include depression, anxiety, suicide, physical injury, eating disorders, STIs, cervical cancer and death[2].

NSW Policy requires that mandatory domestic violence screening is undertaken in the four target programs where significant numbers of women have been found to be at risk: antenatal, early childhood health, mental health and alcohol and other drugs services[23]. This is already underway in SESLHD.

- Data from 2013 show that over 1,300 women were screened by local services. Around 4% of these women were identified as having experienced domestic violence in the previous 12 months.

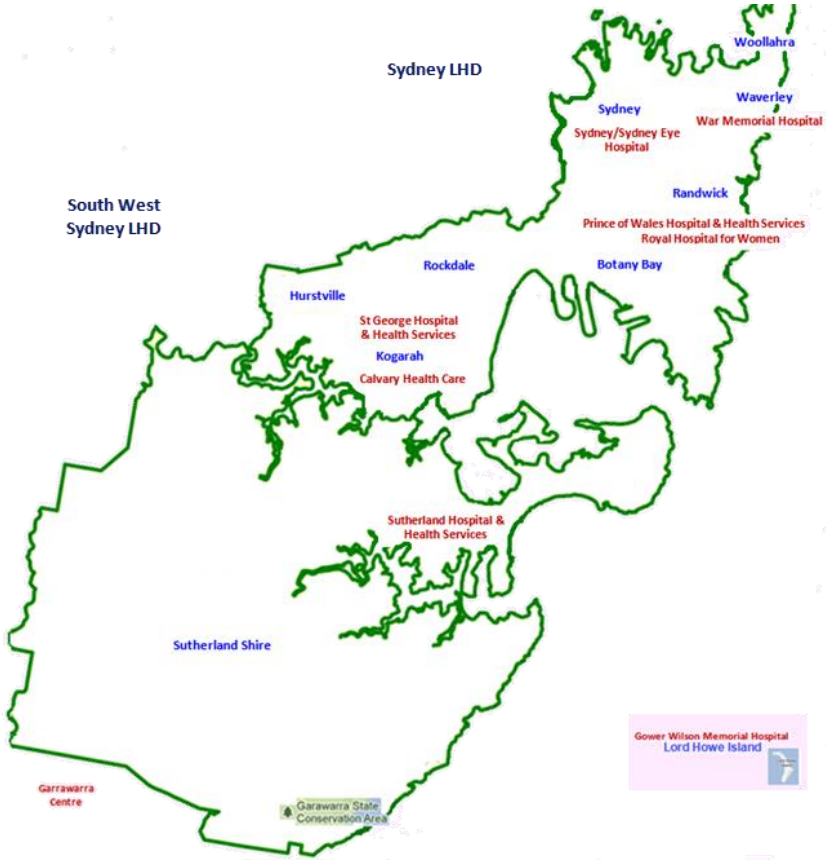
Socioeconomic disadvantage in SESLHD

Despite most people within our District enjoying very good health and service access, some individuals and communities do not.

Within our District, there are pockets of socioeconomic disadvantage, such as the Statistical Local Areas of Botany Bay, Inner Sydney and Rockdale. SESLHD is home to a large number of people who experience disadvantage or other vulnerabilities.

According to the *SESLHD Strategy 2012-2017*[11]:

- About 23% of NSW's identified homeless population live in the Statistical subdivisions of Inner Sydney, Eastern Suburbs, and St George-Sutherland, equating to over 6,000 people.
- Botany Bay, Randwick and Sydney LGAs have a higher proportion of public housing than the NSW average. In Botany Bay LGA 11% of all dwellings are public housing, with up to 70% in some suburbs.



Aboriginal women

Over 6,000 Aboriginal people live in our District, equating to just under 1% of our total population. The highest proportions of Aboriginal residents live in the Botany and Randwick local government areas[11].

With higher levels of fertility and lower life expectancies than other Australians, Aboriginal people living in our District have a different population age structure: there are proportionally more young Aboriginal people under 15 years of age (28% versus 16%) and proportionally less Aboriginal people aged 65 years and over (6% versus 14%)[11].

In SESLHD as elsewhere in Australia, there is a substantial gap between the health and welfare of Aboriginal peoples and that of other Australians. As reported by the Australian Institute of Health and Welfare in the most recent national review of Aboriginal health[24]:

- The life expectancy of Aboriginal women is around 10 years less than non-Aboriginal women (approximately 73 versus 83 years).
- About 80% of the mortality gap (in terms of potential years of life lost) can be attributed to chronic diseases. For example, cardiovascular diseases account for around 27% of all Aboriginal deaths. A significant proportion of these deaths (37%) occurred in those aged 45 to 64 years – a much higher figure than for non-Indigenous Australians (9%) – leading to extensive loss of potential years of life.
- Motherhood during the teenage years is much more common among Aboriginal than non-Aboriginal girls (21% compared with 4% of all births)[24].
- Babies born to Aboriginal mothers are twice as likely to be of low birth weight compared with babies born to other Australian mothers [24].
- Whilst the Aboriginal infant mortality rate is declining, it remains almost twice that of non-Aboriginal infants[24].
- Aboriginal women are six times more likely to be victims of domestic and family violence than non-Aboriginal women[22].
- The rate of hospitalisation for Aboriginal women due to interpersonal violence (domestic or otherwise) was 12 times higher than non-Aboriginal women[25].

Women from culturally and linguistically diverse backgrounds

SESLHD has a vibrant multicultural heritage. Around 37% of our residents were born overseas (compared to 25% across NSW) with almost three-quarters of these being from a non-English speaking country[26].

It is important to understand that people from culturally and linguistically diverse backgrounds are not a homogenous group. Refugees, international students, young people from developing Asian countries and ageing European post-World War II migrants are completely different cohorts of people with different lifestyles, risks and health issues. Their health cannot be measured in a single statistic, and their needs will differ.

One focus of this plan is to increase the use of mainstream health services by women who do not typically do so. Women from diverse backgrounds are one such group. Migrant women often present to services relatively late in pregnancy, particularly recent arrivals from non-English speaking countries[26]. With over one-third of all births in SESLHD public hospitals being to a mother born in a non-English speaking country, this represents a large number of women who could benefit from more appropriate service access[26]. Barriers to accessing services more generally can include cultural practices and beliefs, social isolation and language difficulties[26]. Migrant women experiencing domestic violence may fear that they will not be able to remain in Australia if they leave a violent relationship[4].

Improving the health literacy of people from culturally and linguistically diverse backgrounds is another priority recognised locally[26] and more widely[27]. Health literacy is one's ability to obtain, process, and understand health information, to then make informed health decisions[27,28]. Low health literacy has been linked to poorer health knowledge and comprehension of health messages, lower use of preventive health care (eg breast screening), higher use of acute care (eg emergency care and hospitalisations), poorer self-management of chronic diseases (eg use of medicines) and overall poorer health outcomes[29]. Poor English proficiency is a strong predictor of low health literacy[30].

THE WOMEN'S HEALTH EQUITY PROGRAM

The new program

Based on the review and strategic planning processes, key new directions for the program are as follows.

- The new program title reflects the continuing commitment to women who experience inequities. In the first instance, this will focus on Aboriginal women and women from culturally and linguistically diverse groups, particularly women whose cultural or religious background may influence their interactions with health services. There is potential for a broader scope in the future, but in the shorter-term there is a need to define targets that are more achievable within program resources, and to do that well.

- Clinical service delivery will continue to be delivered, targeting women who experience disadvantage. Improved strategies, management processes and evaluation will clarify the scope and increase the impact of these clinical services. Linking and improving access to existing clinical services will be a key feature of the program.

- A new and specific role will be introduced to contribute to local implementation of *It Stops Here - the NSW Government's Domestic and Family Violence Framework for Reform*[4]. This will build upon initial implementation work that has commenced in partnership with NSW Kids and Families.

- Finally but perhaps most importantly from a strategic planning perspective, all of this activity will occur under a more coordinated and strategic umbrella. A new Women's Health Coordinator will take a lead role in developing strategic expertise in women's health that goes beyond the scope of the specific clinical and reform initiatives described above. What are the broader needs of local women across our District, now and into the future? How can SESLHD services and programs meet these needs more appropriately and effectively? And what will this program do to advocate for and support such action?

This plan is consistent with:

- *The SESLHD Strategy 2012-2017*[11]
- *The National Women's Health Policy 2010*[2]
- *The NSW Health Framework for Women's Health 2013*[3]
- *It Stops Here - the NSW Government's Domestic and Family Violence Framework for Reform*[4]

This plan is consistent with the requirements of the NSW Ministry of Health women's health funding and has undergone an Aboriginal Health Impact Assessment.

Principles

The SESLHD Women's Health Equity Program will be designed, delivered and managed in accordance with the following principles. These are consistent in context with principles described in the National Policy[2] and the NSW Framework[3], as well as the *SESLHD Strategy 2012-2017*[11].

The program will:

- Reflect the NSW Health's CORE values: Collaboration, Openness, Respect and Empowerment.
- Acknowledge and respect the prior work that has been done by the former *Well Women's Health Program*.
- Acknowledge and respect the work that is currently being done by others, both across SESLHD services and more widely by other health and welfare organisations across the community. This program is one small but important cog in a much larger system.
- Build effective partnerships to deliver actions and outcomes.
- Include a strong focus on equity, and on the social determinants of health that contribute to inequities.
- Take a broad perspective in strategic planning, with particular consideration of the priorities described: chronic disease and risk factors, mental health and wellbeing, sexual and reproductive health, healthy ageing, and domestic and family violence reforms.
- Take a narrower focus for clinical service delivery that is feasible within limited resources, specifically targeting women who experience disadvantage and other vulnerabilities.
- Link and improve access to existing clinical services, and support them to respond appropriately to the needs of women who experience disadvantage and other vulnerabilities.
- Take a life course approach that considers the health of women across the life span. This will include a focus on access to services, prevention and early intervention.
- Recognise that women take on a range of caring responsibilities throughout their lives, from children and families to frail, elderly or disabled people, and that this can have a significant impact upon their own health and wellbeing.
- Empower women to be active participants in decisions affecting their health and health care.
- Base service planning on the best evidence available, and contribute to evidence based practice wherever possible through appropriate and meaningful evaluation and dissemination of results.
- Adopt a management structure that facilitates strong leadership, unified vision and team cohesion.
- Monitor progress against a range of practical indicators.
- Strive to achieve maximum value-for-money while ensuring that services are delivered within the available budget.

Implementation of the program is described in the following tables.

More detailed information describing the implementation of all three objectives is available in a separate document.

Program implementation

Objective 1: Provide strategic leadership and advocacy for women's health across SESLHD, with a particular focus on equity.

What we will do

1.1 Appoint a Women's Health Coordinator to lead and coordinate the team and the actions described in this plan.

1.2 Develop strategic expertise in Women's Health.

- Monitor and analyse women's health policy, research and practice at the international, national and state levels.
- Develop strategic partnerships to deliver the plan.
- Provide expert input regarding women's health issues and strategies to relevant services and plans across the District.

1.3 Apply a gender lens to service planning and improvement.

- Track local plans and services to maintain a clear picture of who is doing what and where, and how this relates to women's health policy and strategic priorities.
- Identify service gaps and potential opportunities for action.
- Utilise planning tools such as Gender Impact Analysis.

1.4 Advocate for action to address the health needs of SESLHD women, particularly those who experience disadvantage.

- Identify strategies that are in line with policy and best practice, and using evidence-based models for organisational change and service improvement.
- Develop business cases for these proposed strategies to be implemented, to submit to SESLHD senior management.

Partnerships we will build

Ongoing key partnerships will include:

- SESLHD services and teams, including clinical services, Emergency Departments, Mental Health services, Drug and Alcohol services, and the Population Health and Planning Directorate
- SESLHD Aboriginal Health and SESLHD Multicultural Health Services
- External organisations with expertise in women's health (eg NGOs) and relevant to primary health care (eg Medicare Locals/Primary Health Networks)
- Academics and research institutions with expertise in women's health
- NSW Ministry of Health & women's health teams across NSW

How we will track our progress

Indicators will include but not be limited to the following:

- Evidence of partnerships built with key stakeholders.
- Indicators describing outcomes relevant to service planning, such as:
  - Identification of evidence-based priorities for service planning
  - Evidence of advocacy and influence, such as making meaningful contributions to the development of local plans.
- Indicators describing outcomes relevant to service improvement, such as:
  - Identification of evidence-based priorities for service improvement
  - Evidence of advocacy and influence, such as the approval of business cases for proposed strategies to improve health services for women.

Objective 2: Deliver targeted short-term clinical services for women who experience disadvantage, and support engagement with, and development of, mainstream services for their ongoing care.

What we will do

2.1 Appoint Women's Health Nurses to deliver this objective and contribute more broadly to the delivery of the whole plan.

2.2 Commence with a focus on Aboriginal women and women from culturally and linguistically diverse groups, particularly women whose cultural or religious background may influence their interactions with health services.

2.3 Develop clinical service protocols.

2.4 Focus on a specific area and population for a fixed period implementation (eg Aboriginal women living in Botany Bay).

- Undertake a local needs assessment including epidemiologic profiles, health risks, service use and barriers.
- Determine the service availability relevant to the scope.
- Build relevant local partnerships to support implementation.

2.5 Deliver short-term clinical services in the target area.

- Implement promotional strategies to engage target women.
- Deliver clinical services for a fixed period of time.
- Follow up women at one- and six-months post appointment.

2.6 Work with existing local services to improve longer-term service access and appropriateness for the target women.

- Consider and respond to issues identified during the process.
- Support local service improvements where appropriate and feasible, and/or link back to Objective 1 for future action.

2.7 Continue implementation (2.4-2.6) in the next area/setting.

Partnerships we will build

Essential partnerships will be developed with local service providers in each focus area, and at the District level.

Additional ongoing key partnerships will include:

- Local services such as Drug and Alcohol and Mental Health
- SESLHD Aboriginal Health, Aboriginal Interagency Group and communities
- SESLHD Multicultural Health Service & Stakeholder Advisory Committee
- Local multicultural services and community organisations
- Primary care providers and organisations (eg Medicare Locals/Primary Health Networks)

How we will track our progress

Indicators will include but not be limited to the following:

- Number of appointments made, clinical services actually delivered and follow-up calls completed, including demographic descriptors of the women and considerations of the reach of the service within that context.
- Indicators will also be collected to describe the specific components of the clinical service delivery, such as:
  - The health issues and risks identified
  - Referrals into mainstream services and other recommendations
  - Uptake of those referrals into mainstream services and other recommendations
  - Consumer feedback

Objective 3: Support implementation of the NSW Government's domestic and family violence reforms.

What we will do

3.1 Appoint a Domestic and Family Violence Reform Officer to deliver this objective and contribute more broadly to the delivery of the whole plan.

3.2 Provide high level leadership, direction, advice and coordination in SESLHD for the implementation of the NSW Domestic and Family Violence reforms.

3.3 Develop robust guidelines and procedures for staff and services involved in the reform package, ensuring relevance for the diverse population.

3.4 Coordinate the process across the district to ensure relevant information is actioned on a weekly basis.

3.5 Establish effective partnerships with other government and non-government agencies pertinent to the domestic and family violence reforms.

Key elements for effective reform implementation will include:

3.6 Support the implementation of new pathways and processes for Health workers.

3.7 Coordinate SESLHD's participation at the Safety Action Meetings, including supporting SESLHD staff who attend the meeting.

3.8 Identify resourcing issues and support appropriate strategies to ensure attendance at Safety Action Meetings.

Partnerships we will build

Ongoing key partnerships will include:

- Relevant local clinical services such as Emergency Departments
- SESLHD Mental Health Services
- SESLHD Drug and Alcohol Services
- SESLHD Aboriginal Health Service
- SESLHD Multicultural Health Service
- NSW Kids and Families
- Government and non-government agencies pertinent to the reforms, including Police and Family and Community Services

How we will track our progress

Indicators will include but not be limited to the following:

- Evidence of partnerships built with key stakeholders
- Evidence that 100% of cases presented at the Safety Action Meeting have been reviewed by identified health staff
- Evidence of clear pathways implemented across the District

Governance and reporting

The SESLHD Women's Health Equity Program sits within the Ambulatory and Primary Health Care Directorate, with direct report to the Child, Youth, Women's and Families Manager.

A reporting framework and timetable will be established, including annual reports to the Deputy Director, Ambulatory and Primary Health Care Directorate and additional interim progress reports throughout the year to the Manager, Child, Youth, Women and Families.

Appropriate communication strategies will be developed to ensure the engagement of and regular contact with other key stakeholders.

Program personnel

Program funding includes salaries for 3.0 full-time equivalent (FTE) personnel. This plan represents a new direction for the program, and as such, requires staff with the appropriate qualifications, skills and experience to deliver the goal and objectives described. Personnel will be appointed as described in Table 1.

Table 1: Program personnel

Position	FTE	Primary Responsibilities
Women's Health Coordinator	1.0FTE	Team leadership and management, plus responsibility for Objective 1 (strategic coordination and advocacy)
Women's Health Nurses (2)	1.4FTE	Two positions totalling 1.4FTE with responsibility for Objective 2 (includes clinical service delivery) – ideally with one person taking a lead role on working with Aboriginal women and the other taking a lead role on working with women from culturally and linguistically diverse backgrounds
Domestic and Family Violence Reform Officer	0.6FTE	Responsibility for Objective 3 (reform implementation) in partnership with other relevant District positions/teams and partners such as NSW Kids and Families

Indicators

This quick-reference summary represents the indicators described in the earlier tables.

Table 2: Summary of indicators

Program Goal: To improve the health and wellbeing of women living in the SEDLHD, particularly those who experience health inequities.	
Objective 1: Provide strategic leadership and advocacy for women's health across SESLHD, with a particular focus on equity issues.	• Evidence of partnerships built with key stakeholders. • Indicators describing outcomes relevant to service planning, such as: – Identification of evidence-based priorities for service planning – Evidence of advocacy and influence, such as making meaningful contributions to the development of local plans. • Indicators describing outcomes relevant to service improvement, such as: – Identification of evidence-based priorities for service improvement • Evidence of advocacy and influence, such as the approval of business cases for proposed strategies to improve health services for women.
Objective 2: Deliver targeted short-term clinical services for women who experience disadvantage, and support engagement with, and development of, mainstream services for their ongoing care.	• Number of appointments made, clinical services actually delivered and follow-up calls completed, including demographic descriptors of the women and considerations of the reach of the service within that context. • Indicators will also be collected to describe the specific components of the clinical service delivery, such as: – The health issues and risks identified – The referrals and recommendations made – The uptake of those recommendations and referrals • Consumer feedback
Objective 3: Support implementation of the NSW Government's domestic and family violence reforms.	• Evidence of partnerships built with key stakeholders • Evidence that 100% of cases presented at the Safety Action Meeting have been reviewed by identified health staff • Evidence of clear pathways implemented across the District

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