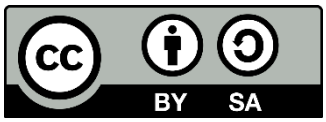
women's health nsw

The Women's Health Sector Model of Service Delivery in NSW Australia



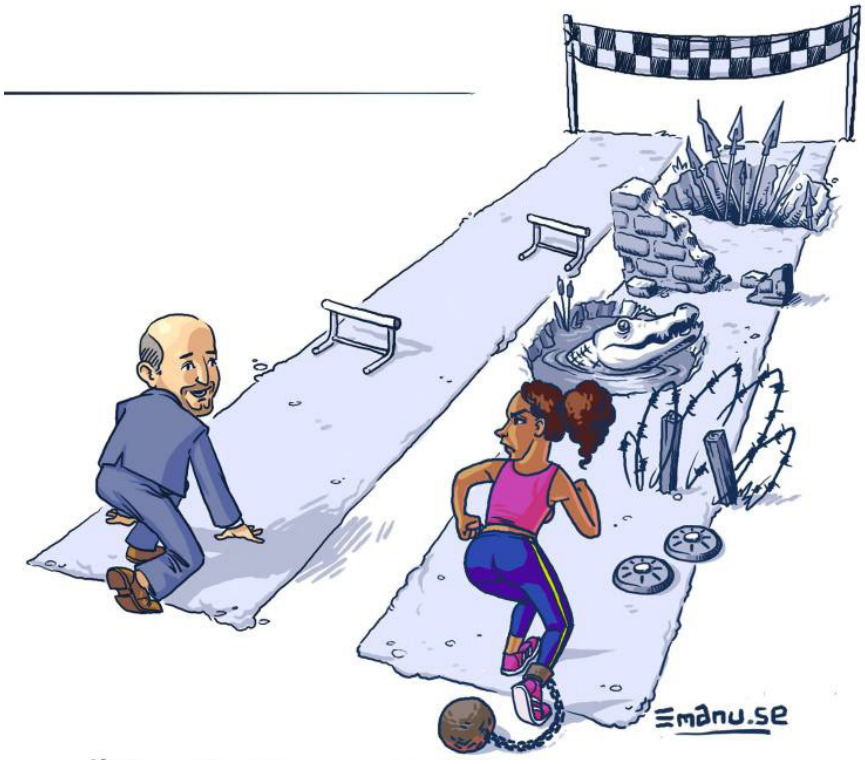
Research conducted with permission from Women's Health NSW
PO Box 341, Leichhardt NSW 2040
http://whnsw.asn.au

Schroeder J. The Women's Health Sector Model of Service Delivery in NSW, Australia. University of New England, Armidale, Australia; 2017. DOI 10.4226/95/5a568dea3ddf9.
Released under Creative Commons: CC BY-SA 4.0

Cover image: © iStock.com/DGL Images

"We don't look at individuals as the problem.
Rather than asking women 'what's the problem with you?',
we ask women 'what happened to you?'"

Margherita Basile, Research Reference Group Member
Manager, Sydney Women's Counselling Centre
Chair, Women's Health NSW



"What's the matter?
It's the same distance!"

Reprinted with the permission of the artist, Emanu.

Table of Contents

List of tables

Table of figures

Acknowledgements

This study was conducted with support from Women's Health NSW (WHNSW), the peak body for community-based women's health centres in NSW.

A special thank you goes to Denele Crozier, CEO of WHNSW, for her support and contribution to this research; the WHNSW Board for its support; and managers of women's health centres (WHC) who invested their valuable time to participate in the survey.

The Research Reference Group, made up of representatives of the Women's Health Sector (WHS), contributed their time, knowledge and experience to provide comment and feedback about the development, implementation and reporting of the survey.

Members of the Research Reference Group included:

- Denele Crozier AM, CEO WHNSW.
- Toni Schofield, A/Prof. School of Education, University of New England; Faculty of Health Sciences, The University of Sydney; Chairperson, Sydney Women's Counselling Centre.
- Margherita Basile, Manager, Sydney Women's Counselling Centre, Chairperson, WHNSW.
- Roxanne McMurray, Manager, Leichhardt Women's Community Health Centre.
- Sally Stevenson AM, General Manager, Illawarra Women's Health Centre.
- Betty Green, PhD Candidate, Western Sydney University.

Research has been undertaken by Jacqueline Schroeder as part of a Doctor of Philosophy at the School of Education at the University of New England.

Valuable insights were gained from all of the women involved, and others who took an interest in the project, many of whom have spent decades of their lives committed to developing and sustaining an approach to health care for women that meets their health needs. The knowledge, experience and wisdom of these women was an invaluable source of information to this project.

Acronyms

ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and linguistically diverse
CM	Complementary medicine
LBTI	Lesbian, bisexual, transgender or inter-sex
LHD	Local Health District
MoH	Ministry of Health
NPM	New Public Management
PHC	Primary health care
SES	Socio-economic status
WHC	Women's health centre
WHM	Women's Health Movement
WHNSW	Women's Health NSW
WHO	World Health Organisation
WHP	Women's Health Program
WHS	Women's Health Sector

Executive Summary

Background and introduction

The Women's Health Sector (WHS) was established in the early 1970s, at a time when the state and the Women's Health Movement (WHM) shared common goals for advancing women's health. The early 2000s, however, ushered in a new era with the adoption by the state[1] of New Public Management (NPM) principles and values more akin to the private sector.

The early WHM challenged the treatment of women by medical professions, claiming it was not only unresponsive to women's health needs, but was actively harming women. High on the WHM's agenda was male violence and abuse against women, women's poorer mental and emotional health outcomes, and their misunderstood and mismanaged sexual and reproductive health.

Since the emergence of the NPM, understandings and representations of 'women's health' and the role that gender inequality plays in shaping it have diverged in health policy settings from that previously shared with the WHS. The NPM has fostered a 'gender-neutral' conception of health, shifting the focus from gender (women's social circumstances) to sex (biological and physiological differences in relation to men). Understandings in policy settings have therefore narrowed to perspectives more aligned with biomedical perspectives.

A social approach to women's health care is supported by current international research evidence into the social determinants of health, and research into the complexity of women's health needs due to gender inequality. Women's most pressing health needs globally remain related to male violence and abuse, and their poorer psycho-social outcomes, which have been linked to the development of chronic illnesses. Women's continuing subordinate status provides evidence that a social model for advancing women's health is as relevant today as it was in the 1970s.

In the context of a mature NPM culture in the Ministry of Health (MoH), and continuing demand for WHS services, the MoH commissioned a state-wide study in 2016-7 of the WHS in NSW. The aim of the study was to learn more about the WHS in NSW to inform greater alignment of the WHS services to policy goals, as part of the *Partnerships for Health* reform (1, 2). The WHS survey reported here was conducted within the same time-frame, to generate evidence regarding the contribution of the WHS model of service delivery to women's health and well-being, and to the broader health system.

Methodology

Data collection included an online survey of managers of women's health centres (WHC) and document analysis of publicly available WHS literature. A research reference group guided the development and analysis of the survey through a participatory action research approach. Thematic analysis was used to analyse the data.

1 For the purposes of this study, 'the state' is defined as encompassing all levels of government and the public institutions under its control, including the judicial system, the law, health and welfare bureaucracies.

Key findings

Why women's health?

Women's major health issues were reported by managers as violence and abuse, mental and emotional health issues, smoking and substance use, and conditions related to chronic illnesses. This finding supports current research that links women's disproportionate experience of violence and abuse to their poorer mental and emotional, and physical health outcomes.

Women using the services

The women using the services were marginalised on the basis of gender and other social structures such as class, Aboriginality, ethnicity, sexuality and level of physical ability. Overwhelmingly women had histories of violence and abuse at some point in their lives.

Major presenting health issues

Findings revealed that health issues related to violence and abuse, and the poor state of women's mental health and wellbeing, were the two main reasons why women attended WHCs. Women also attended WHCs for other reasons, including medical care for physical health issues and to access support for the worries in their lives, through a range of psycho-social services. This pattern of health need supports current evidence that links women's disproportionate exposure to violence and abuse to their poorer mental and emotional health to their physical health outcomes.

Health issues prioritised by the WHC aligned with the most commonly presenting health issues reported by WHCs across the sector, suggesting that WHCs were responsive to the needs of the women using the services.

WHS service delivery approach: Integrated, coordinated care, delivered through a primary health care framework

As women's most pressing health issues can be traced back to their social circumstances, individual services help women to identify the links between their individual health needs and their broader social and cultural context. Through this process, women are empowered to recognise patterns of social control over their lives and to take control of the social determinants of their health.

The WHS also recognises the need for a particular configuration and delivery of multi-disciplinary health care. There is growing recognition in research and practice that women with histories of violence and abuse typically present to services with a range of inter-related, complex care needs. Single-service responses tend to be ineffective on their own, because women need integrative explanations and skills-building programs as they progress through their recovery from their experiences of violence and abuse.

The WHS leverages further gains for women by embedding this integrated care within a primary health care (PHC) framework. PHC in the context of the WHS is conceptualised according to a broad definition, based on the World Health Organisation's (WHO) Alma Ata Declara-

tion. This perspective refers to an explicitly people-centred health care approach, that seeks to empower individuals, in combination with a focus on illness prevention through engagement with civil society[2] and public institutions[3].

WHS services: What does the WHS do?

Core services include crisis support, medical care, allied health, counselling, complementary medicine, and health education/self-management groups (including therapeutic, health education, support and physical activity groups). Access to a range of tailored *referral services*, through widespread networks and alliances with external health and social agencies complement the core services, linking women to a comprehensive range of the most gender-appropriate health services available.

Preventive services provided to *civil society* and interactions with *public or corporate institutions* aim to address the harmful impacts of women's everyday social circumstances, due to the impact of gender on their lives. Services provided within local communities aim to reach women who may not attend WHCs and build awareness of women's health needs to local groups, businesses and other organisations. In addition, interactions with public institutions involve knowledge exchange and systems advocacy directed to the influential people in a position to enact social change where women's health is impacted negatively due to discriminatory law, policy or processes.

Conclusion

This report demonstrates that the WHS does not simply duplicate mainstream services, nor does it simply provide a pathway for under-served women into the broader health system. Through its gender-specialised response, and unique configuration and delivery of services, the WHS represents a foundation for the development of urgently needed services to address one of the nation's most pressing social failures: the routine threat to the health and safety of Australia's women and girls.

The WHS offers a valuable cost-effective contribution to the health system, through the provision of health services to meet women's immediate health needs, combined with preventive interventions that aim to improve their lives over the long term.

While evidence exists to support various components of the WHS approach to women's health, the overall model itself remains under-researched. Further investigation is required to determine the health outcomes for marginalised women, and to support the development of a 'best-practice' model, based on the significant expertise of the WHS. Any research findings should be widely disseminated within the context of research, policy and practice in order to raise the profile and traction of this unique model of service delivery.

2 Civil society, referred to as the 'third sector' of society, is defined here as the aggregate of non-governmental organisations and institutions that manifests the interests and the will of citizens. Distinct from both government and business, this sector includes the family and the private sphere.

3 The term 'public institutions' refers here to the instruments governments use to maintain governance and to enact change including government departments and agencies (e.g. crime enforcement, regulatory bodies, and government bureaucracy).

1. *Introduction and Background*

The NSW non-government, community-based WHS developed from the outset through the relationship between the Women's Health Movement (WHM) and the Whitlam Labor Government in the early 1970s. This was a time when the WHM – with its vision for more accessible, adequate and appropriate health services for women – and the government – with its landmark Community Health Program – shared common goals for social change, particularly in relation to health care (3). The relationship between the two established the groundwork for the first National Women's Health Policy and Program that funded the WHS from the early 1990s.

Following the lead of the Reagan and Thatcher Governments in the 1980s, the Keating Labor Government ushered in some of the principles and practices of the NPM in Australia. This development began the transformation of the public sector to an institution more attuned to the goals and methods of the private sector (e.g. 4, 5, 6). Since the early 2000s, one of the main consequences of this new national approach to governance has been a distancing of the relationship between governments and health service providers – based on an International Monetary Fund imperative to separate service funding and provision (5). Corporate management goals such as 'cost efficiencies', and methods such as performance management, have been prioritised (4-6). Market imperatives, such as competition and 'consumer choice', have prevailed over former approaches that incorporated health equity as a major goal (4, 5, 7, 8).

In light of these developments, the NSW MoH announced plans in 2013 to establish a new funding arrangement for the WHS based on NPM principles as part of their *Partnerships for Health* reform (2). This reflects a broader shift to procurement- and performance-based funding arrangements of community-based non-government organisations (NGOs), where states are aiming to more closely align strategic directions to policy goals (e.g. 9). Due to an election commitment in NSW in 2015, the existing MoH funding arrangements for special purpose centres such as the WHCs was extended (1). However, the MoH has plans to evaluate and 'align' NGO women's health services to policy goals between 2017-2019, in preparation for a planned shift to more 'strategic' purchasing arrangements under the *Partnerships for Health* reforms in the future (2).

To inform this 'realignment', the MoH commissioned a state-wide study in 2016-17 of the community-based WHS in NSW. The aim was to gain a greater understanding of the sector's structure and function, alignment with NSW Health and Local Health District (LHD) priorities, and contributions to improved health outcomes (1). The survey of the WHS social model of women's health reported here was conducted within the same timeframe.

When researching and analysing the WHS in NSW, it is important to recognise that 'women's health' has been represented and understood in a variety of ways since the 1970s in Australia. The early WHM in the 1970s recognised women's illnesses as being inextricably related to gender inequality and the subordination of women (e.g. 3, 10, 11). The WHM claimed that women's roles and responsibilities were foundational to their subordinate position (e.g. 3, 10, 11). Greater responsibility for reproduction and unpaid work in the home placed women in a more precarious position with respect to paid employment, where women were employed in lower-status occu-

pations. The WHM saw medicine and the state as sharing an agenda of 'patriarchal social control' (e.g. 3, 10, 11). Feminists launched a critique of medical care that was not only unresponsive to women's reproductive and mental/emotional health, but actively harming women.

There was widespread agreement among feminists in the WHM that due to gender discrimination women lacked control over their own health and wellbeing. The most visible embodied expressions of women's social subordination included violence and abuse perpetrated by men against them, and poorer mental and emotional health outcomes that typically accompany such treatment (e.g. 3, 10, 11). High on the WHM agenda was women's misunderstood and mismanaged sexual and reproductive health and wellbeing, including fertility control, childbirth, menstruation, maternity and menopause.

In response, the WHM developed a new model of women's health care that combined biomedical diagnosis and treatment with psycho-social care and aimed to establish women as more empowered users and providers of health care (e.g. 3, 10, 11). The WHM supplemented their services with preventative strategies to address women's 'control over their own bodies', identifying the political project of women's emancipation as critical to the process (3, 10-14). The World Health Organization (WHO) Ottawa Charter (1986) was of particular relevance as it provided a framework and language to articulate 'the social view of health' which informed the WHM's approach to health care (15).

However, since the emergence of the NPM in the 1990s, health policy settings globally have narrowed their perspectives of women's health. With the exception of very few socially-oriented approaches to women's health policies internationally (e.g. WHO Commission of the Social Determinants of Health) and in Australia (e.g. the National Women's Health Policy and Program and NSW Health Framework for Women's Health), the dominant approach has been to focus on measurable sex differences in health outcomes more akin to the biomedical view of health (e.g. morbidity and mortality rates, life expectancies, injury rates and causes, rates of health system participation, health behaviour and lifestyle risk factors) (5). Consequently, sex-based differences, rather than differences in everyday social conditions of women and men, have become viewed as central to 'gendered health policy', together with reproductive-sex specific health differences (e.g. prostate or ovarian/cervical/breast cancers).

In contrast to this development, recent research and public discussion, influenced by an international movement on the social determinants of health, supports the WHM's claims of gender inequality and male dominance as determinants of women's inferior health status (16-19). This perspective recognises that women's health is determined by the social, economic and environmental settings in which women are born, grow, live, work and age. For instance, women's subordinate social status remains structurally embedded through the sexual division of labour both at home and in the workplace (Connell, 2009: 73 in 5). The lower status jobs and industries that women tend to occupy are associated with lower levels of control and autonomy, which have been linked to lower incomes, higher levels of stress and poorer physical health outcomes (20-23). As significant to women's health is men's violence and abuse of women and girls, a practice central to gender inequality and women's subordination (16, 24-26). Violence and abuse is the leading cause of physical injuries, disability, child abuse and homelessness for women (16, 24-26). Even more widespread, onerous and long-lasting are its consequences for women's mental and emotional illness, including anxiety, mood disturbances, trauma and associated addiction (24, 27-31).

It is evident that women's health and the role played by gender inequality in shaping it are understood in various ways. The way in which gender is understood has important implications for women's health, particularly when it influences organisations and agencies with the power to enact change. The NPM has played a major role in shaping understandings of gender inequity, particularly in policy settings. One of its most compelling features is the emphasis on individual responsibility and choice for people's health fortunes, rather than their social circumstances and the inequalities that characterise them, including those related to gender.

1.1 *Paper aims, scope and limitations*

This document reports on a survey conducted within the WHS in October 2016. The overarching aim of the survey was to investigate the specialised nature of WHS services, to gain a better understanding of the specific contribution the WHS makes to the broader health system, and what distinguishes it from mainstream health services. Specifically, the survey was concerned with the geographical context, the structure and range of services, staffing and funding arrangements, and sector engagement with civil society and public institutions.

The focus of the survey was on the configuration of services across the sector as a whole, rather than individual WHCs, or the diversity between them. The data collected were based on the knowledge and experience of WHC managers, with reference to their WHC databases when asked for specific information about the 2015 – 2016 financial years, unless otherwise indicated.

The report should be read with due attention to its limitations. It does not attempt to evaluate the WHS, to provide evidence to further validate any of the reports by the WHC managers, nor does it consider whether the framework adopted by the sector is the most effective available way to address women's health issues.

Throughout the report 'primary health care' (PHC) refers to the WHO's definition based on its *Alma Ata Declaration of Health for All (1978)*, incorporating five principles of: equitable distribution of resources, community involvement, emphasis on prevention, use of appropriate technology, and an approach that involves a range of sectors (e.g. housing, education and employment). However, it is important to note that a broad range of health perspectives claims this definition, partly due to different understandings and representations invoked by the word 'primary' (7). In wealthy countries, 'primary' refers to the 'first' place that people go to seek health care, treatment of illnesses in their 'early development', 'accessible and affordable' care, or an 'important' or 'essential' part of the health system (Fry and Baum, 1992 in 7). Consequently, in Australia, the term 'primary health care' has come to be associated with private fee-for-service practitioners (e.g. general practitioners and allied health care practitioners), government agencies (e.g. community health centres), and non-government organisations (including the WHCs). This terminology is revisited in Sections 9.2 and 9.4 of this report. However, from this point onwards, the report refers to 'primary health care' according to the WHO definition, and biomedical approaches to health care as 'medical care' in order to distinguish the two perspectives from one another.

The document begins with an explanation of the methods, followed by the research results. A discussion and concluding comments follow on from the results. A more detailed picture of the results follows the discussion and conclusion (see Appendix).

2. *Methods*

The 20 WHCs – all members of the peak body, WHNSW at the time of data collection – were included in the study. These included 17 generalist and three specialist WHCs located throughout NSW. Managers or their representatives with strategic level knowledge of the WHS were invited to participate.

2.1 *Research methodology*

The survey development was guided by a research reference group through a participatory action research approach. The qualitative research design allowed for new themes to emerge from the responses collected in the open survey questions. The research was conducted in two stages: document analysis of publicly available WHS literature, and an online survey. Thematic analysis was used to analyse the data.

2.2 *Ethical considerations*

It was anticipated that this research posed negligible risk to participants as the focus was on investigating the nature of the WHS as a whole rather than individual WHCs, and was not concerned with evaluating the services or personal information. Unless information was available publicly (e.g. websites and publicly available documentation), individuals or individual WHCs were not identified without seeking their permission. The study was approved by The University of Sydney Human Research Ethics Committee.

3. *Results*

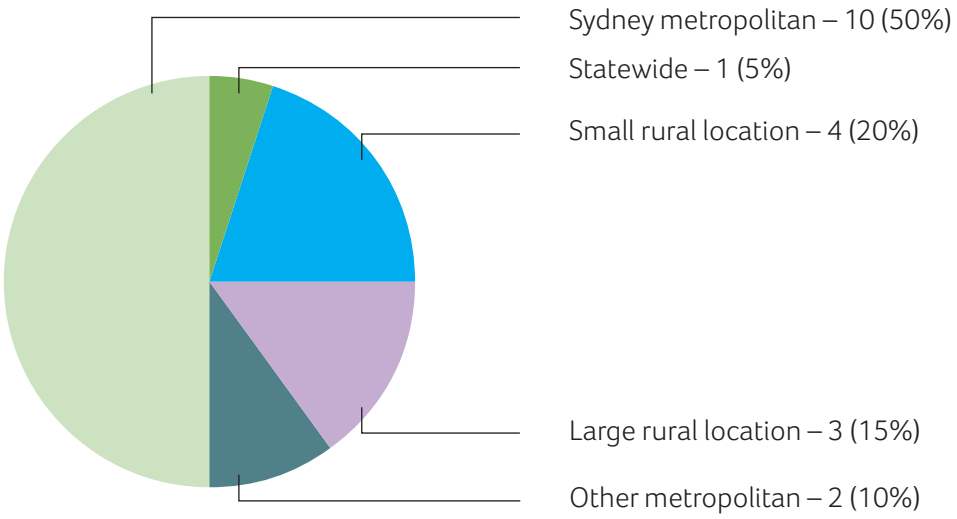
3.1 *Location, funding and staffing*

The survey collected information about the location, funding and staffing arrangements of WHCs.

3.1.1 Location of women's health centres

For the purposes of the survey, the locations of WHCs were classified as metropolitan or rural using the Rural, Regional and Metropolitan Health (RRMA) classification scheme, provided by the Australian Institute of Health and Welfare (32). Accordingly, almost two thirds of the WHCs could be defined as 'metropolitan' (n=12, 60%), including Sydney and other large outer urban locations of Newcastle and Wollongong. Seven (35%) WHCs were located in small or large rural locations throughout NSW, and one (n=1, 5%) WHC reported state-wide service provision of a majority of their services.

Figure 1: Location of Women's Health Centres using RRMA zones



*One WHC was included in the Sydney metropolitan area, but reported state-wide service provision.
(Adapted from AIHW, 2004).

3.1.2 Local Health District alignment

Each Local Health District (LHD) administers the contract for the WHCs that fall within their jurisdiction, based on a generic contract for the Women's Health Program (WHP). This allows LHDs to adapt their contracts to the health needs of their local regions.

Most WHCs reported that their services aligned geographically with their LHD (see Table 1).

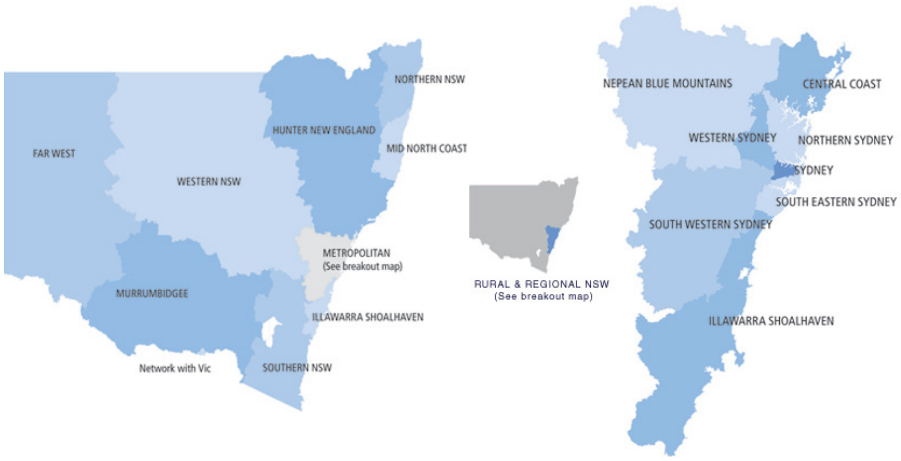
Exceptions included one WHC that provided state-wide services, and another that also accepted women from surrounding LHDs.

Table 1: Local Health District alignment

Local Health District	Women's Health Centres
Central Coast	Central Coast Community WHC
Hunter New England	Hunter Women's Centre
Illawarra Shoalhaven	Illawarra WHC South Coast Women's Health and Welfare Aboriginal Corporation Shoalhaven WHC
Mid North Coast	Coffs Harbour Women's Health Centre
Murrumbidgee	Women's Centre for Health & Wellbeing (Albury/Wodonga) Wagga WHC
Nepean Blue Mountains	Penrith WHC Inc. Blue Mountains Women's Health and Resource Centre
Northern NSW	Lismore Women's Health & Resource Centre
South Western Sydney	Bankstown WHC Liverpool WHC WILMA WHC
Sydney	Leichhardt Women's Community Health Centre Sydney Women's Counselling Centre
Western Sydney	Cumberland WHC Blacktown Women's and Girls' Health Centre
Western NSW	Central West WHC

The geographical regions serviced by the WHS overlapped with 11 of the 15 LHDs, including some of the more remote areas of NSW. The Far West, Southern and two metropolitan LHDs did not have WHCs servicing their regions.

Figure 2: Local Health Districts in NSW and Sydney Metropolitan area



Sourced from: http://www.health.nsw.gov.au/lhd/pages/default.aspx, as at 20/10/2016.

3.2 *Funding sources*

The WHP funding is delivered through the Ministerially Approved Grants Program of the Health and Social Policy Branch of NSW Health, administered by the LHDs. In the 2015 – 2016 financial year, the WHS received $10.1 million across the 20 WHCs (33) of the total 20.7 Billion health budget delivered by NSW Health (34). WHNSW received additional funding of $205, 500 to support its peak body role. This translates to a relatively small amount, even within the NGO context alone, where the 395 Ministerially Approved Grants to 310 NGOs across NSW received $150 million in the same financial year.

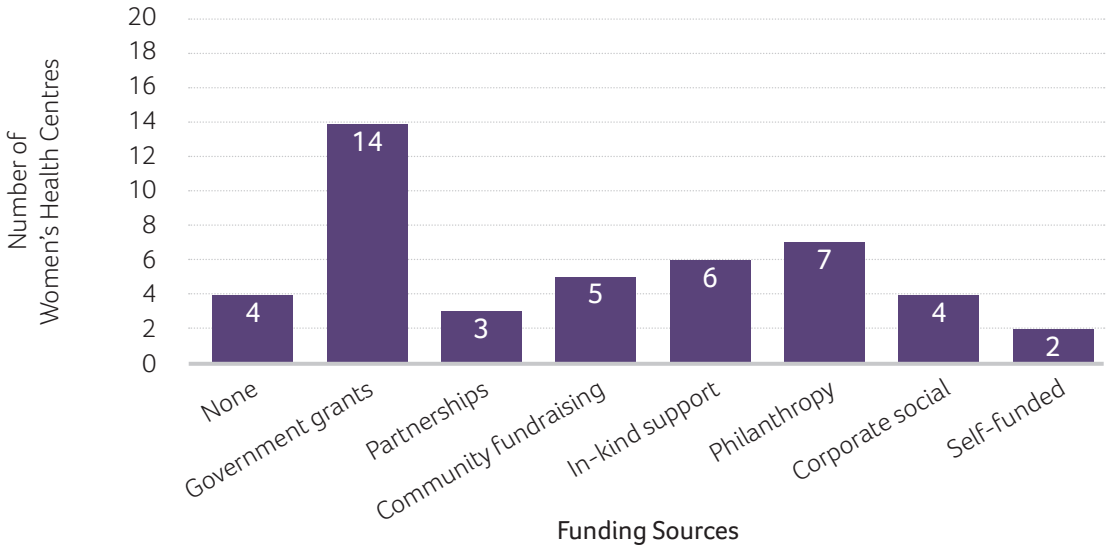
The WHCs also receive funding external to that of the WHP, as discussed in Section 3.2.1, below. This funding is referred to as 'external funding sources' in the remaining document.

3.2.1 *External funding sources*

Managers reported funding received over the two previous financial years (2014-2016), from sources not including the WHP funding received from the MoH.

The majority of WHCs (n=16, 80%) sourced funding additional to that of the WHP, including program, grant and other government funding. Fourteen (29%) managers reported funding from other government programs, and a substantial amount was received across the sector through community fundraising (n=11, 23%). Other funding included that received through partnerships, in-kind, philanthropy support and public donations.

Figure 3: Non-Women's Health Program funding sources



3.2.2 Expanded services

The survey explored how funds from sources in addition to the WHP were being used to leverage further services for women. Managers were asked to provide one example of services funded through each funding source.

WHCs received additional funding through a broad range of sources which could be grouped as follows: (1) Grants from federal and state governments and their agencies for programs other than the WHP, (2) Partnerships with organisations (including local businesses) with access to funding, (3) Fund-raising activities initiated by themselves or other organisations on their behalf, (4) In-kind support provided by community groups/organisations, (5) Philanthropy or corporate social responsibility programs, and (6) Self-funding.

This funding was used in various ways, including to provide service infrastructure and to support particularly marginalised women, as well as other groups such as children and adolescents, and men at risk of perpetrating violence against women.

Duration of funding ranged from very short-term to recurring or ongoing provision. Funding tended to be used in the local area, although in a few cases it was used for services beyond the LHD, including across NSW and even nationally.

Table 2: Additional funding sources

Funding source	Funding range	Activities	Target groups	Timeframes	Regions
Government grants	$76,000 – 1,000,000	Counselling Mentoring Violence and abuse Addiction Primary care services Court advocacy service No interest loans Childcare	Children and adolescents Women who had or were experiencing domestic violence/(and their supporters) Aboriginal women Women with disabilities	Grants ranged between one to seven years and some with the possibility of extension for some.	Aligned with their LHD or local areas Sydney metropolitan area State-wide service.
Partnerships	$2,700 – 274,000	Accommodation Respite services Counselling Trauma services	Women who had or were experiencing domestic violence Aboriginal women Men at risk of perpetrating VAW Women using mainstream mental health services	Most were ongoing, but a pilot study was only for six months.	Aligned with their LHD Sydney metropolitan area Nationally
Community fund raising	$1,000 – 60,000	Basic whitegoods available through the No Interest Loan Scheme (NILS) Subsidised workshop Women and Girl's Emergency fund Counselling Health services Case management Practical crisis support Primary care services Subsidised medical care Costs for financially disadvantaged women experiencing violence and abuse	Women who had or were experiencing violence and abuse Young women Financially disadvantaged women	Timeframes were flexible and could be rolled over into the next financial year.	LHD or local area

Funding source	Funding range	Activities	Target groups	Timeframes	Regions
In-kind support	$3,600 – 130,000	Computers Storage Catering Funding Facility upgrade Strategic-level advice	All women that used the services Women who had or were experiencing violence and abuse Women who were financially or socially disadvantaged	Support was used when it was available.	LHD or local area State-wide
Philanthropy	$1,000 – 100,000	Expanded services for women: Workshops Violence and abuse Counselling services Support and expand current services Access to training/educational opportunities Stress-relieving health services	Vulnerable and disadvantaged women with complex care needs Women who had or were experiencing violence and abuse All women using the services	Timeframes varied: No timeframe Ongoing Use within the previous two financial years.	Local area State-wide National
Corporate social responsibility grants	$5,000 – 100,000	Mentoring Technology hub Establish a doctor's service Community program Case management A Women's Crisis Fund Additional workshops	Vulnerable and disadvantaged women Women with complex care needs Women and children experiencing homelessness as a result of violence and abuse All women using the services	Timeframes varied: No timeframe Ongoing Use within the previous two financial years.	LHD or local area
Self-funded	$3,100 – 30,000	Schools' programs DV mentoring program	Aboriginal girls Women who had left DV and were out of the crisis period	Timeframes varied: No timeframe Ongoing Use within the previous two financial years.	Local area

3.3 *Staffing arrangements*

The survey explored staffing arrangements in terms of 'occupation' and 'employment' categories. 'Occupation' referred to the types of services staff members delivered, whereas 'employment' referred to whether a staff member was employed casually, temporarily on a contract, on a continuing basis, or as volunteers and students.

Given that many occupational categories in the WHS overlap due to funding limitations and the expectation that staff perform multiple roles, managers were instructed to provide information in terms of how their staff had been *primarily* employed. For example, while many counsellors are engaged in case work, managers were required to categorise them as counsellors, not case workers if that was their primary role. For the purposes of the survey, we were more concerned with the role staff played, rather than the discipline they were trained in. For example, if a social worker qualified in delivering counselling services was in a counselling role, we categorised them as such.

3.3.1 *Occupations*

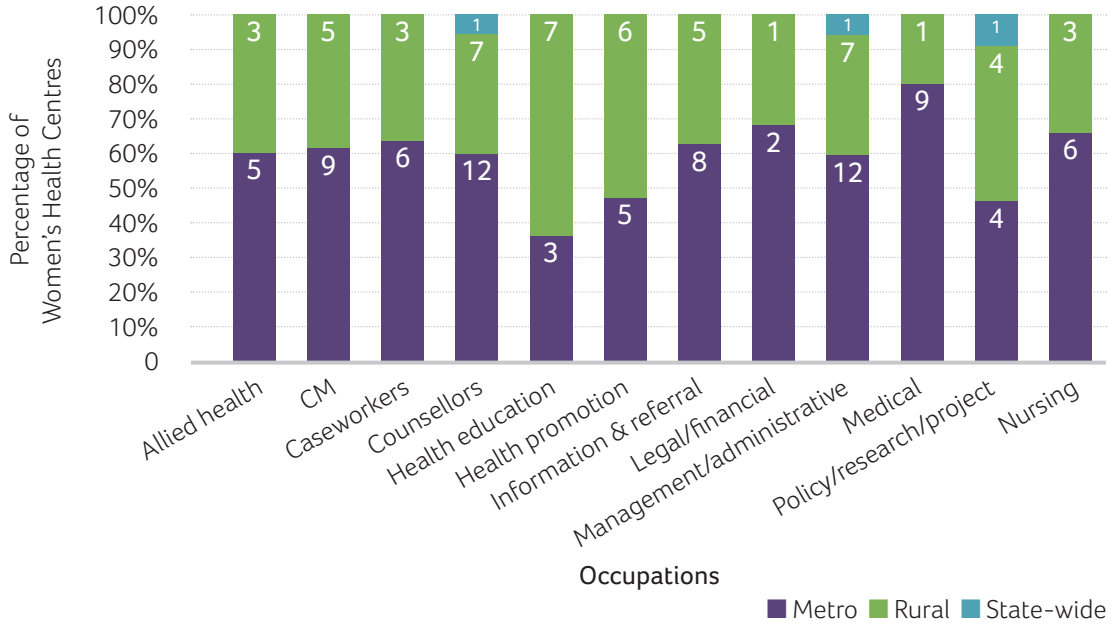
Managers of all the WHCs reported employment of staff from a wide range of occupations to deliver their multi-disciplinary services. All managers reported staff who deliver counselling[4] and management staff, with many employing complementary medical practitioners (CM) (n=14, 70%), and information and referral staff (n=13, 65%). More than half employed medical staff (n=12, 60%).

Similarities and differences were observed in staffing arrangements across different geographical regions. WHCs in rural locations were more likely to employ health education staff (n=7/3) and less likely to employ medical practitioners (n=3/9).

Figure 4: Occupational categories employed by the Women's Health Sector

4 Staff delivering counselling services include those from a wide range of qualified disciplines, including social workers, counsellors, therapists and psychologists.

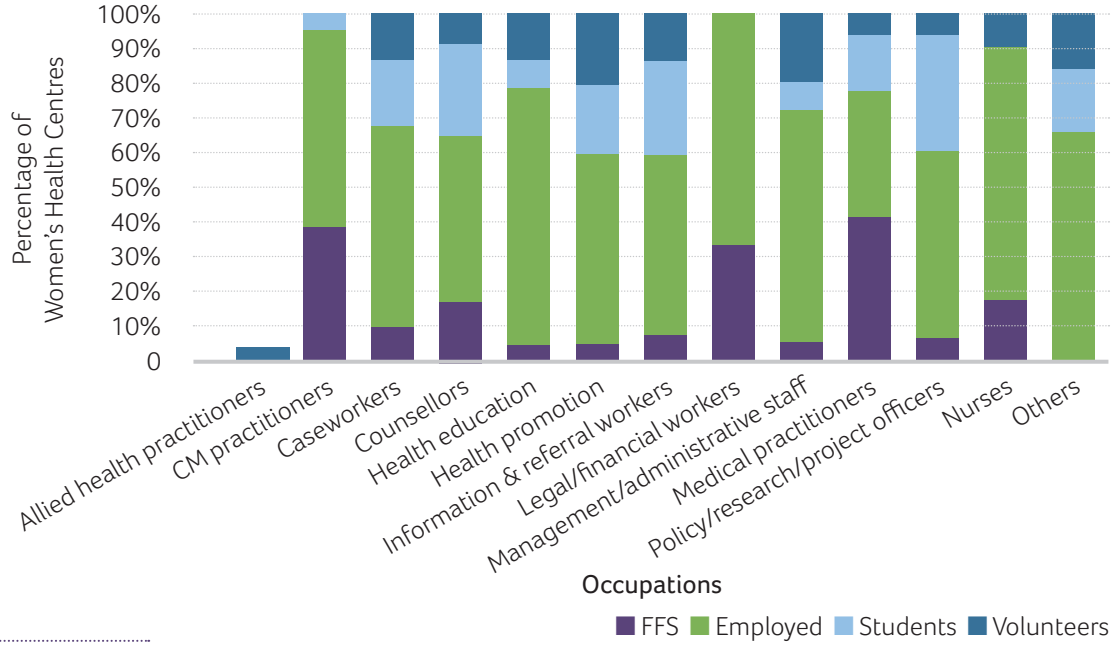
Figure 5: Geographical spread of occupations



3.3.2 *Employment*

Staff were typically salaried employees ('employed')[5], but just over 50 per cent of allied health and medical practitioners were employed on a fee-for-service basis. Students were placed across all occupational categories with the exception of nursing. Placements were most common in counselling (n=20), management (n =20), information and referral (n=12), and health education (n=10). Volunteers were reported across all occupations with the exception of CM.

Figure 6: Staff employment patterns across occupational categories



5 Employment categories were defined as follows:

Employed staff – those in receipt of a salary from the WHC (including full-time, part-time, casual, contract, and services remunerated on a sessional basis).

Fee-for-service – practitioners employed indirectly by charging the women using the services (e.g. Medicare/bulk-billing practitioners, partial/full charge practitioners or a practitioner operating a private business).

Students placed within the WHC.

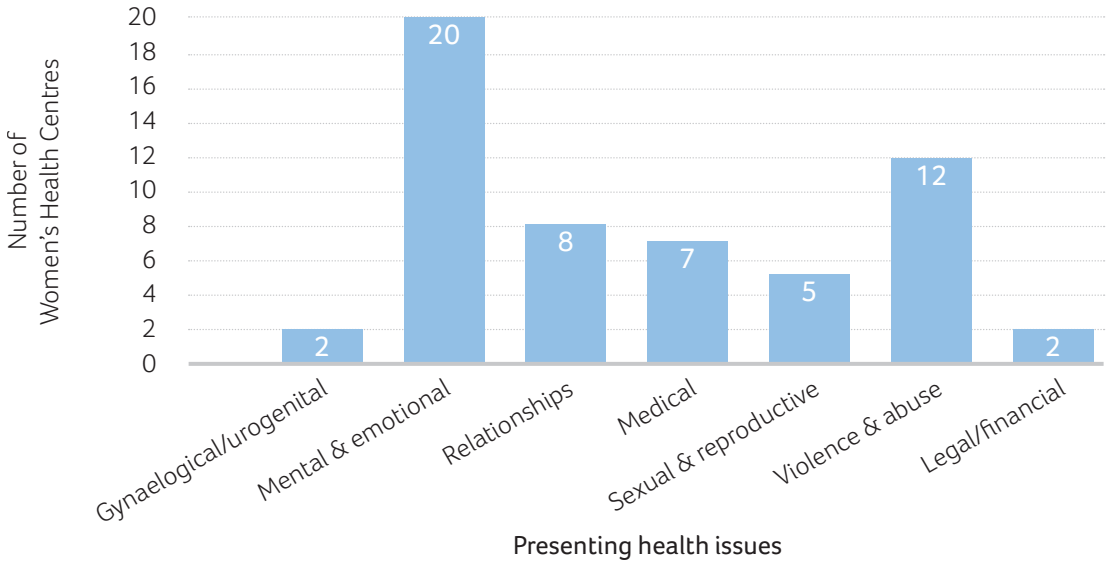
Volunteers – people (excluding directors of boards) who worked for the WHC without remuneration.

4. *Women Using the Services*

4.1 *Presenting health issues of women using the services*

Managers were asked about the three most common health issues that brought women to WHCs. Mental health (n=20, 100%) and health issues related to women experiencing or having experienced violence and abuse (n=12, 60%) stood out as the top presenting health issues in both urban and rural locations. Presentations for medical reasons (n=7, 35%) and to address relationship issues (n=8, 35%) also featured prominently across the sector, with rural WHCs reporting marginally higher presentations for medical (n=3/n=4) and relationship issues (n=3/n=5).

Figure 7: Major presenting health issues



4.2 *Women prioritised by women's health centres*

The survey also explored the groups of women WHCs prioritised in their service delivery. WHCs across the sector consistently reported that they prioritised women who were currently or had been subject to violence and abuse. A majority also prioritised women of low socio-economic status (n=16, 80%), Aboriginal and Torres Strait Islander (ATSI) women (n=14, 70%) and socially isolated women (n=12, 60%). Other priority groups of women included women living with disability, carers, and lesbian, bisexual transgender or inter-sex (LBTI) women.

Findings revealed that health issues most frequently addressed by WHCs aligned with the health concerns of women using the services (see Results, Section 5.2, and Figure 7).

Despite consistency in the groups of women being prioritised across the sector as a whole, differences did emerge in proportions between rural and urban regions. Approximately half as many WHCs in rural regions prioritised culturally and linguistically diverse (CALD) women, women with disability, and LBTI women than their metropolitan counterparts. On the other hand, approximately 50 per cent more rural WHCs reported violence and abuse and women of low socio-economic status as the urban-based WHCs. Rurally-based WHCs also reported a focus on geographically isolated women.

Figure 8: Groups of women prioritised by WHCs

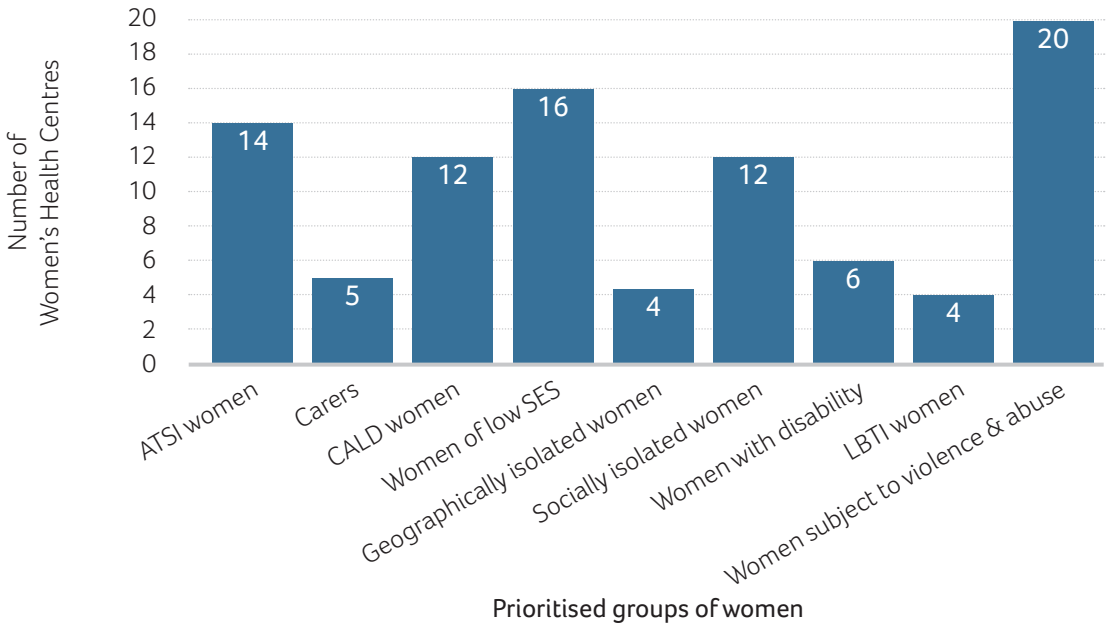
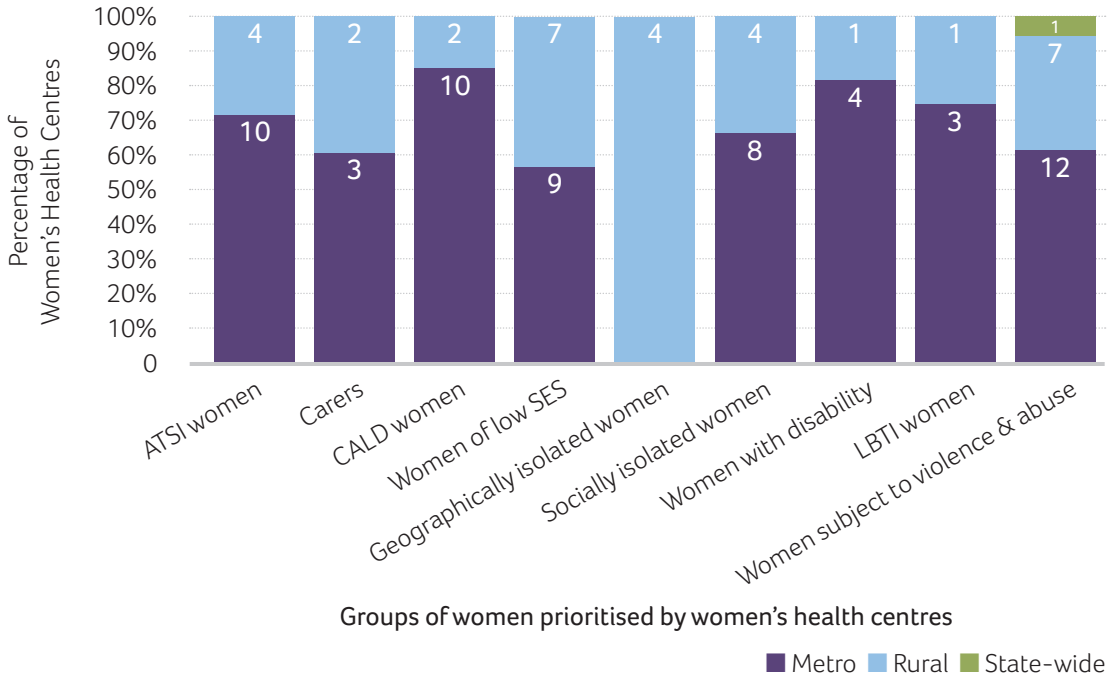


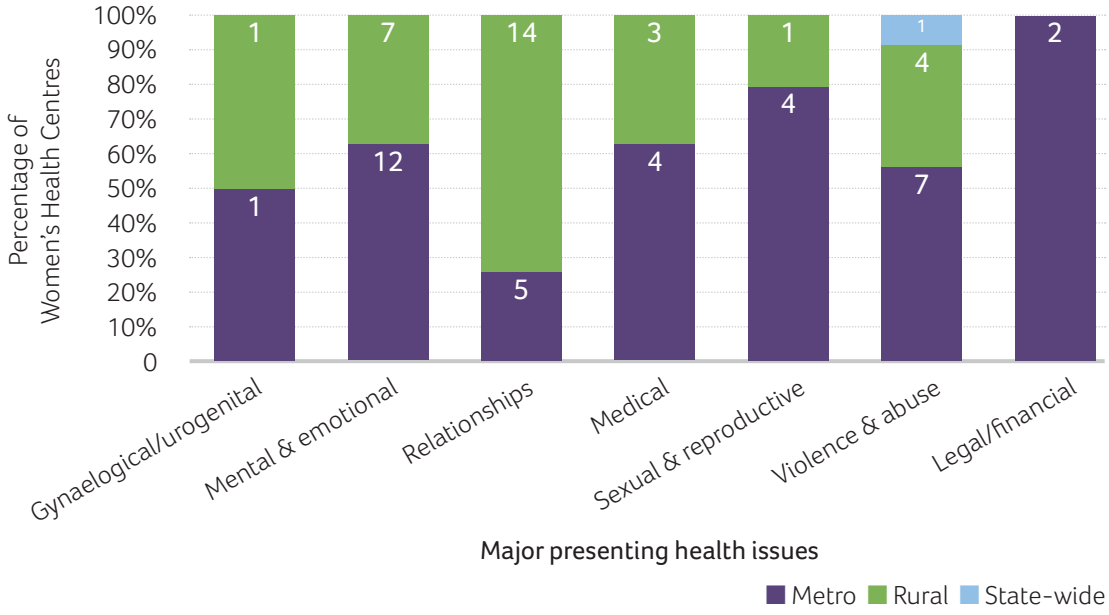
Figure 9: Prioritised groups of women by geographic location of WHC



*Rural calculations include corrections for fewer rurally-based centres.

A similar picture emerged regarding presenting health issues between rural and urban-based WHCs. While there was consistency in the *range* of health issues presenting to WHCs across the sector as a whole, some similarities and differences between regions were observed. After correcting for fewer rural WHCs, presentations to WHCs for mental and emotional health issues, violence and abuse, and relationships occurred at similar rates. However, rural centres reported almost twice as many presentations for gynaecological/urogenital (n=1.9, 1) and almost 50 per cent more medical presentations (n=5.7, 4) compared to urban centres. Rural centres did not report any legal/financial presentations.

Figure 10: Major presenting health issues by geographical location of WHCs



*Rural calculations include corrections for fewer rurally-based centres (i.e. thereby providing a comparison of rate, rather than number, of presenting health issues).

5. *Core Services*

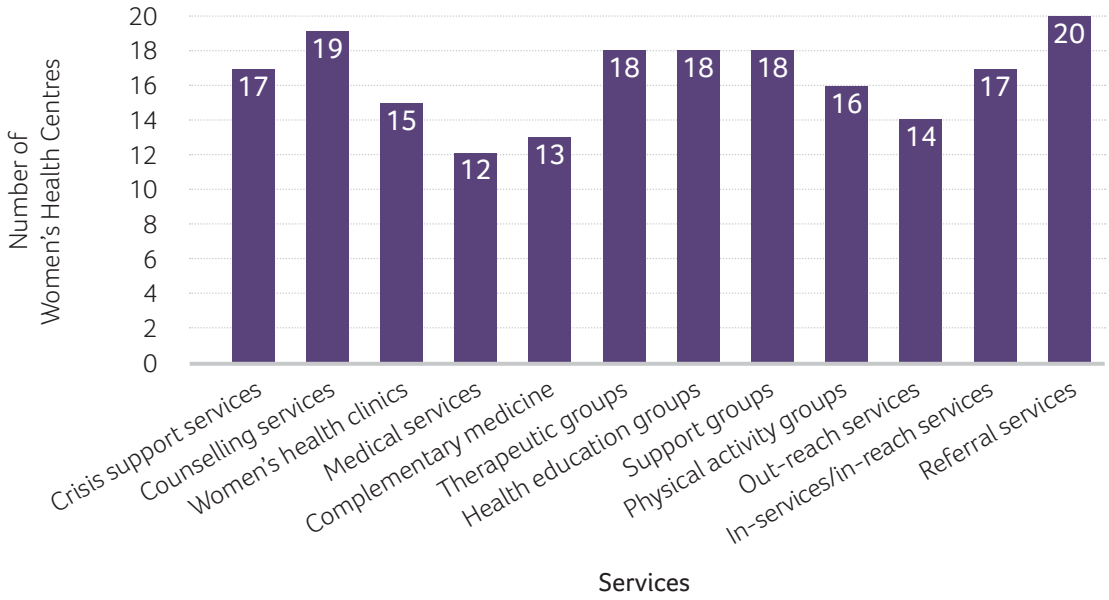
'Core services' were defined as co-located services provided to women who attended WHCs. A range of services was reported by each of the managers of the WHCs, with little variation across the sector. Services provided by a majority of WHCs included: crisis support (n=17, 85%), counselling (n=19, 95%), groups including therapeutic (n=18, 90%), health education (n=18, 90%), support (n=18, 90%) and physical activity n=16, 80%), in-services/in-reach (17, 85%), and referral services (n=20, 100%). Other services provided across the sector included medical services (n=12, 60%), complementary medicine (n=13, 65%), and out-reach services (n=14, 70%) delivered at external agencies.

This section provides an overview of the findings for each of the core services. See for Appendix for further detail.

Table 3: Definitions of core services

Core services	Definitions
Crisis support	Services providing emergency assistance to meet with the urgent needs of women whose safety or health is at risk.
Counselling	Therapeutic services that support women to better understand and manage their mental and emotional health issues.
Medical services	Services provided in a safe, non-judgemental environment.
Complementary medicine	Includes a range of treatments such as acupuncture, Chinese herbal medicine, naturopathy and massage therapies that are united by their consideration of the whole person, including the body, mind and spirit.
Therapeutic groups	Structured, multi-sessional groups led by professional counsellors, that aim to support healing or management of emotional and mental health issues.
Support groups	Groups that provide knowledge, life-skills and social support to empower particularly marginalised women to take control of their health.
Health education groups	Groups that provide health information and build women's health literacy to improve their knowledge and skills to better manage health, well-being and illness.
Physical activity groups	Groups that encourage women to engage in physical movement to enhance their mental and emotional well-being and reduce the risk of developing chronic illnesses.
Allied health services	Services consisting of mainly physiotherapy, provided by practitioners trained to provide a safe and non-judgemental environment.

Figure 11: Women's Health Sector service provision in 2015–2016



5.1 *Diversity across the sector*

Diversity was most notable in the WHCs that aimed to provide specialised services, and one centre that focused on provision of medical services.

(1) Coffs Harbour Women's Health Centre is the only WHC that does not offer counselling services, focusing instead on the delivery of medical and women's health clinic service provision in combination with other women's and youth health services.

(2) Rape & Domestic Violence Services Australia provides a state-wide approach to service delivery that includes crisis support, telephone and on-line counselling, face-to-face trauma-specialised counselling services delivered through six WHCs across NSW, and professional development training and counselling supervision services.

(3) South Coast Women's Health and Welfare Aboriginal Corporation offers the full range of core services delivered in a culturally appropriate manner specifically for Aboriginal women.

(4) Sydney Women's Counselling Centre specialises in the provision of counselling services but also provides crisis support and a range of women's peer group programs.

Apart from the four WHCs that distinguished themselves by specialising in particular ways, there was little difference across the sector in terms of delivery of core services (see Table 4). Only three of the 'generalist' WHCs did not provide crisis support and several did not provide medical care and/or CM services. There were some minor differences between rural and metropolitan-based WHCs in terms of their service response and the women presenting to their services (see Section 4).

Table 4: Diversity across the WHS in the delivery of core services

Core services	Women's Health Centres: Specialised WHCs				Generalist WHCs																
	RDVSA	SWCC	*WAMINDA	*Coffs Harbour WHC	Bankstown WHC	Hunter Women's Centre	*Women's Centre for Health & Wellbeing (Albury/Wodonga)	Cumberland Women's Health Centre	Blue Mountains Women's Health and Resource Centre	*Central West Women's Health Centre Inc.	*Lismore Women's Health & Resource Centre	Blacktown Women's and Girls' Health Centre	Liverpool Women's Health Centre	Central Coast Community Women's Health Centre	Illawarra Women's Health Centre	WILMA Women's Health Centre	*Shoalhaven Women's Health Centre	*Wagga Women's Health Centre	Leichhardt Women's Community Health Centre	Penrith Women's Health Centre Inc.
Crisis support	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	■	■
Counselling	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Medical services			■	■	■				■	■		■	■	■	■	■	■		■	■
Complementary medicine			■	■				■	■	■		■	■	■	■	■		■	■	■
Therapeutic groups		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Health education groups		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Support groups		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■
Physical activity groups		■	■	■	■		■	■	■	■		■	■	■	■	■	■		■	■

*N=7 WHCs based in rural locations (see Section 3.1), according to the RRMI classification used for the purposes of this survey.

5.2 *Health issues addressed by women's health services*

Managers were asked to identify the major health issues addressed by their core services. The responses are provided in Table 5, below. This question sought to identify commonly provided services across the sector as a whole, rather than individual WHCs, which vary in their service provision. The following therefore provides a 'snapshot' of the services women are most likely to access when they attend a WHC. See Appendix for a detailed descriptive statistical analysis of each of the individual services. Individual services address health issues in distinctive ways, yet their aims also complement other services. Table 5 (below) highlights where core services were brought together to address particular women's health issues. For example, women subject to violence and abuse have access to a range of services through the WHS, including: crisis support, counselling, therapeutic groups, health education and primary medical care services. While service offerings varied between individual WHCs, the sector as a whole provided a consistent suite of services for each of the major presenting health issues.

Table 5: Major health issues addressed by services

Services	Major health issues																						
	Violence & abuse	Trauma (complex/emotional)	Mental/emotional health	Self-esteem	Grief and/or loss	Relationships	Suicide	Stress	Cancer	Eating disorders	Reproductive health	Gynaecological/sexual health	Tiredness/fatigue	Gastrointestinal	Musculoskeletal/pain	Pain	Physical/medical	Special interest	Social isolation	Fitness	Yoga	Strength and balance	Relaxation/meditation
Crisis support	■	■	■																				
Counselling	■	■	■	■	■	■	■	■															
Medical services			■								■	■											
Women's Health Clinics			■							■		■	■										
Complementary medicine			■						■				■	■	■	■							
Therapeutic groups	■	■		■																			
Health education groups	■		■			■											■						
Support groups	■					■											■	■	■				
Physical activity groups																				■	■	■	■

5.3 *Crisis support services*

Crisis support is emergency assistance for women that meets the urgent needs of women whose safety or health is at risk. Eighteen (90%) managers of WHCs reported provision of crisis support services. A relatively consistent picture of issues addressed emerged across the sector, including: complex trauma, sexual assault, childhood sexual assault, financial problems, homelessness and unplanned pregnancy.

5.4 *Medical care*

Medical services in the WHS are primarily concerned with provision of health assessments and treatment, but may also provide additional services such as women's health clinics for gynaecological and urogenital care. Service delivery is distinguished from the mainstream health system through an emphasis on provision of a safe, non-judgmental and supportive environment for women (e.g. 35). Care is provided by experienced female general practitioners and nurses.

Twelve (60%) WHCs provided medical services, however a larger number provided women's health clinics 15 (75%). As medical services were known to focus on treatment and diagnosis, the survey collected data about the health issues addressed by women's health clinics. Managers reported their most health presentations were for gynaecological, mental and emotional and reproductive health issues.

5.5 *Allied health services*

Allied health services are provided by female practitioners trained to provide a safe and supportive environment. Eight (40%) managers reported that their WHC provided physiotherapy services to women.

5.6 *Counselling services*

Counselling in the WHS consists of therapeutic services that support women to better understand and manage their mental and emotional health. Counselling is provided by qualified staff from a range of disciplines and with diverse approaches. Nineteen (95%) of the WHCs provided counselling services. All WHCs reported addressing health issues associated with violence and abuse, almost all addressed emotional trauma, grief and/or loss, relationships, self-esteem, suicidal thoughts, and many addressed self-harm, stress, eating disorders and post-natal depression.

5.6.1 Modes of counselling

WHCs reported a broad range of counselling modes including: Acceptance and Commitment Therapy, Dialectical Behavioural Therapy, Narrative Therapy, Behavioural Therapy, Cognitive Behavioural Therapy, Systemic Therapy, Solution – focused Therapy, Psychotherapy, and Trauma Specialisation. Health issues presenting to counselling services were relatively consistent across the sector. The most commonly addressed issues related to violence and abuse, emotional trauma, grief and/or loss, relationships, self-esteem, and suicide.

5.7 Complementary medicine

CM includes a range of treatments such as acupuncture, Chinese herbal medicine, naturopathy and massage therapies, which are united by their consideration of the whole person, including the body, mind and spirit. Fourteen (70%) of WHCs provided complementary medical services. Managers reported the most commonly addressed health issues to these services as mental and emotional issues, gastrointestinal and musculoskeletal complaints, pain and tiredness or fatigue.

5.8 Health education/self-management group programs

Health education and self-management programs provide women with health education and self-management skills to support and empower them to take control of their health. These fall into four main categories of therapeutic, health education, support and physical activity groups.

5.8.1 Therapeutic groups

Therapeutic groups are structured, multi-sessional groups led by professional counsellors (including all disciplines, e.g. psychologists, psychotherapists), that aim to support healing or management of emotional and mental health issues. Nineteen (95%) of WHCs provided therapeutic groups. The top presenting health issues across the sector included those related to violence and abuse, self-esteem, trauma and depression.

5.8.2 Health education groups

Health education groups provide health information and build women's health literacy to improve their knowledge and skills to better manage health, well-being and illness. Nineteen (95%) WHCs offered health education groups. The top health issues addressed through these groups across the sector included physical or medical, relationships, violence and abuse, and gynaecological/urogenital health issues.

5.8.3 Support groups

Support groups provide knowledge, life-skills and social support to empower particularly marginalised women to take control of their health. Eighteen (90%) WHC offered support groups. Most WHCs addressed the needs of 'special interest groups' (i.e. particularly marginalised women, including CALD women) and socially isolated women. Some also addressed issues related to relationships, violence and abuse, and physical health.

5.8.4 Physical activity groups

Physical activity groups were provided to encourage women to engage in physical movement to enhance their mental and emotional well-being and reduce the risk of developing chronic illnesses. Sixteen (80%) of WHCs offered physical activity groups, which featured relaxation, meditation and yoga, and fitness, strength and balance training.

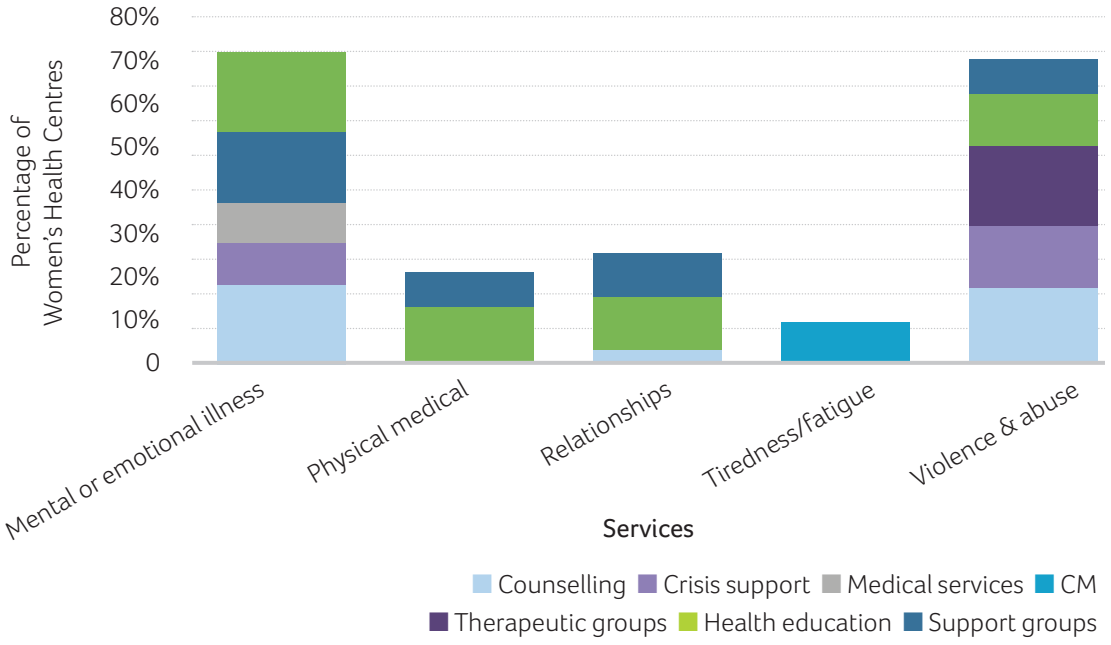
5.9 *Multi-disciplinary service approach*

Some presenting health issues were addressed primarily by a particular service discipline (see Table 5). For example, eating disorders, gynaecological and sexual health issues were addressed primarily through medical services; whereas cancer, gastrointestinal issues and pain were addressed mainly by CM practitioners.

Several other health issues were addressed by two or three women's health services, demonstrating the multi-disciplinary nature of the services throughout the WHS. These included physical/medical health issues, addressed by health education and support groups; relationship issues, addressed through counselling, health education and support groups; and tiredness and fatigue, addressed by medical services and CM services.

However, the two most pressing of women's health needs, mental/emotional illness and health issues related to violence and abuse, stood out as being addressed by a broad range of multidisciplinary services (see Figure 12). Both were addressed through counselling, crisis support, therapeutic groups and health education services. Additionally, medical services played a key role in managing mental and emotional illness, while support groups were widely used in relation to violence and abuse.

Figure 12: Major health issues addressed by a multi-disciplinary suite of services



5.10 *Multi-disciplinary staffing arrangements*

A broad range of staff were involved in the delivery of many of the core services across the sector including *crisis support services* (counsellors, management/administrative staff, nurses and information/referral staff); health education/self-management groups including *health education groups* (counsellors, and CM, allied health and health education/promotion practitioners); *support groups* (counsellors, nurses, and CM, allied health and health education/promotion practitioners) and *physical activity groups* (CM, allied health and health education/pro-

motion practitioners). The most active occupational group involved in the delivery of many of the core services were counsellors (crisis support, counselling, therapeutic, health education and support groups), CM staff (CM, health education, support and physical activity groups) and nurses (crisis support, medical services, and support groups).

Table 6: Staff occupations involved in delivering core services

Core services	Staff occupational categories								
	Counsellors	Management/administrative	Doctors	Nurses	Information/referral	CM practitioners	Allied health practitioners	Health education/promotion	
Crisis support	■	■		■	■				
Counselling	■								
Medical services			■	■		■			
Complementary medicine						■			
Therapeutic groups	■								
Health education groups	■					■	■	■	
Support groups	■			■		■	■	■	
Physical activity groups						■	■	■	

5.11 *Additional services that enhance women's access to appropriate care*

5.11.1 Outreach services

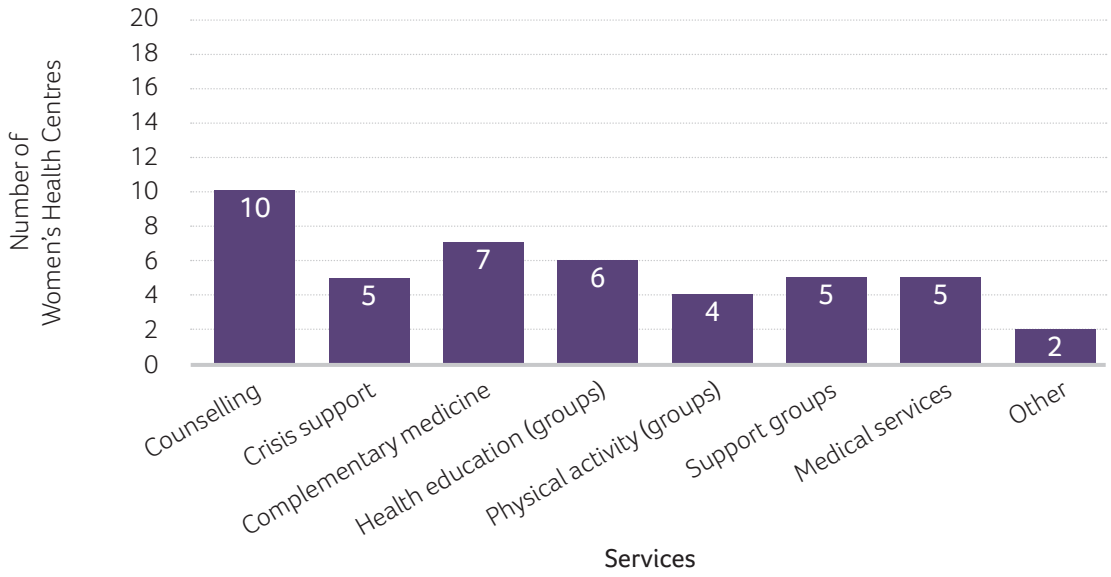
Outreach services[6] are delivered through staff placements or rented office spaces at external agencies. Fourteen (70%) WHCs provided outreach services. Those most commonly provided included health education groups (n=11, 79%), counselling (n=10, 71%), and CM services (n=7, 50%). One novel approach was through provision of a community kitchen to local communities.

6 Outreach services were not intended to include:

(1) Individual practitioner/staff member service provision that has not been deliberately placed by a WHC within another agency (e.g. home-visiting, meeting a client at another agency);

(2) Services provided in community settings (e.g. local shopping centres, organisations, sporting institutions, organised groups) (see SERVICES DELIVERED AT THE COMMUNITY LEVEL). Services provided in community settings (e.g. local shopping centres, organisations, sporting institutions, organised groups).

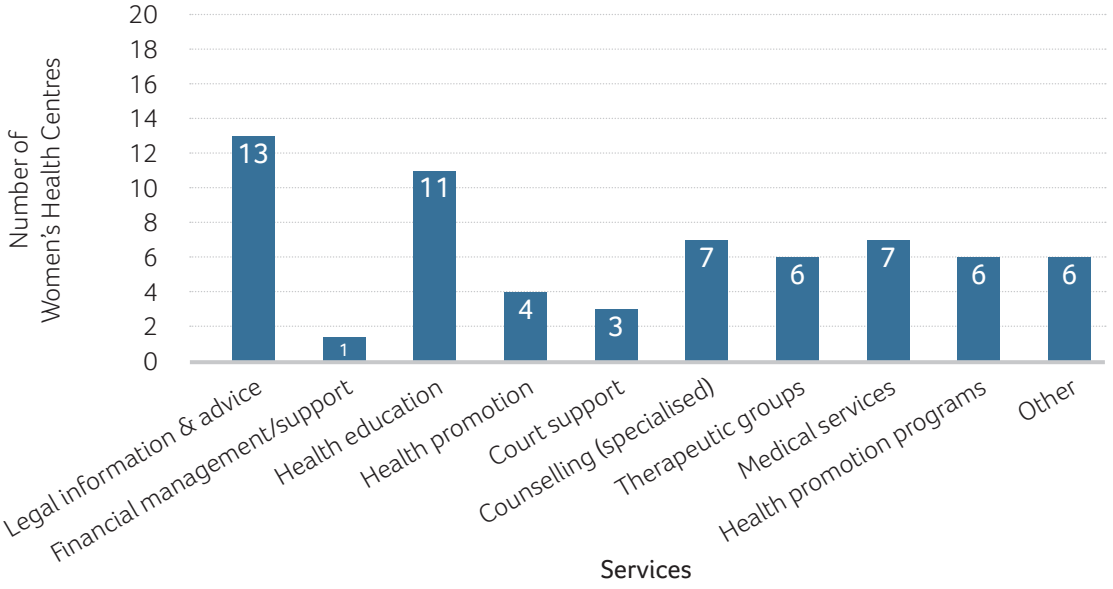
Figure 13: Outreach services provided by WHCs



5.11.2 In-services/in-reach services

Seventeen (85%) of the WHCs provided in-services/in-reach services – or services conducted on-site by external health and social service agencies. Legal information (n=13, 75%) and health education (n=11, 65%) were most commonly provided through this channel, although adult survivors of childhood sexual assault support and medical services also featured (n=7, 41%). Four of the six entries by managers in the 'other' category of this survey question were related to services associated with violence and abuse (see Figure 14, below).

Figure 14: In-services/In-reach services provided by WHCs



*Violence and abuse was an emergent category from entries by managers in the 'other' category provided in addition to the suggested categories.

5.12 *Referral services*

The question about referral services was concerned about the extent to which WHC services interacted with external health and social care agencies in their local communities to advocate for additional services for women and provide continuity of care. All managers of WHCs reported provision of referral services. Interactions with particular types of services were relatively consistent across the sector, with WHC all reportedly referring women to alcohol and other drug services, child and family services, domestic violence/sexual assault services, medical and counselling services. Accommodation services, legal/financial and support/community health services were also almost universally provided (n=19, 95%) (refer to Figure 15).

Figure 15: Referral agencies accessed by WHCs

6. *Provision of Services to Local Communities*

Services provided to 'local communities' were those designed to (1) Reach out to specific groups of women who might not attend a women's health centre (e.g. Aboriginal, non-English speaking, or older women, or women with particular health issues) to enhance their knowledge and/or skills about health issues, and (2) Assist organisations and businesses within the local community to improve the conditions in which women live, work and play in order to enhance their women's health interests.

Seventeen (85%) WHCs reported that they provided services to their local communities. These included provision of health information that aimed to address women's health literacy regarding the determinants of their health as well as their more immediate health issues. Approaches varied, but five themes emerged, according to aims and the manner in which services reached out to women. These included: (1) *Information sessions*, designed to raise awareness of particular illness-inducing conditions faced by women (e.g. violence and various forms of abuse), were directed towards women in the general population attending shopping centres, service clubs or community events; (2) *Health services*, including health screening and medical services, focused on specific groups of particularly marginalised and under-serviced women (e.g. sex workers, homeless women); (3) *Health education*, activities that targeted individual women or groups, and aimed to provide health literacy and personal skills about particular health issues to enable women to make decisions that support their health and well-being (e.g. nutrition, sleep management, sexual health); (4) *Health promotion*, activities focused beyond the level of individual women and groups of women, in order to address social structures of society that impact on women's health; (5) *Health education/promotion combined,* activities that aimed to provide both information and skills about a particular health issue, at the same time as addressing the structural drivers of that health issue (see Table 7).

Table 7: Examples of service provision to local communities

Description	Aim/s	Time-frame	Duration	Target group/s	Setting	Outcome/s
Information sessions						
Information stand	Raise awareness of domestic and family violence	8 single sessions/year	One day	All community members	Shopping centres, service clubs, outdoor events	Increased awareness of DV
Community and services forum	Increase knowledge and recognition of financial abuse	Single session	3 hours	Allied health Community agencies Women in the community	Community event	Raise awareness and build women's financial resilience
Health services						
Health screenings	Increase access to screening	Monthly	One day	Aboriginal Women	Community halls	Increase in screenings
Women's health clinic	Cervical/breast screening and general health checks	Monthly	2 hours	Sex-workers Homeless women	Drop in centre	Increased access to services
Health education regarding risk factors (e.g. cholesterol testing, blood pressure checks, and referral services)	Raise awareness regarding risk factors & prevention strategies	4 major events/year 3 outside organisations fortnightly 2 hour drop in clinics at WHC	Single sessions	All women in the community Disadvantaged women	Hospital, community events, WHC	Changes in knowledge & intended behaviour changes
Kitchen provided opportunity to develop skills and knowledge about health eating	Address: Diabetes and chronic health risk factors through healthy nutrition Social isolation Access to affordable, healthy food	9 weeks /term	3 hour sessions	Aboriginal women and men Ethnic groups	Two locations within the local area	Increased knowledge about: - Nutritious affordable meals - How to prepare and cook - Where to access affordable healthy food - Increased access to the local community

*Sessions designed to increase knowledge and/or skills about health issues directed towards individual women or groups
**Sessions designed to influence the drivers of health that make women sick in the first place

Description	Aim/s	Time-frame	Duration	Target group/s	Setting	Outcome/s
Health education*						
Health education groups	Education on cervical screening	Six weeks / term	4 hours	CALD women who have not had a cervical screening	Cultural centre training room	Increased cervical screening
Health education session	Raise awareness of respectful relationships	Single session	Half day	School girls in years 11 and 12	School	Raised awareness of issues related to gender based violence and respect in relationships
Film screening – *Suffragette*	Raise awareness of feminism/history/ suffrage	International Women's Day	Single session	Women, especially young, Aboriginal and CALD women	Regional Arts Centre	Increased awareness of feminism/history/suffrage
Day of Action with other community services	Raising awareness of sexual assault	Single session	One day	General community and survivors of sexual assault	Community event	Increased awareness measured by amount of information given out
Incontinence workshop and exercise group	Normalise incontinence and decrease social isolation	8 weeks	2-hour workshop/ 1-hour exercise groups	Chinese community and older women	Community hall and retirement village	Improved health and wellbeing Reduced isolation Health related information
Health education group	Raise awareness of domestic violence and support services available	Single session	N/A	General population	Community event	Increased awareness of domestic violence
Program and health education for ATSI women to increase physical health and well-being	Reconnect with the ATSI community Address social Isolation	7 weeks	3 hours	Socially isolated Aboriginal Women	Swimming centre	Increased knowledge Social interaction Increased physical well-being

*Sessions designed to increase knowledge and/or skills about health issues directed towards individual women or groups
**Sessions designed to influence the drivers of health that make women sick in the first place

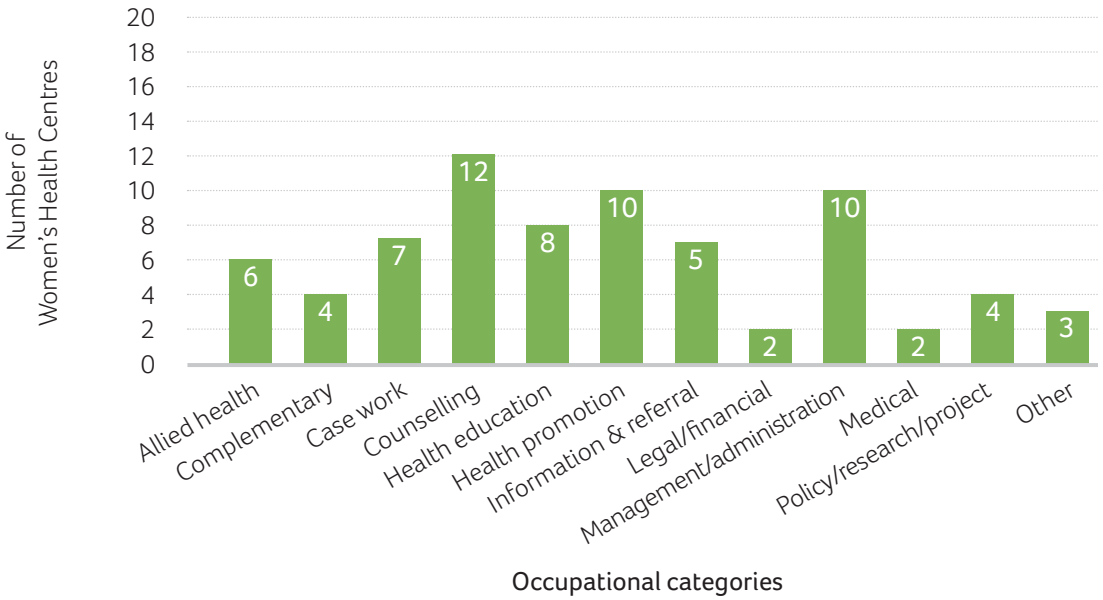
Description	Aim/s	Time-frame	Duration	Target group/s	Setting	Outcome/s
Health promotion**						
Facilitated discussion to increase awareness about violence against women in the community	Increase understanding about the link between gender inequality and violence and abuse of women	Single session	30-60 mins	General population	Community organisations, businesses, and service clubs	Increased knowledge
Meetings with community members and internet/social media presence to raise awareness about VAW	Raise awareness of VAW and healthy relationships in the local government area	2 years	Varied	Women, families, young people, businesses and sporting club members in local government area	Council sporting clubs businesses	Increased DFV referrals Increased DV and relationships in clinics and counselling Improved awareness and capacity of women regarding healthy relationships
Nationally recognised training regarding support and care to people experiencing mental health crisis	Mental health First Aid	2-day course	7 hour sessions	Community health workers, health professionals and carers	Community venue	Increased knowledge regarding support and care of someone experiencing a mental health crisis
Health education/promotion combined						
Presentation about mental and emotional health and wellbeing	Improved emotional and mental wellbeing More knowledgeable women as leaders responsible for junior personnel Increased awareness of local services/ supports	Single session	3 hours	Women who are leaders in a shifting population	Defence force base	Increased knowledge of emotional and mental wellbeing Access to the tools to build individual capacity Ongoing relationships supported and expanded Increased knowledge of local services and their capacity A greater scope on their personnel being aware of local services and their capacity

*Sessions designed to increase knowledge and/or skills about health issues directed towards individual women or groups
**Sessions designed to influence the drivers of health that make women sick in the first place

6.1 *Staff involvement in delivering services to the local community*

Staff who predominated in delivering services to the local community included counsellors (n=12, 71%), health promotion (n=10, 59%), and management (n=10, 59%). However, a broad range of staff was reportedly involved across the sector, including allied health and complementary medicine practitioners, case workers, and health education, information and referral, and policy/research/project staff.

Figure 16: Occupational categories of staff delivering services to local community

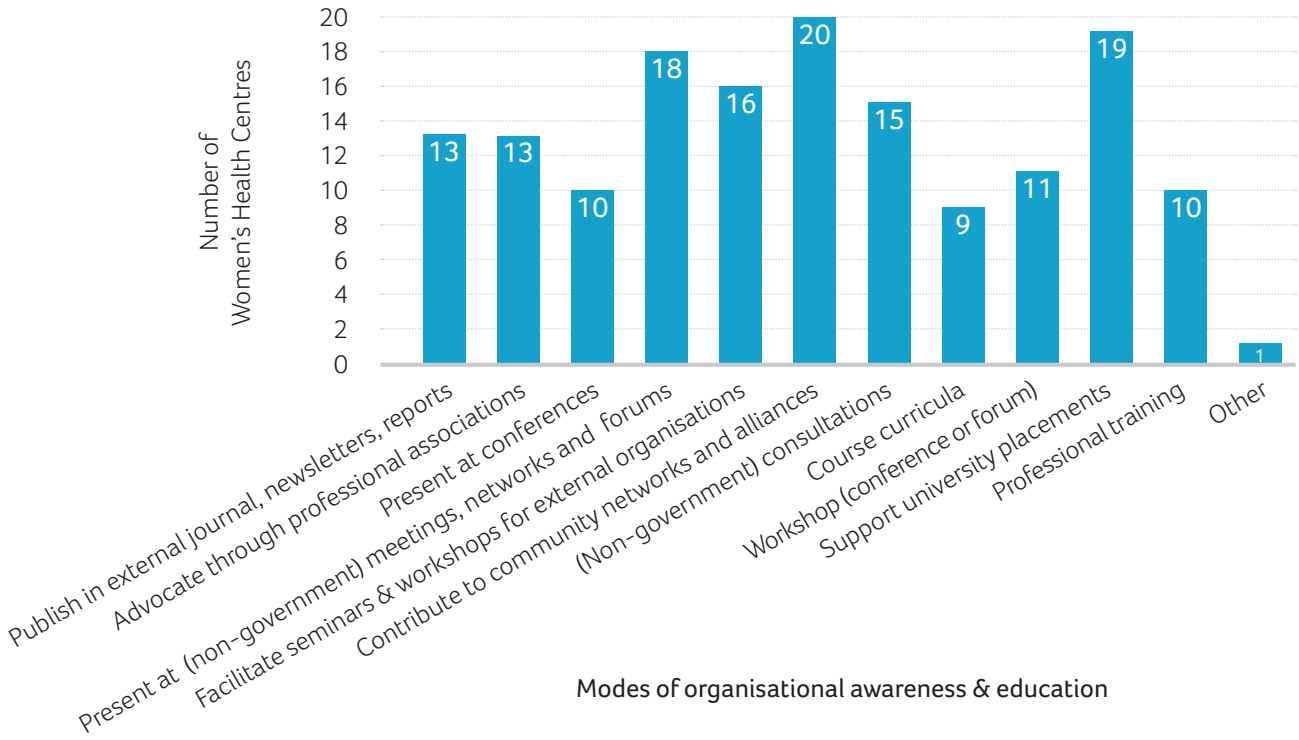


6.2 *Organisational awareness and education*

'Organisational awareness and education' refers to the practice of engaging with other organisations to build awareness, knowledge and skills about concepts that advance women's health interests. All 20 WHCs were reportedly involved in this practice within their local communities.

All WHCs contributed to community networks and alliances and almost all supported student placements (n=19, 95%). Most had staff presenting at (non-government) meetings, networks or forums (n=18, 90%), facilitating seminars and workshops for external organisations (n=16, 80%) and participating in (non-government) consultations on women's health issues (n=15, 75%). Other activities WHCs were engaged in included running workshops (n=11, 55%), provision of professional training (n=10, 50%), and a wide range of dissemination activities aimed at engaging with other organisations to address the determinants of women's health.

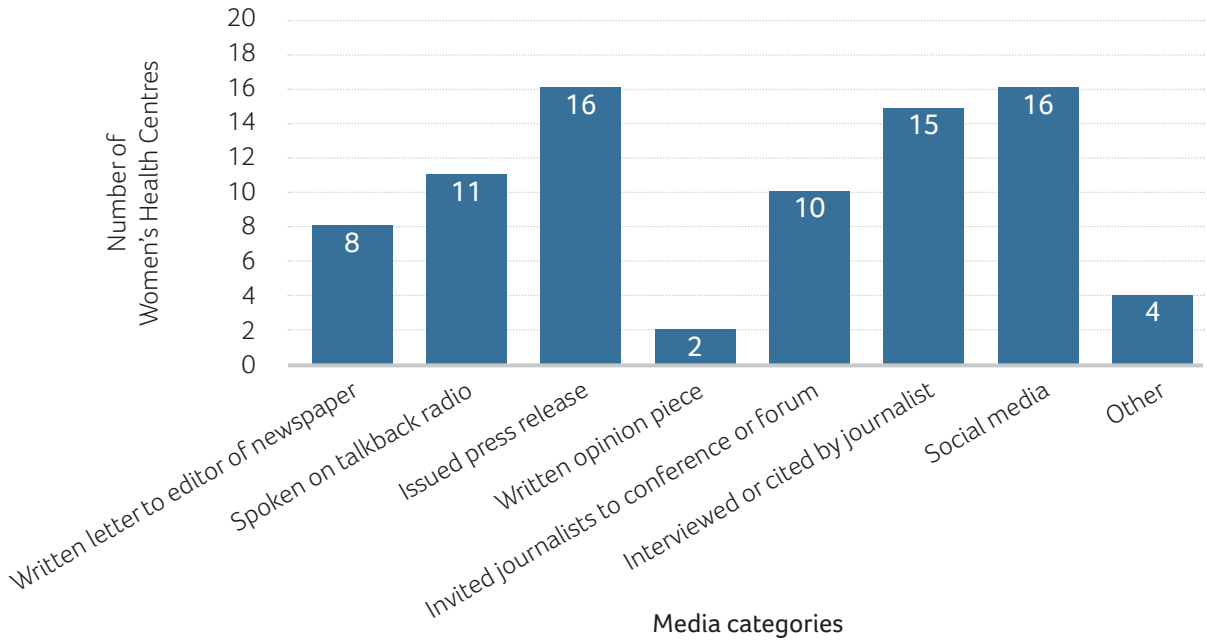
Figure 17: Engagement in organisational awareness & education



6.3 *Media advocacy*

Nineteen (95%) managers of WHCs reported that their WHCs engaged in media activities to raise awareness about women's health issues. This most commonly involved issuing a press release, engaging with social media (n=16, 84%), media interviews (n=15, 79%) and inviting journalists to conferences (n=11, 58%).

Figure 18: Engagement with the media



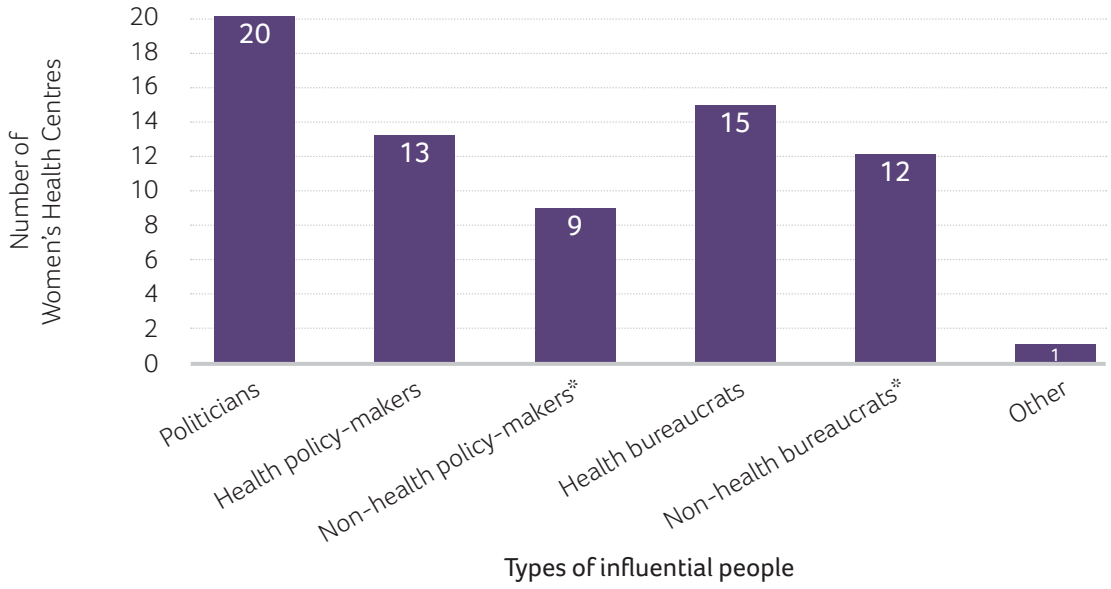
7. Activities Undertaken in Public and Corporate Institutions

Activities undertaken at the level of public and corporate institutions include advocating for reforms designed to address women's health inequities in order to prevent health issues emerging in the first place. While the category of 'corporate institutions' was included to include work with private corporations, but findings revealed this work largely involved advocacy and representations to policymakers and politicians.

7.1 *Engagement with influential people*

All managers reported engagement with influential individuals in a position to enact change to advance women's health. Managers reported interactions with politicians (n=20, 100%), health bureaucrats (n=15, 75%), and health (n=13, 65%) and non-health policy-makers (n=12, 60%) about the determinants of women's health.

Figure 19: Engagement with influential people

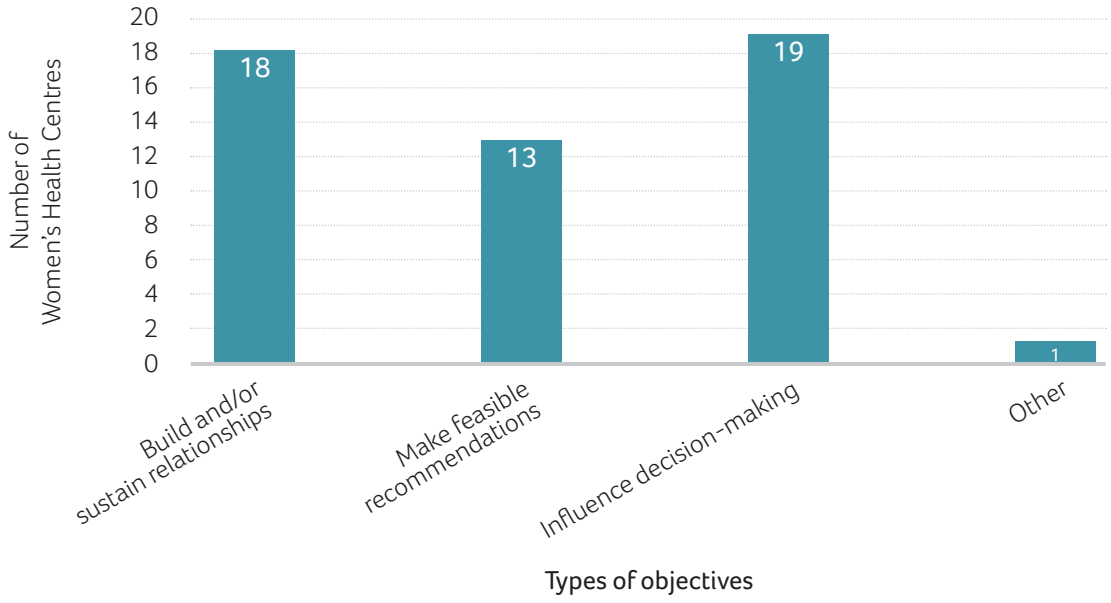


*In areas that have the capacity to affect women's health.

7.1.1 *Objectives of engagement*

Managers reported their objectives in engaging with influential people as mainly related to influencing decision-making (n=19, 95%) and build or sustain relationships (n=18, 90%), but also to make recommendations (n=13, 65%).

Figure 20: Objectives of the engagement with influential people

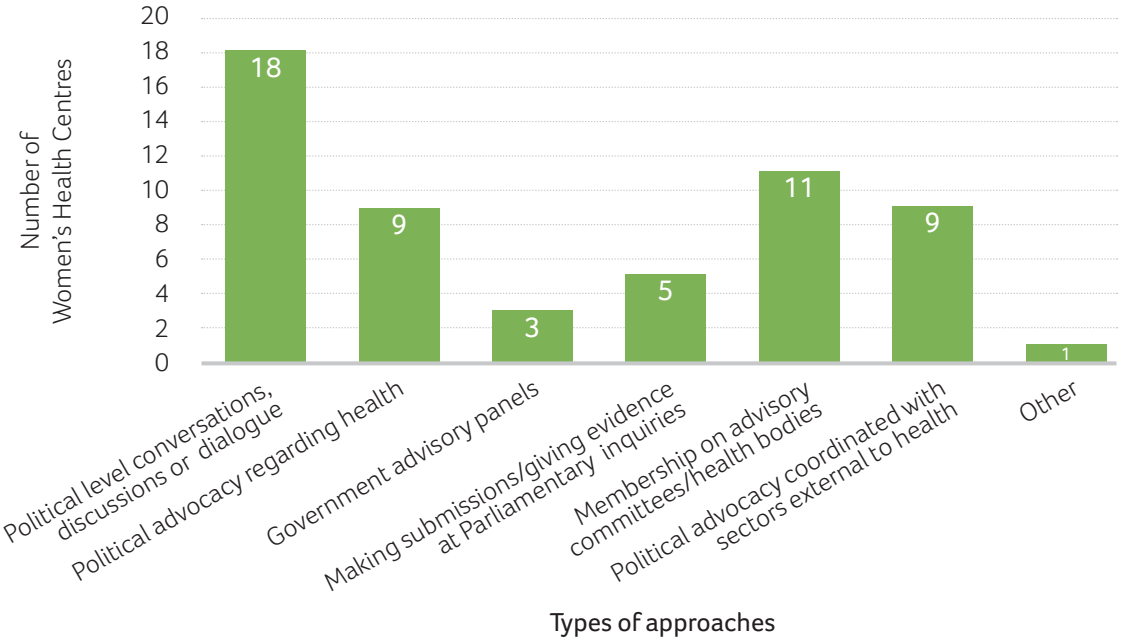


7.1.2 *Approaches involved in engaging with public and corporate institutions*

The survey asked managers about how they engaged with their local, state or federal political or policy decision-makers to challenge the inequalities associated with particular women's health issues. All managers reported that they engaged politicians and policy decision-makers in various ways including political level conversations, discussions or dialogue (n=18, 90%), membership on advisory committees/health bodies (n=11, 55%), and political advocacy* regarding factors related to women's health (n=9, 45%).

*For the purpose of this survey, 'political advocacy' was defined as delivering a tailored, strategic campaign (not just an opportunistic discussion or signing a petition).

Figure 21: Approach to the engagement with influential people



7.2 *Nature of systems advocacy involvement*

Managers reported that their WHCs both led systems advocacy initiatives (n=16, 80%) and participated in those led by other organisations (n=19, 95%). Advocacy was conducted both in an organised manner (e.g. planned in advance, and documented in strategic or business plans and/or reports) (n=16, 80%), and on an opportunistic basis (n=13, 65%).

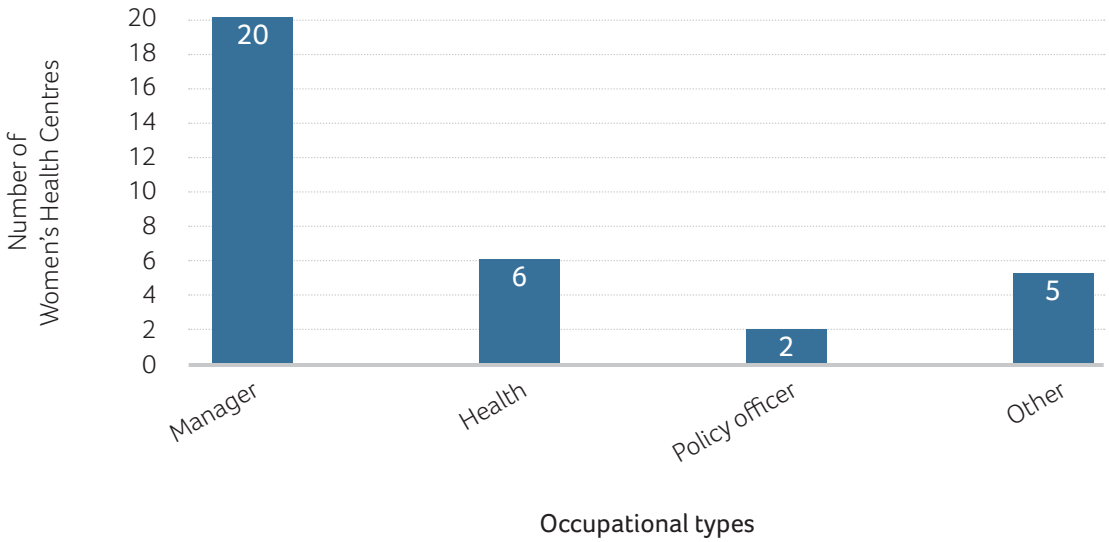
Table 8: Nature of systems advocacy involvement

Level of involvement	No. WHCs	% WHCs
Initiated and led by the WHC	16	80
Participated in an engagement led by another organisation	19	95
Opportunistic	13	65
Organised	16	80

7.3 *Occupational categories involved*

Managers were by far the most likely staff to lead systems advocacy work. However, a multi-disciplinary range of staff reportedly also played a role, including health promotion and policy officers, although to a lesser extent.

Figure 22: Occupational categories involved



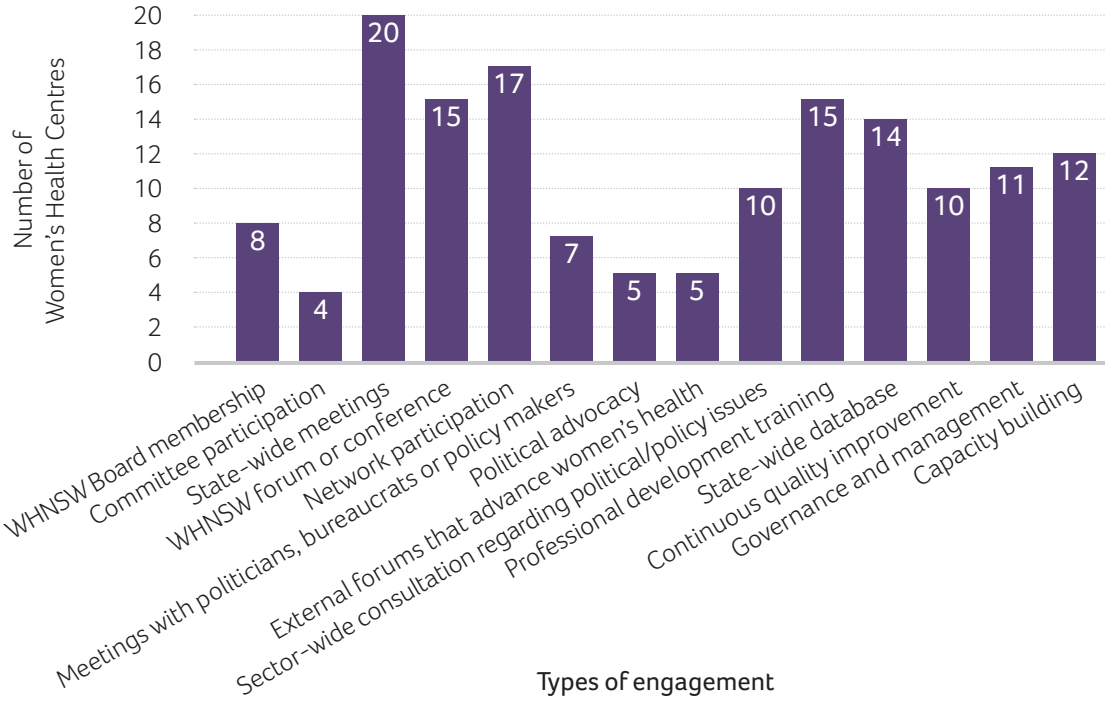
8. *Internal Sector Engagement*

All WHCs reported internal sector engagement, including interactions with the peak body, WHNSW, as well as other WHCs.

8.1 *Peak body engagement*

The majority of managers reported that they and their staff participated in numerous activities provided by the peak body, WHNSW including: state-wide meetings (n=20, 100%), network participation (n=17, 85%), professional development training or forums and conferences (n=15, 75%), and the state-wide database (n=14, 70%). Around half also participated in capacity building activities (n=12, 60%), governance and management activities (n=11), and sector-wide consultation regarding political/policy issues or continuous quality improvement (n=10, 50%).

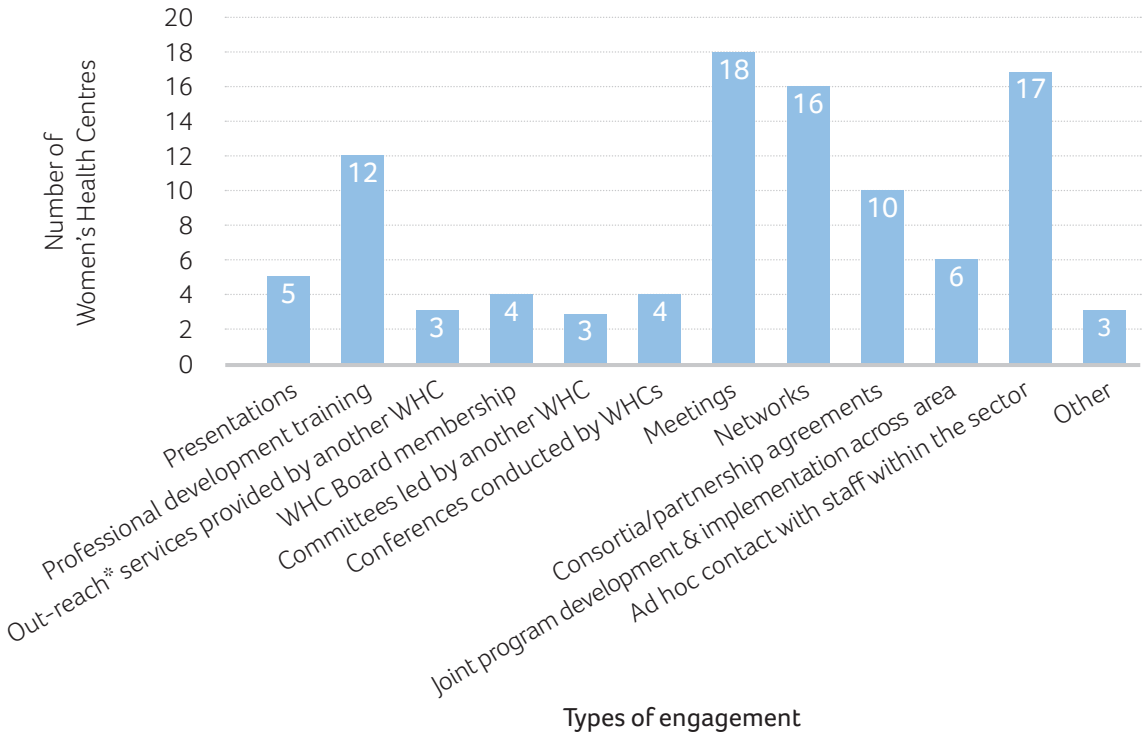
Figure 23: Peak body engagement (WHNSW)



8.2 *Engagement with other women's health centres*

Engagement with other WHCs mainly involved networking (n=16, 80%) and participation in meetings (n=15, 75%). However, it also included professional development training (n=12, 60%), and involvement in the development of consortia/partnership agreements (n=10, 50%).

Figure 24: Engagement with other Women's Health Centres



9. Discussion

9.1 The women using the services

9.1.1 Key presenting health issues and client base

Health issues related to violence and abuse, and the poor state of women's mental health and wellbeing, were the two main reasons why women attended WHCs (see Section 4.1). Managers reported a consistent picture across the sector of intensive demand for crisis support for women experiencing violence and abuse, and for services for mental and emotional health issues related to this.

This finding supports existing research that violence and abuse of women and girls, and associated mental and emotional health damage, are the most significant health challenges for women in high-income nations (e.g. 24, 26, 31, 36, 37, 38). As mentioned in the introduction, such a pattern embodies a key dimension of 'the social' in contemporary life: gender inequality and the power disparities between women and men.

A consistent picture emerged in the client-base across the sector, with WHCs prioritising women who were marginalised on the basis of not only gender, but of other social structures including class, Aboriginality and ethnicity (see Section 4.2)[7]. Accordingly, the majority of the WHS's clients were comprised of women with low incomes, Aboriginal women and women from non-English speaking backgrounds.

9.2 Integrated, coordinated service provision, embedded in a primary health care framework

Managers across the sector consistently reported a service response that prioritised the top two presenting health issues (i.e. violence and abuse, and mental and emotional health issues) (see Figure 7). Survey findings revealed that WHCs responded to these priority health issues with a multi-disciplinary suite of services, including a range of medical and psycho-social services (see Figure 12).

Pattern of complex health need

This pattern of health need supports a growing body of evidence that demonstrates that women with histories of violence and abuse often experience mental and emotional health issues, together with a range of complex health needs (e.g. 24, 26, 31, 36-43), including smoking and substance use (including alcohol), psycho-social distress and somatisation. Somatisation refers to the ways in which psycho-social stress faced by women works its way into their bodies, manifesting in a range of physical symptoms such as pain and lethargy. This psycho-social stress represents a significant health risk for women under sustained stress as research has shown that they are more likely to develop chronic diseases over their lifetimes (e.g. 12, 44). This link between psycho-social stress, somatisation and the development of chronic illness highlights the importance of a multi-disciplinary service response, including

7 The 'client-base' is not necessarily the same as the women prioritised by the WHCs (see Results, Section 4).

health education/self-management support groups (see Results, Section 5.8 and Appendix, Section 5-8), and complementary services for marginalised women (see Results, Section 5.7 and Appendix, Section 4).

Configuration of services

There is growing recognition in research and practice of the complex range of health issues faced by women with histories of violence and abuse, and that women need a coordinated, integrated, psycho-social service response to manage their stressful life circumstances (e.g. 39, 43, 45-47). An emerging body of research has uncovered a pattern of co-occurring, inter-related health needs, particularly in women exposed to multiple forms violence and abuse, thereby explaining why interventions tend to be ineffective when addressed by single services alone (e.g. 41, 48, 49). This research shows, for example, that women living with addiction tend to benefit more from integrative explanations and skills-building programs as they progress though their recovery from a history of violence and abuse.

Prevention

The early WHM described prevention in terms of a double-agenda through provision of health services, while simultaneously addressing the social circumstances of women's lives that make them sick in the first place (e.g. 3, 10, 11). Prevention was later conceptualised with reference to the *WHO Alma Ata Declaration (1978)*, which defined PHC as encompassing the need to address the fundamental conditions of and resources for health, including social justice and equity (15). Taken together, the 'social view of health', as the PHC approach is commonly referred to in the WHS (e.g. 35), translates in practice to the provision of medical and psycho-social care in combination with a focus on addressing the social determinants of health through engagement with civil society and public institutions (detailed in Sections 9.2.2 and 9.2.3, below).

'People-centred' service model

The PHC approach of the WHS is inherently 'people-centred'. This is evident in service delivery responses that address women's health needs from their perspective through core services directed to individual women or groups of women attending the WHC premises; services provided to under-served women in their local communities, or to raise the voices of women by engaging with their local communities about their health needs; and, through systems advocacy addressing public institutions, to share specialised knowledge and influence people and organisations in a position to enact social change to advance women's health.

9.2.1 Core suite of women's health centre services

The configuration of medical and psycho-social care in the WHS is grounded in the recognition of the ways in which gender shapes women's social circumstances, and how it features in their recovery. These services (see Section 5) are distinguished from the mainstream in important ways due to the feminist, PHC framework in which they are embedded. First, links between women's individual health needs and their broader social and cultural context are actively brought into focus for women, to better enable them to make decisions about their health. Second, the people-centred services provide a culture that is explicitly tailored to the gendered health needs of the women, many of whom have a history of male violence and

abuse and/or discrimination. For example, provision of a safe, welcoming, non-judgemental, woman-only space for women, which guarantees privacy and confidentiality (35).

9.2.2 *Community-based services*

A key finding of this research was the *degree* to which WHCs integrated with their local communities, the range of activities that resulted and the funding opportunities that came about through the relationships established.

WHC managers reported a number of strategies to advance women's health in partnership with local organisations, businesses and organised groups in their communities. These strategies included, (1) reaching out to particularly marginalised women known to under-utilise preventive health services, (2) engaging with groups of women regarding particular women's health issues, and (3) working with the leaders of community-based organisations to assist them in addressing organisational norms and cultural practices that perpetuate women's social inequality (see Table 7). Services emerged as multi-purpose responses because, in addition to their primary aims, they offered a range of supportive social messages to help women to take control of their health (see Section 6).

As part of this significant engagement of WHCs with their local communities, WHC staff have built extensive networks and alliances with local health and social care agencies (see Section 5.12). By working together on shared aims for advancing women's health build and maintain a high profile with their local communities.

The survey also revealed that WHC engagement and interactions with their local communities helped them to identify and access funding opportunities. This additional funding was used to expand existing services, or to fund infrastructure projects not accessible through the WHP funding received from the state (see Table 2).

While clearly useful, this funding consisted primarily of small amounts, sourced through a wide range of different organisational interests, that appear too patchy, unfocused and unreliable to support the WHS without WHP funding. The WHP funding was found to enable the WHS to leverage additional funding in a way that is sustainable.

9.2.3 *Interventions at the institutional level*

Interventions at the institutional level involved advocacy of women's health issues directed towards public institutions[8] and the influential individuals working in them (see Section 7). Two streams of activity emerged in the findings, including: (1) Engagement with influential people for the purposes of sharing women's health knowledge to raise awareness, or building and sustaining relationships (e.g. political discussions, membership on committees and health bodies), and (2) Active interventions that aimed to address the social determinants of women's health (e.g. political advocacy) (see Section 7.1.1). This involved a deliberate effort to engage decision-makers in a position to enact change to address the determinants of women's health.

8 The term '**public institutions'** refers to governments and the instruments mobilised to maintain governance and to enact change (e.g. police, local government).

9.3 *Governance and organisation*

The WHS emerged in the findings as an important site of sustained 'feminist practice', through its continuing commitment to advancing the health of women and girls. Governance and organisation of the WHS remains informed by a feminist, PHC approach, in recognition of the role gender plays in women's lives. This approach is organisationally instituted throughout the WHS, appearing in mission statements, and informing the aims and objectives, service delivery, training and development and policies regarding staff relations with the women using the services (35, 50). Practices central to this gender-specialised approach include recognition that some women are subject to *multiple forms of marginalisation* (e.g. Aboriginal women, women living with disability), *placing women at the centre of their care* (empowering women to 'take control of their health'), and *provision of a 'safe' environment* (welcoming, non-judgemental, woman-only spaces, guaranteeing women privacy and confidentiality from potential perpetrators of violence and abuse) (e.g. 35).

The peak body, WHNSW, plays a key role in sustaining and developing the WHM vision across the WHS. This commitment to feminist practice is instituted organisationally through the delivery of policy and planning, sector-wide staff training and development, and consultation between members (35). Feminist practice also determines its strategies for sector-wide activities (e.g. raising awareness of critical women's health issues and advocating for a re-orientation of the health system to better meet women's health needs) (51). Full peak body membership and strong support of sector-wide activities (52) supported this feminist commitment. This evidence of a collective 'feminist identity' supported the finding that the WHS represents a contemporary site of 'WHM activity' (see Figure 23).

9.4 *Women's health sector limitations*

Despite high levels of commitment and strategic use of limited funding through the WHP, the WHS still falls short of demand by women for their services for two main reasons. First, WHCs are concentrated along the Eastern sea-board, leaving two of the most geographically isolated regions in NSW without a WHC (including regions administered by Far West and Southern LHDs) (see Table 1). Second, even in more populous regions, the WHP funding levels have constrained the capacity for existing WHCs to meet demand for their services. The survey found that WHCs have responded to this shortfall by integrating with their local communities along common interests in order to provide additional services (seee Table 2 and Table 7).

10. *Conclusion*

What this report demonstrates for the first time, on the basis of systematic data, is that the WHS is not duplicating mainstream services, nor is it simply providing a pathway for under-served women into the mainstream system. Through its specialised approach and the ways in which it configures and delivers services, the sector provides a unique response to one of the most challenging and complex health issues faced by women and girls throughout the country: violence and abuse, and the mental and emotional damage that accompanies it. Such a response is unmatched by any other sector of health service provision and provides a foundation for the development of services needed to address one of the nation's most pressing social failures: the daily and ubiquitous threat to the health and safety of Australia's women and girls.

The PHC approach of the WHS leverages considerable gains for women from very limited resources. While much of the sector's work is in early intervention and management of women's most pressing health issues, the PHC approach means it also engages in preventive work in broader society to improve the lives of women over the long term. The continuing commitment of the WHS to WHM principles supports this approach by amplifying the voices of marginalised women and girls in civil society, in which much of the routine gender discrimination takes place. As part of this commitment, the WHS has forged close connections with marginalised women themselves, local groups and businesses with shared aims for advancing women's health, and the people and organisations in powerful positions to foster systems level change. This approach represents a significant contribution to society and value for money for health policymakers.

While evidence exists to support various components of the WHS approach to women's health, the overall model itself remains too under-researched for any claims to 'best-practice' status. However, the service delivery model is under-pinned by a significant body of expertise at the practice level. This consists of experience, skills and knowledge built up in close collaboration with women the WHS serves, as well as extensive connections forged with civil society and public institutions over the 40 years of its history. The WHS therefore represents an unique reservoir of practice knowledge, and an equally unique opportunity for further research to demonstrate the benefits of a social approach to women's health. Research into the model of service delivery and its health outcomes therefore remain untapped resources to support improved health outcomes for marginalised women in NSW and the work of WHS.

1. *Appendix: Analysis of the Core Services*

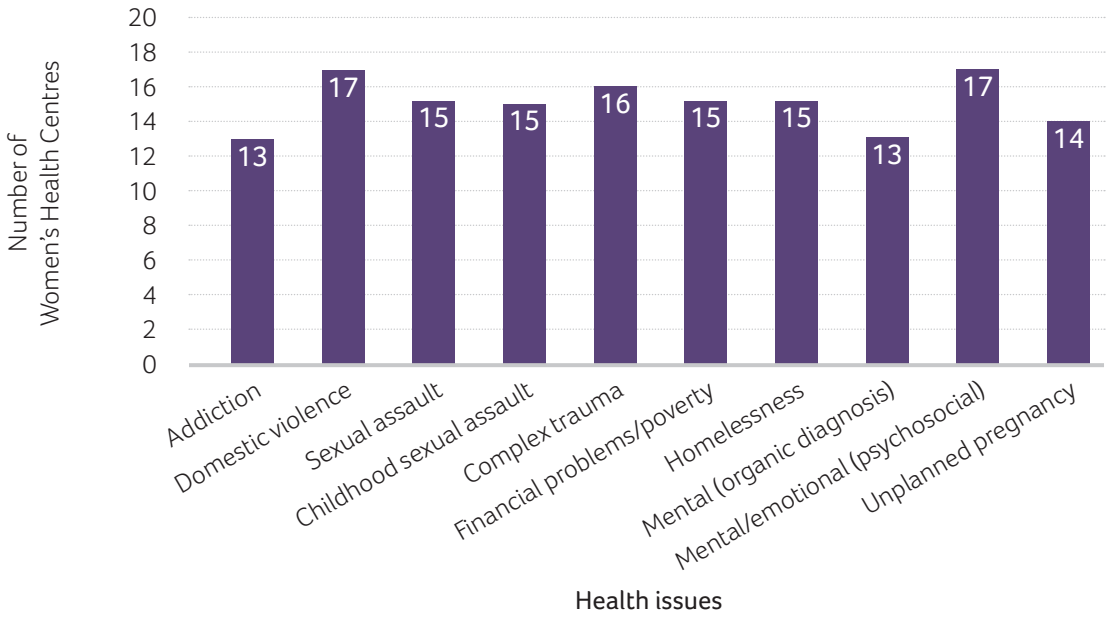
1. *Crisis support services*

Eighteen (90%) WHCs provided crisis support services (during the 2015-2016 financial year).

1.1 *Range of health issues*

The range of health issues addressed by crisis support services was similar across the WHCs, with all WHCs reporting domestic violence and mental illness presentations, with little variation across the remaining categories. Complex trauma presentations (n=16, 94%) were also common amongst WHCs, along with sexual assault, childhood sexual assault, financial problems, homelessness (n=15, 88%) and unplanned pregnancy (n=14, 82%).

Figure 1: Health issues addressed by crisis support services

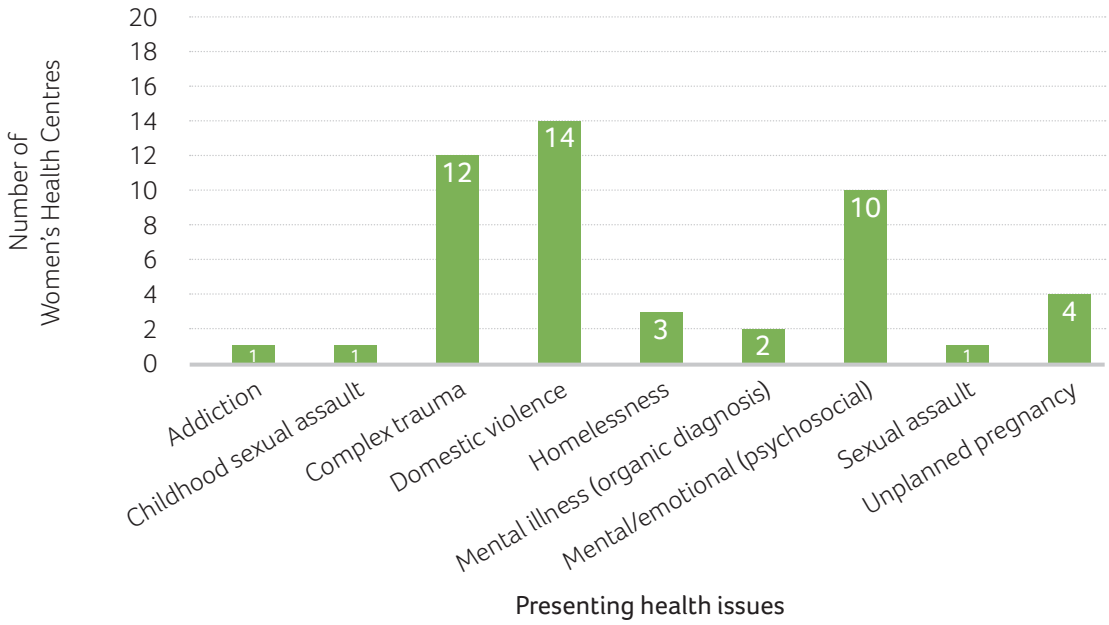


*One WHC did not provide this data, so numbers in this graph are based on n=17.

1.2 *Major presenting health issues*

When asked to indicate their top three presenting health issues to crisis support services, managers across the sector overwhelmingly reported domestic violence (n=14, 82%), complex trauma (n=12, 71%) and mental or emotional health issues (n=10, 59%).

Figure 2: Major presenting health issues to crisis support services



*One WHC did not provide this data, so numbers in this graph are based on n=17.

1.3 *Range of occupational categories involved*

Counsellors (n=9, 53%) and management staff (n=6, 35%) were typically involved in delivering crisis support services. However, a broad range of staff was also likely to be involved, including case workers, information & referral workers, and medical practitioners including doctors and nurses.

Figure 3: Occupational categories most involved in crisis support services

*One WHC did not provide this data, so numbers in this graph are based on n=17 responses.

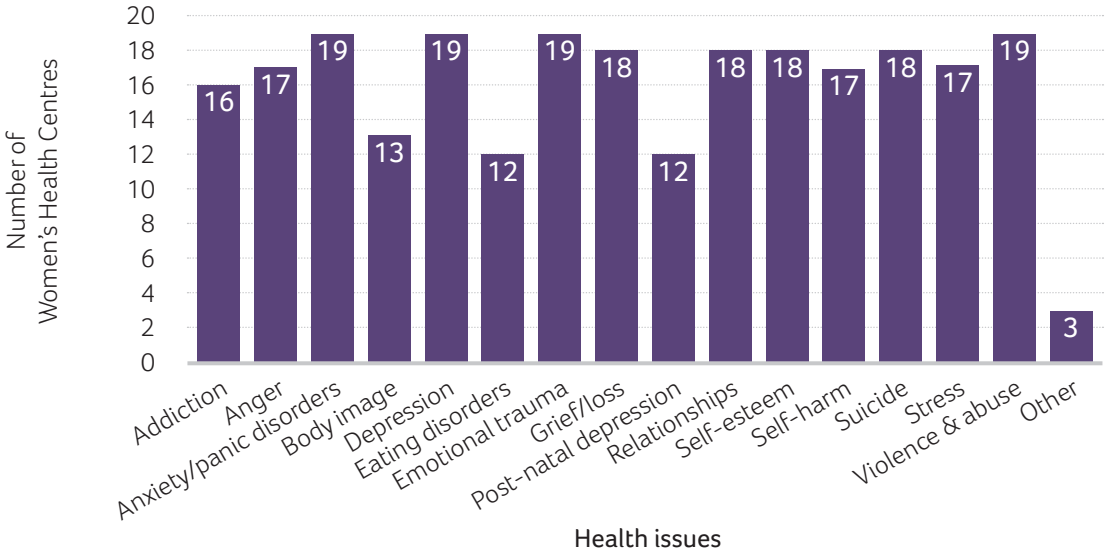
2. *Counselling services*

Nineteen (95%) of the WHCs provided counselling services.

2.1 *Major presenting health issues*

Health issues presenting to counselling services were relatively consistent across the sector, with all 19 WHCs (100%) that offered counselling reporting violence and abuse, or emotional trauma, almost all (n=18, 95%) reporting grief and/or loss, relationships, self-esteem, and suicidal thoughts as presenting health issues, and many (n=17, 89%) reporting self-harm, and stress. Eating disorders and post-natal depression also featured for over half of the WHCs (n=12, 63%).

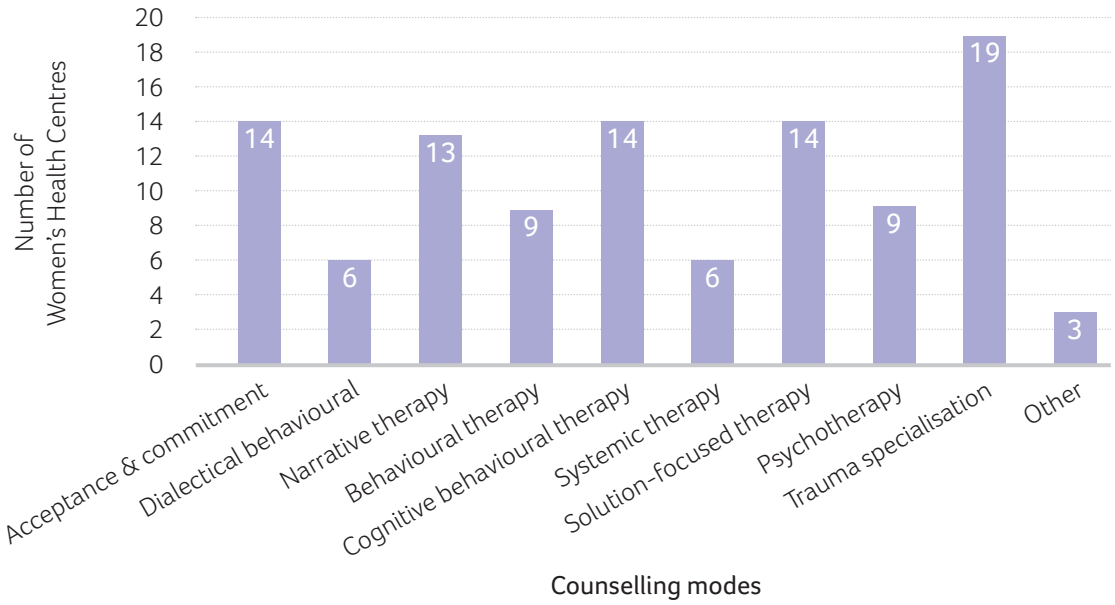
Figure 4: Major presenting health issues to counselling



2.2 *Modes of counselling*

Managers reported a wide range of counselling approaches. All WHCs provided trauma specialisation, many (n=14, 74%) reported acceptance and commitment, cognitive behavioural (CBT) and solution-based therapies. Behavioural therapy and psychotherapy were reported by almost half (47%) of the WHCs.

Figure 5: Modes of counselling provided by Women's Health Centres



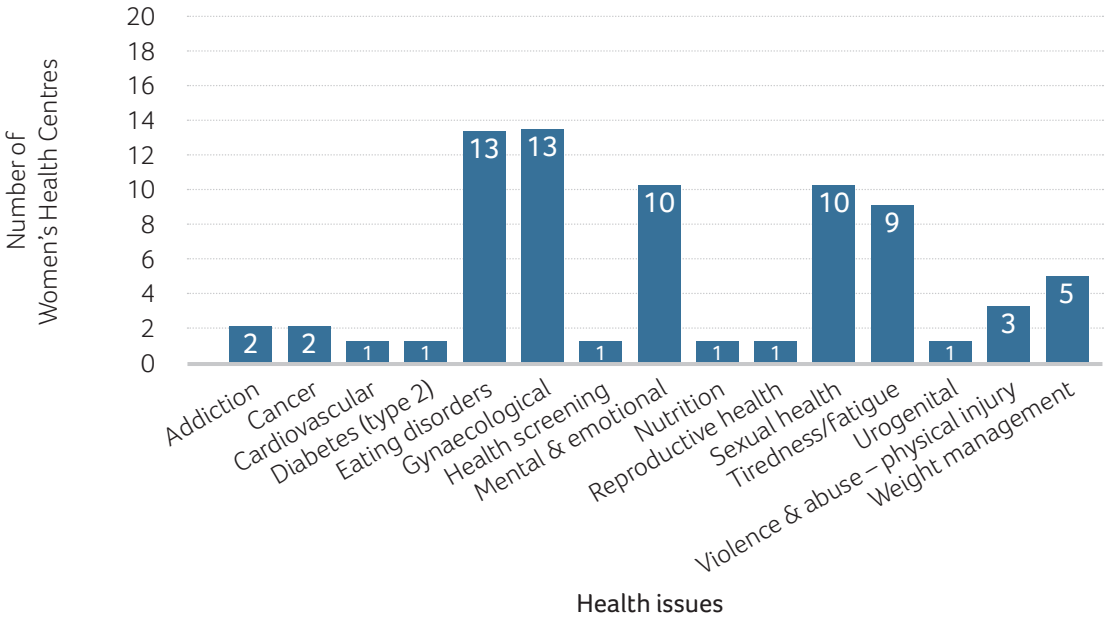
3. *Medical services*

Twelve (60%) WHCs provided medical services. However, 15 (75%) provided women's health clinics. The survey collected detailed data about the health issues addressed by women's health clinics.

3.1 *Major presenting health issues*

Most managers reported that the top five presenting health issues of their WHC included eating disorders (n=13, 87%), gynaecological health (n=13, 87%), mental and emotional health (n=10, 67%), sexual health issues (n=10, 67%) and tiredness and fatigue (n=9, 60%). A range of other women's health issues also commonly featured across the sector.

Figure 6: Health issues addressed by women's health clinics



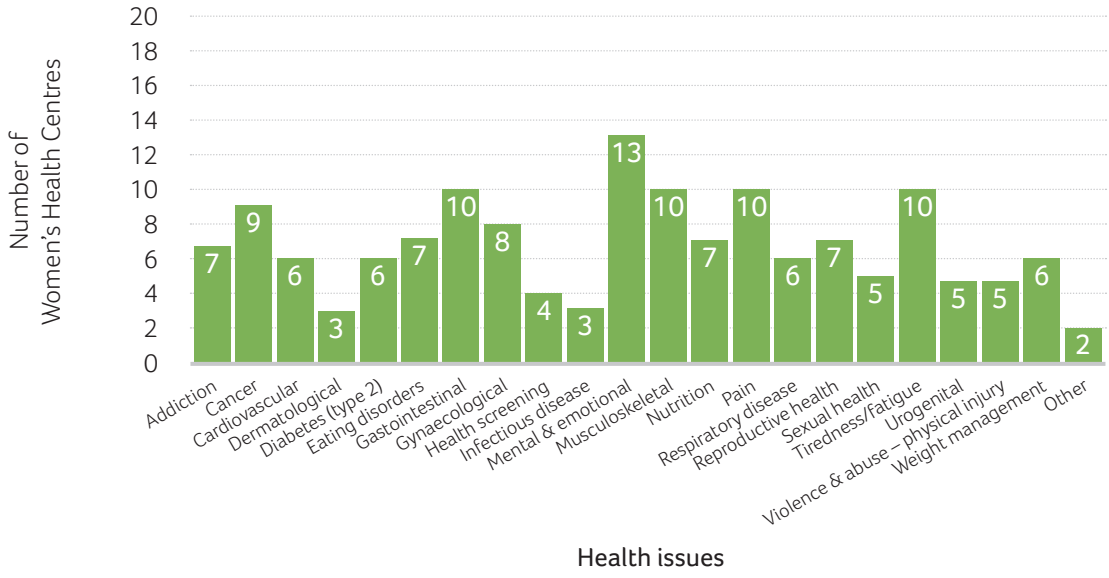
4. *Complementary medicine*

Fourteen (70%) of WHCs provided complementary medical services.

4.1 *Major presenting health issues*

Managers were asked to indicate the top five presenting health issues for their CM services. All 13* that provided detailed data about their CM services reported presentations for mental and emotional health issues, 10 (77%) reported gastrointestinal, musculoskeletal and tiredness and fatigue, nine reported cancers (69%), and seven (54%) reported presentations of addiction, eating disorders, nutritional, and reproductive health issues. The top five presenting health issues to CM services across all the WHCs were: mental and emotional (n=13), gastrointestinal (n=10), musculoskeletal (n=10), pain (n=10) and tiredness or fatigue (n=10).

Figure 7: Major presenting health issues at CM services



*One WHC did not provide data about presenting health issues, so numbers in this graph are based on n=13.

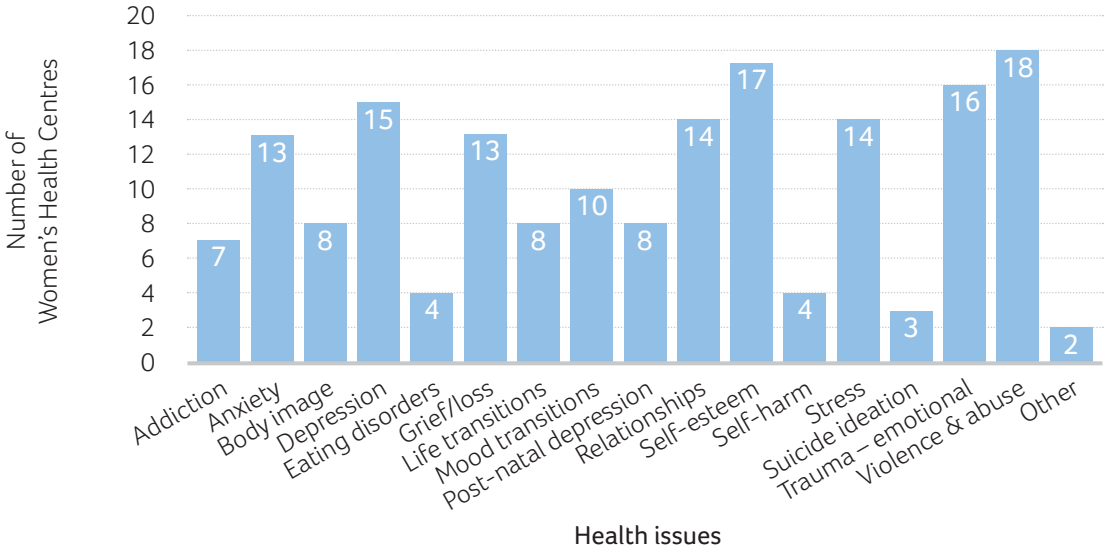
5. *Therapeutic groups*

Therapeutic groups referred to structured, multi-sessional groups led by professional counsellors (including all disciplines, e.g. psychologists, psychotherapists etc.) that aimed to support healing or management of emotional and mental health issues. All but one of the specialised WHCs (n=19, 95%) reported provision of therapeutic groups (see Results, Table 4).

5.1 *Major presenting health issues*

All 18* managers who responded to this survey question reported provision of a group to address violence and abuse. Other groups that featured included self-esteem (n=17, 94%), emotional trauma (n=16, 89%), depression, (n=15, 83%), relationships (n=14, 78%), stress (n=14, 78%), anxiety (n=13, 72%) and grief or loss (n=13, 72%). The top five presenting health issues across the sector included: violence and abuse (n=18, 100%), self-esteem (n=17, 94%), trauma (n=16, 89%), depression (n=15, 83%), and grief and/or loss (n=13, 72%).

Figure 8: Presenting health issues at therapeutic groups



*One respondent did not provide details of health issues addressed, so percentages provided are of the remaining 18 respondents.

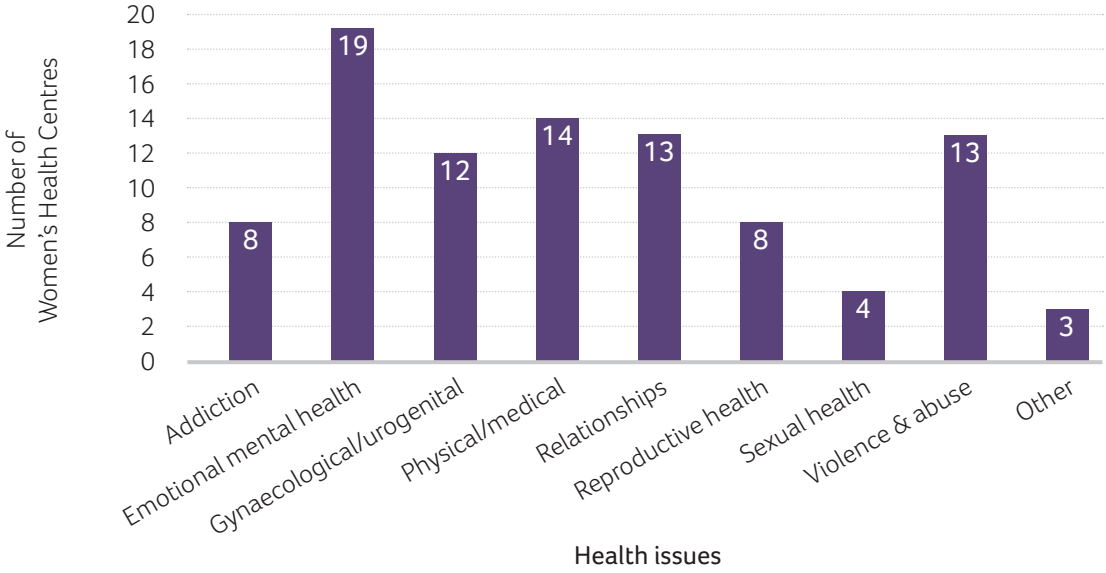
6. *Health education groups*

Health education groups were defined as those that aimed to provide health literacy and personal skills to enable women to make decisions that support their health and well-being. Nineteen (95%) WHCs offered health education groups.

6.1 *Major presenting health issues*

All WHCs provided health education groups that addressed emotional/mental health (n=19, 100%). The top five health issues across the sector included physical or medical (n=14, 74%), relationships (n=13, 68%), violence and abuse (n=13, 68%) and gynaecological/urogenital (n=12, 63%).

Figure 9: Major health issues addressed at health education groups



6.2 *Occupational categories involved in health education groups*

Counsellors were by far the most likely occupational group to facilitate health education groups (n=18, 95%), however nurses (n=12, 63%), dedicated health education/health promotion staff (n=10, 53%) and allied health or complementary medicine practitioners (n=9, 47%) were also reported in the top five most commonly involved.

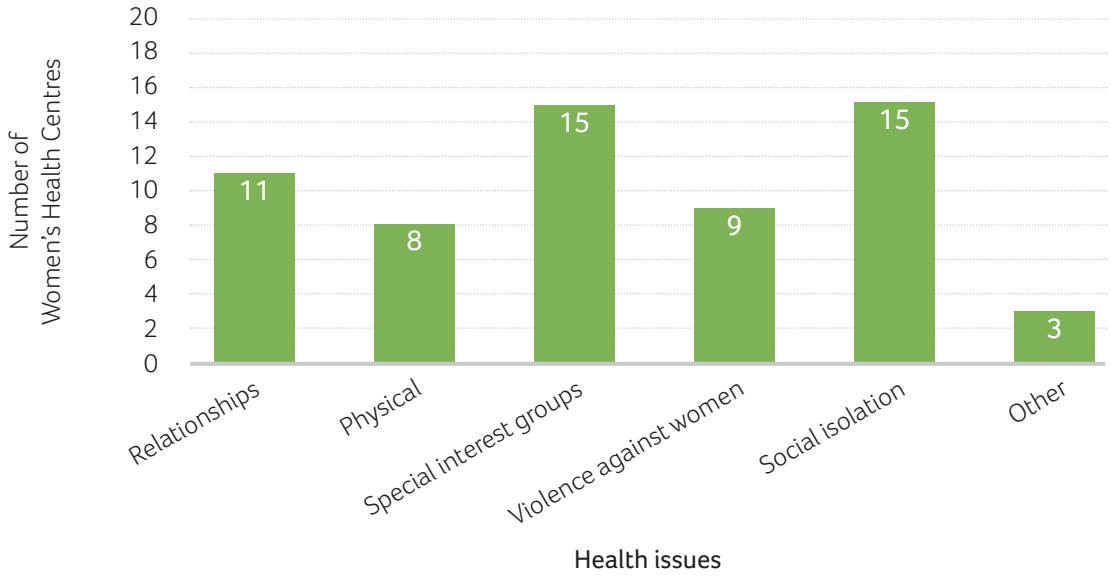
7. Support groups

Support groups aimed to provide knowledge, life-skills and social support to empower marginalised women to take control of their health. Eighteen (90%) managers reported that their WHC offered support groups.

7.1 *Major presenting health issues*

Health issues most commonly addressed included the particular needs of 'special interest groups' (n=15, 83%), social isolation (n=15, 83%) relationships (n=11, 61%), violence and abuse, and physical health (n=8, 44%).

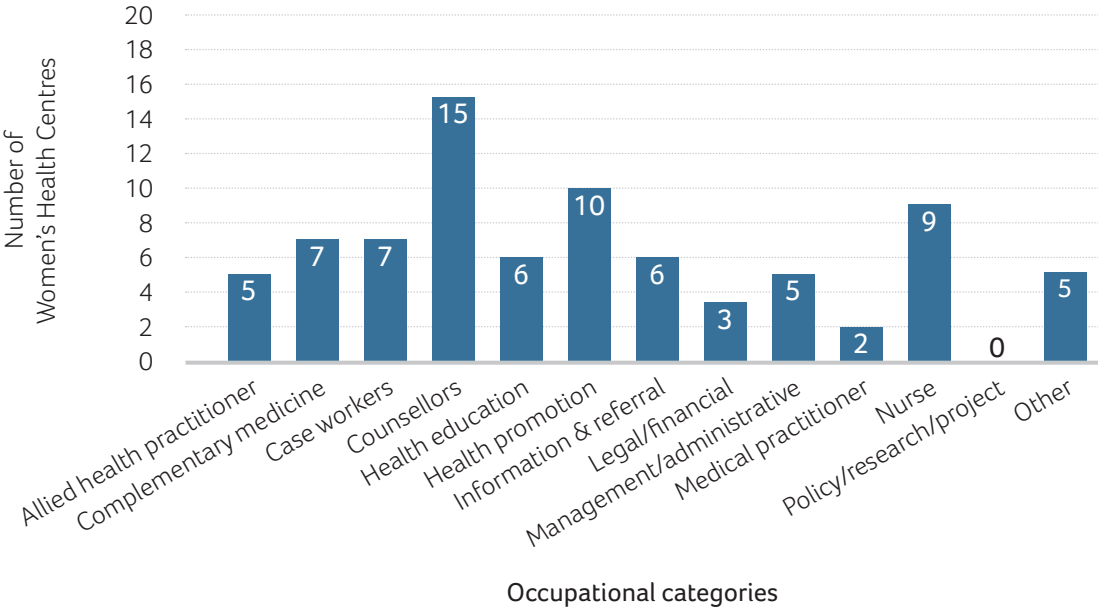
Figure 10: Major health issues addressed at support groups



7.2 *Occupational categories involved*

Counsellors (n=15, 83%) were the most likely staff to lead support groups, followed by dedicated 'health promotion' staff (n=10, 56%) and nurses (n=9, 50%), but facilitation varied widely throughout the sector across a broad range of occupational categories.

Figure 11: Occupational categories involved in delivering support groups



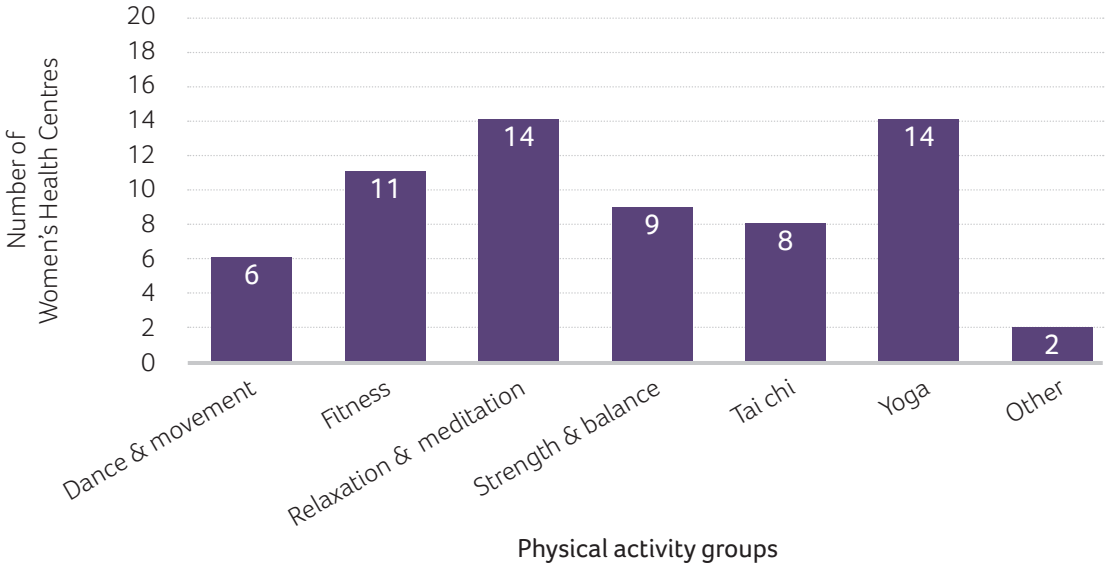
8. *Physical activity groups*

Physical activity groups encourage women to engage in physical movement to enhance their mental and emotional well-being and reduce the risk of developing chronic illnesses. Sixteen (80%) of WHCs reported that they offered physical activity groups.

8.1 *Major physical activity groups provided*

Relaxation and meditation and yoga groups were most commonly addressed across the sector by physical activity groups (n=14, 88%), followed by fitness groups (n=11, 69%) and strength and balance (n=9, 56%).

Figure 12: Major physical activity groups provided



8.2 *Occupational categories involved*

A broad range of staff were involved in delivering the physical activity groups. Dedicated health education (n=9, 56%), health promotion staff (n=8, 50%) and allied health and CM staff (n=7, 44%) were most likely to lead the groups, but nurses and external facilitators with expertise in particular areas were also involved (n=5, 31%).

Figure 13: Occupational categories involved at physical activity groups

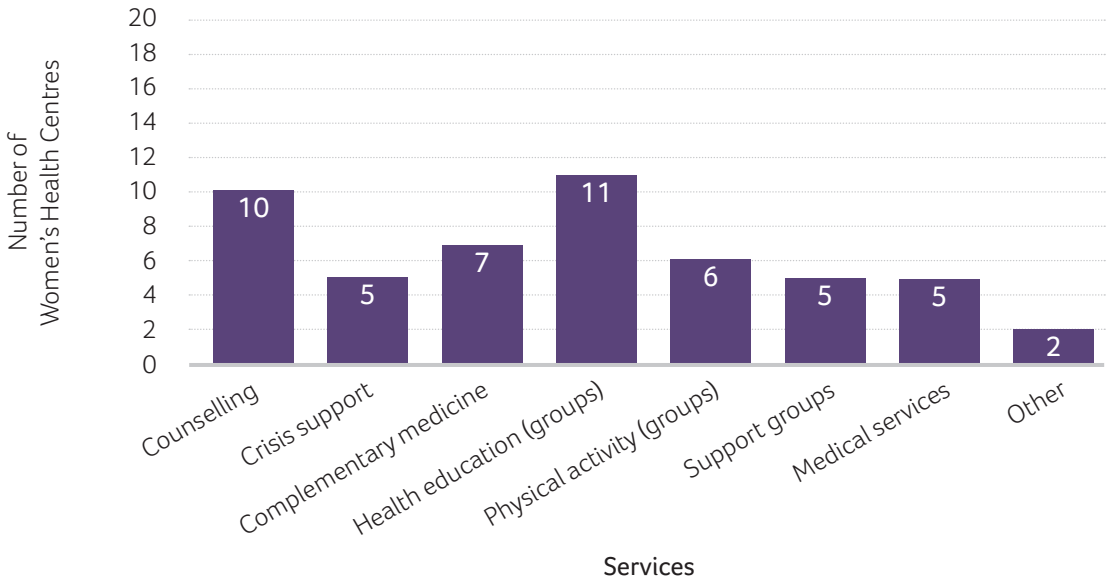
9. *Outreach services*

This question concerned outreach services[9] or WHC services delivered through staff placements or rented office spaces at external agencies to provide services to the women accessing services at that location.

9.1 *Services provided*

Fourteen (70%) WHCs reportedly provided outreach services. Most commonly service provision included health education groups (n=11, 79%), counselling (n=10, 71%), and CM services (n=7, 50%). One novel approach was through provision of a community kitchen to local communities (see Table 7).

Figure 14: Outreach services



9 We did not mean to include:

(1) *Individual practitioner/staff member* service provision without being deliberately placed by your WHC within another agency to do so (e.g. home-visiting, meeting a client at another agency);

(2) *Community education*, which targets specific population groups women or health issues in the community (e.g. sporting institutions; schools; organised groups – CALD, refugees etc.);

(3) *Professional training*, which applies specialised knowledge to provide awareness and skills training to external agencies (e.g. vicarious trauma, or gender-specific awareness training to institutions such as police, education or sporting bodies).

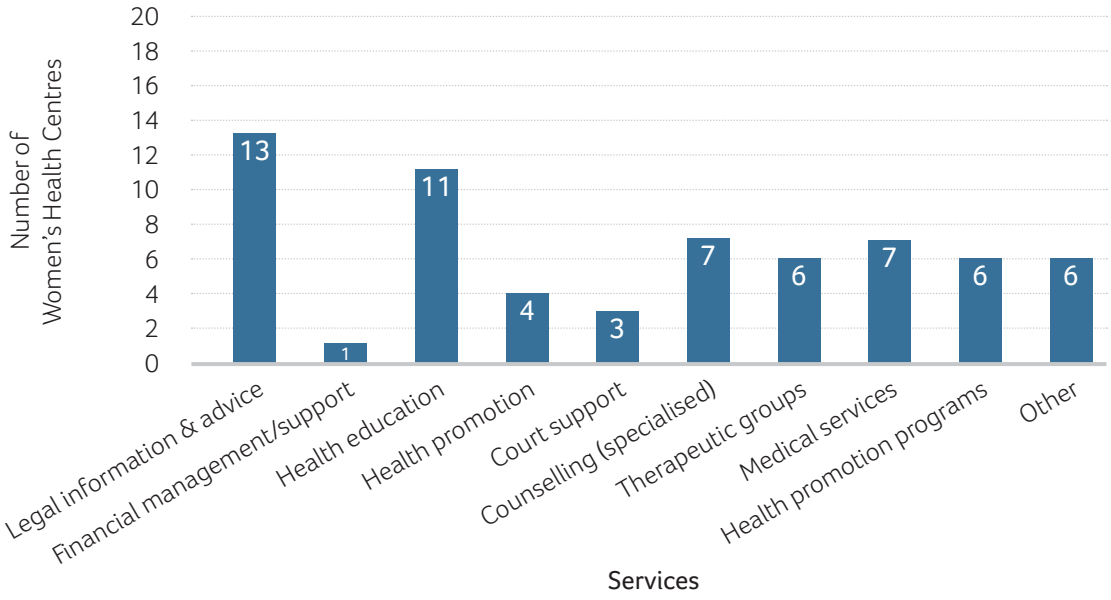
10. *In-services/in-reach services*

This question concerned in-services/in-reach services[10], or services conducted onsite at WHCs by staff of other health and social service agencies (excluding staff training or placements). Seventeen (85%) of WHCs provided in-services/in-reach services.

10.1 *Services provided*

Legal information (n=13, 75%) and health education (n=11, 65%) were most commonly provided, but adult survivors of childhood sexual assault and medical services (i.e. women's health clinics) also featured (n=7, 41%). Four of the six 'other' entries were related to violence and abuse.

Figure 15: In-services/in-reach services provided through WHCs

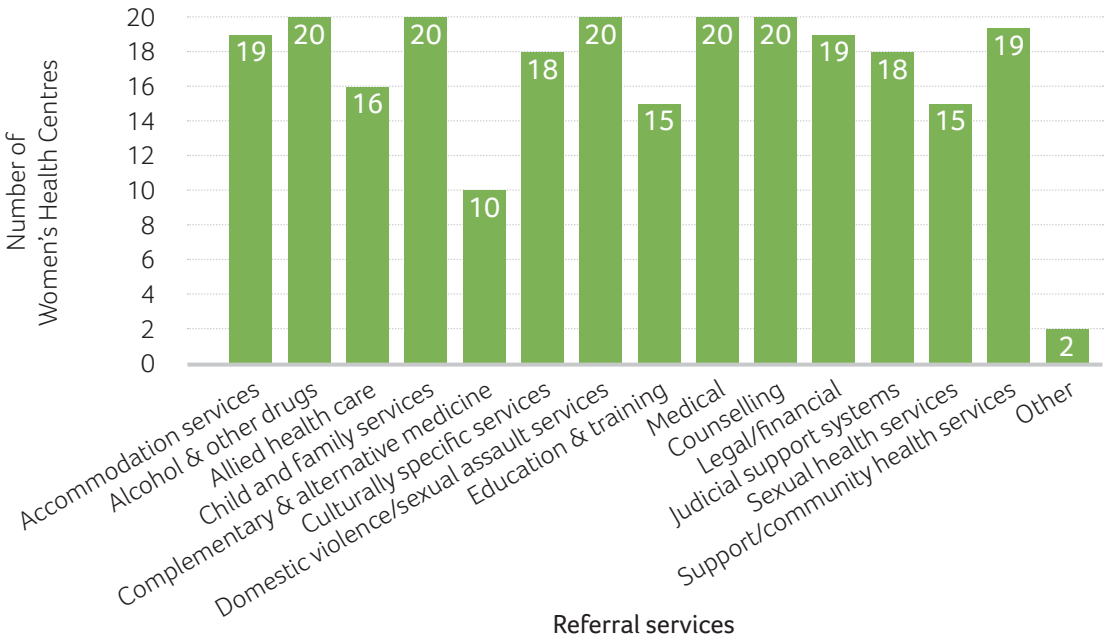


10 This did not include external agencies renting office space in the WHC. See Section 5.12, Referral services.

11. *Referral services*

The question regarding referral services was concerned with the extent to which WHC services were integrated with external health and social care agencies to advocate for additional services for women with complex care needs. All of the WHCs provided referral services. The referral services provided were relatively consistent across the WHCs, with all referring women to alcohol and other drug services, child and family services domestic violence/sexual assault services, medical and counselling services. Accommodation services, legal/financial and Support/community health services were also almost universally provided (n=19, 95%) and a range of other referral services were also reported by many of the WHCs.

Figure 16: Referral agencies engaged by WHCs



12. *References*

1. Health and Social Policy Branch PPU. Women's Health Centres in NSW Mapping Project. North Sydney NSW Ministry of Health; 2017.
2. NSW Ministry of Health. Partnerships for Health: A response to the Grants Management Improvement Program Taskforce Report March 2013. North Sydney: NSW Ministry of Health; 2013.
3. Broom DH. Damned If We Do: Contradictions in Women's Health Care. Sydney, Australia: Allen & Unwin; 1991.
4. Rawsthorne M, Howard A. Working with Communities: critical perspectives. Illinois, USA: Common Ground Publishing LLC; 2011.
5. Schofield T. A Sociological Approach to Health Determinants. Cambridge, Port Melbourne: Cambridge University Press; 2015.
6. Hamilton C, Maddison S. Silencing Dissent: How the Australian government is controlling public opinion and stifling debate. Crows Nest: Allen & Unwin; 2007.
7. Baum F. The New Public Health. 3rd ed. South Melbourne, Australia: Oxford University Press; 2008.
8. Van Lerberghe W. Primary health care: now more than ever: World Health Organization; 2008.
9. Carmel E, Harlock J. Instituting the 'third sector' as a governable terrain: partnership, procurement and performance in the UK. Policy & Politics. 2008;36(2):155-71.
10. Doyal L. What Makes Women Sick: Gender and the Political Economy of Health. Hampshire & London, UK: Macmillan Press Ltd; 1995.
11. Morgen S. Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990. New Brunswick, New Jersey and London: Rutgers University Press; 2002.
12. Marmot MG, Shipley MJ, Rose G. Inequalities in death-specific explanations of a general pattern? Lancet. 1984;1(8384):1003-6.
13. Boston Women's Health Book Collective. Our Bodies, Ourselves: A Book by and for Women. New York: Simon and Schuster; 1973.
14. Dreifus C. Seizing our bodies: Vintage Books; 1977.
15. Kickbusch I. Health promotion: a global perspective. Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique. 1986;77(5):321-6.
16. Sen G, Ostlin P. Unequal, unfair, ineffective and inefficient. Gender inequity in health: why it exists and how we can change it – Final report of the Women and Gender Equity Knowledge Network Geneva: WHO; 2007.
17. Iyer A, Sen G, Östlin P. The intersections of gender and class in health status and health care. Global Public Health. 2008;3(sup1):13-24.
18. WHO. Gender and women's mental health: The Facts 2011.
19. WHO. Gender, women and primary health care renewal: a discussion paper. WHO; 2010.
20. WHO. Gender Disparities in Mental Health World Health Organization Dependence DoMHaS; 2011.
21. Marmot MG, Smith GD, Stansfeld S, Patel C, North F, Head J, et al. Health inequalities among British civil servants: the Whitehall II study. Lancet. 1991;337(8754):1387-93.
22. Marmot MG. Status syndrome: a challenge to medicine. Jama. 2006;295(11):1304-7.
23. Weissbecker. The Impact of Violence and Abuse on Women' Physical Health: Can Trauma-Informed Treatment Make a Difference? Journal of Community Psychology. 2007;35(7):15.
24. WHO. World report on violence and health. 2002.
25. Greenan L. Violence Against Women, a literature review. Glasgow: National Group on Violence Against Women in Scotland; 2005 August 2004.
26. WHO. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: London School of Hygiene & Tropical Medicine, the south African Medical Research Council; 2013.

27. Lundy M, Grossman S. Clinical Research and Practice with Battered Women: What We Know, What We Need to Know. Trauma, Violence, & Abuse. 2001;2(2):120-41.
28. Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, et al. Lifetime Prevalence of Gender-based Violence in Women and the Relationships with Mental Disorders and Psychosocial Function. Journal of the Americal Medical Association. 2011;306(5):513-21.
29. Astbury J. Mental health: gender bias, social position, and depression In: Sen GGA, Ostlin P, editors. Engendering international health. Cambridge: MIT Press; 2002.
30. Campbell JC. Health consequences of intimate partner violence. Lancet. 2002;359(9314):1331-6.
31. WHO. WHO multi-country study on women's health and domestic violence against women. 2005.
32. Australian Institute of Health and Welfare. Rural, regional and remote health: a guide to remoteness classifications. Canberra: Australian Institute of Health and Welfare; 2004. Contract No.: AIHW cat. no. PHE 53.
33. Kurti L, Tomiczek C, Roberts S, Barki L. Mapping of NSW Women's Health Centres: Final Report. Australia: URBIS; 2017.
34. NSW Ministry of Health. NSW Health 2015-16 Annual Report. North Sydney 2016.
35. Women's Health NSW. Principles of Women's Health Care: Profiling NSW Statewide Service Provision. Leichhardt: WHNSW; 2009.
36. Garcia-Moreno C, Heise L, Jansen HA, Ellsberg M, Watts C. Public health. Violence against women. Science. 2005;310(5752):1282-3.
37. Taft A. Promoting women's mental health: the challenges of intimate/domestic violence against women. Australian Domestic & Family Violence CLEARINGHOUSE Issues Paper [Internet]. 2003; (8):[1-24 pp.]. Available from: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=234766
38. WHO. Women's Mental Health. Geneva, Switzerland: World Health Organization; 2000 2000.
39. Cocozza JJ, Jackson EW, Hennigan K, Morrissey JP, Reed BG, Fallot R, et al. Outcomes for women with co-occurring disorders and trauma: program-level effects. J Subst Abuse Treat. 2005;28(2):109-19.
40. Harris M, Fallot RD. Envisioning a trauma-informed service system: a vital paradigm shift. New Dir Ment Health Serv. 2001(89):3-22.
41. McHugo GJ, Kammerer N, Jackson EW, Markoff LS, Gatz M, Larson MJ, et al. Women, Co-occurring Disorders, and Violence Study: evaluation design and study population. J Subst Abuse Treat. 2005;28(2):91-107.
42. McNutt LA, Carlson BE, Persaud M, Postmus J. Cumulative abuse experiences, physical health and health behaviors. Annals of epidemiology. 2002;12(2):123-30.
43. Morrissey JP, Ellis AR, Gatz M, Amaro H, Reed BG, Savage A, et al. Outcomes for women with co-occurring disorders and trauma: program and person-level effects. J Subst Abuse Treat. 2005;28(2):121-33.
44. Marmot MG. Status Syndrome: How your Social Standing Directly Affects your Health and Life Expectancy. Oxford: Bloomsbury; 2004.
45. Harris M, Fallot RD. Designing trauma-informed addictions services. New Dir Ment Health Serv. 2001(89):57-73.
46. Fallot RD, McHugo GJ, Harris M, Xie H. The Trauma Recovery and Empowerment Model: A Quasi-Experimental Effectiveness Study. J Dual Diagn. 2011;7(1-2):74-89.
47. Evans K, Sullivan JM. Treating Addicted Survivors of Trauma. New York: Guilford Press; 1995.
48. Fallot RD, Harris M. The Trauma Recovery and Empowerment Model (TREM): conceptual and practical issues in a group intervention for women. Community Ment Health J. 2002;38(6):475-85.
49. Quadara A. Implementing trauma-informed systems of care in health settings: The WITH study. State of knowledge paper. ANROWS; 2015.
50. Women's Health Information Resource and Crisis Centres Association NSW. Manual of Standards for Women's Health Centres. Leichhardt: WHIRCCA; 1995.
51. Women's Health NSW. Women's Health NSW Strategic Plan 2013-2016. Leichhardt: WHNSW; 2017.
52. Women's Health NSW. Women's Health NSW Leichhardt: WHNSW; 2017 [Available from: http://whnsw.asn.au/about-whnsw.

The Women's Health Sector Model of Service Delivery in NSW Australia

Interim Report