Jean Hailes
FOR WOMEN'S HEALTH

Jean Hailes
Women's Health Survey 2017

Understanding health information needs
and health behaviour of women in Australia

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Table of Contents

About Jean Hailes for Women's Health

Who we are

Jean Hailes for Women's Health is a national not-for-profit organisation dedicated to improving the knowledge of women's health throughout the various stages of their lives, and to provide a trusted world-class health service for women.

We combine research, clinical care and practical education for women and health professionals. Our key point of difference is the translation and dissemination of research and medical evidence into easy to understand health information, delivered in multiple ways, to suit our audiences.

Our aim is to inspire confidence to create a healthier future for all women.

Founded in 1992 in honour of an extraordinary medical practitioner, Dr Jean Hailes, Jean Hailes for Women's Health reflects the enduring legacy that she made to women's health. Jean had a far-sighted vision to improve the quality of women's lives and give them practical information based on the best available evidence. She is credited with being the pioneer of menopause management in Australia.

Our guiding ethics

The mission of Jean Hailes is to be a world-class health service for women; working through research, clinical practice, translation and education to:

- **Give** women reliable and clear information to help them understand their health and the options and choices available
- **Encourage** women to take preventive steps to improve their health and wellbeing
- **Respect** the concerns, needs and choices of women
- **Build** partnerships with key groups to solve complex health problems and provide the care and information women need
- **Improve** service responses to women in Australia in sought-after yet under-represented areas, emphasising complex conditions, lifestyle factors and disease prevention
- **Develop** evidence-based guidelines and frameworks for the management of women's health, with particular attention to specific groups including older women, rural women, Indigenous women, and women from culturally diverse backgrounds
- **Educate** healthcare professionals in the prevention, early detection and management of illnesses experienced by women
- **Support** evidence-based practice by general practitioners and other health professionals working with women and their families

About the Jean Hailes for Women's Health Survey

Survey background

The 2017 Jean Hailes for Women's Health Survey was the third annual survey implemented across Australia to better understand the health information needs and behaviours of women living in Australia. This survey was developed to help inform future directions of the Jean Hailes Organisation (including the annual national Women's Health Week campaign) to better target specific health needs most relevant to Australian women as well as optimise the efficiency of information provision.

Survey aims

The Jean Hailes for Women's Health 2017 Survey had three main aims:

1. To examine the perceived gaps in women's health information identified by women
2. To identify and understand future health needs of women living in Australia as identified by women
3. To explore and understand current health knowledge and behaviours of women in Australia.

Summary of key findings

Your health

- Three quarters of women describe their overall health as ‘good’ or ‘very good’.
- Most identify as being ‘about the right weight’ or ‘slightly overweight’.

Health concerns and information needs

- Top 2 requested health topic information areas are:
  - Health eating/nutrition
  - Mindfulness.
- Women are most concerned about:
  - Menopause, bone health, breast and bowel health, and painful sex.
- Health professionals are the most trusted source of health information.
- Wikipedia and Google have been identified as regularly used forms of health information sources, greater than VIC Health and the Australian Government Health Department websites.

Mental health

- Approximately 40% of women have been professionally diagnosed with depression or anxiety.
- Women aged 18-35 years are the most anxious age group among women in Australia, experiencing ‘mild’ levels of anxiety.
- Nearly half of women report that on several days they:
  - Worry excessively about different things
  - Become easily annoyed or distracted
  - Have trouble sleeping.

Health behaviours

- Approximately 60% of women are not taking part in at least 2.5 hours of moderate physical activity per week.
- Being too tired and lack of time are the main barriers to regular physical activity.
- 95% of women are non-smokers.
- Majority of women are aware that cigarette smoking, diabetes and excess weight are risk factors for a heart attack and stroke.

Health checks and screening

- Annual GP visits range between 1-5 sessions.
- Most women prefer to see a female doctor for women’s health issues.
- Blood pressure, Pap smears, blood sugars, mammogram and skin checks are the most common health checks in the last 5 years.
- Only a quarter of women underwent a screen for sexually transmitted infections in the last 5 years.
- Nearly all women can easily attend their doctor or local health service, know where to access local healthcare, and understand information provided to them.
- Three quarters of women have time to attend health appointments.
- 83% of women feel they can afford healthcare programs.

Main report

1.0 Introduction

1.1 Survey need and translation

The Jean Hailes Women's Health Survey is an annual review of the current health behaviours, knowledge and information needs of women in Australia. Bringing to light these specific health gaps helps tailor future services and information provided by Jean Hailes to best meet the needs of Australian women and overcome their identified health needs.

1.2 Current gaps and health needs across women's health in Australia

Women currently comprise approximately 51% of the Australian population and constitute a growing proportion of the older population [(1)] experiencing a greater percentage of chronic disease and disability compared to men. [(2)] Women also report increased incidents of ill health, medical and allied health appointment attendances, and medication use. [(3)] As such, women have a large impact on national service demand and health policy development in Australia.

Many measures of health status show differences between the health of men and women. These differences result from sex-specific biological factors as well as gender based roles, behaviours and attitudes, and the environments in which they take place.

Health disparities also exist within the female population, with Aboriginal or Torres Strait Islanders experiencing poorer health outcomes across all health areas when compared to non-Indigenous women. [(4)] Furthermore, women living in rural and remote areas, from migrant or refugee backgrounds, or those with a disability also experience particular health inequities that must be addressed in order to equally improve women's health nationwide.[(5)]

The 2017 survey aimed to incorporate a greater representation of culturally and linguistically diverse groups to better inform the unique requirements of all women across Australia, as approximately 31% of Australians are born overseas, of which two-thirds are born in non-English speaking countries. [(6)] Jean Hailes understands that the needs of all women are diverse due to different languages, beliefs, culture and accessibility, impacting how, where and what services are to be provided, allowing for equal opportunity, inclusion and improved health for all women. Hence, this survey aims to identify current health information and provision needs of all women living in Australia.

2.0 Survey methods

2.1 Ethics

The study was approved by Bellberry Human Research Ethics Committee. All women who participated gave consent by opting to click 'next' after reading the plain language statement on line. Hard copies were also available through Jean Hailes medical centres across Melbourne, and verbal consent was approved for this. Consent was also implied through participation and completion of each survey.

2.2 Participants

10,586 participants took part in the survey. 209 respondents were excluded due to being younger than 18 years (n=37) and/or completing less than 10% of the survey (n=172), leaving a final study sample of 10,377 women.

Note: figures in tables are based on valid responses.

2.3 Recruitment

Participants were recruited through established Jean Hailes communication channels and community partners. Invitations to participants, accompanied by links to the survey, were published through the Jean Hailes website, social media and email updates. A diverse range of national community partners, including health, government and retail organisations, promoted and disseminated the survey Australia wide.

3.0 Report results

3.1 Participant demographics

3.1.1 Age

Respondents who met inclusion criteria were aged 18 years and older with an average age of 46.6 years. Survey results were most representative of women aged between 51 – 65 years (35.7%), followed by 36 – 50 year olds (28.0%). Women aged 80 years and older were the least represented (0.3%) (Table 1).

3.1.2 States and territories

Women completed the survey from all Australian states and territories, however majority of respondents resided in Victoria (43.7%). An increase in participation across all states was evident when compared to the 2016 survey, including Western Australia (+7%), New South Wales (+3%), Queensland (+3%), Australian Capital Territory (+2%), South Australia (+1%) and Tasmania (+1%).

3.1.3 Geographical remoteness

Geographical remoteness was classified into 5 categories. Women located in major cities comprised the greatest number of respondents (74.1%), with 1.23% reported residing in remote regions and 0.5% in very remote locations across Australia (Table 2).

3.1.4 Country/region of birth

The majority of respondents were Australian born (81.3%), followed by women born in UK/Ireland (7.8%) and Asia (3.5%) (Table 1). Of those women born overseas, 89.3% resided in Australia for greater than 6 years and only 1.3% for less than 1 year. Aboriginal and Torres Strait Islanders represented 1.4% of the sample.

3.1.5 English competency

The majority of women stated that they understood and spoke English very well (99.0%). 98.0% spoke only English at home and only 0.1% found it difficult to understand and speak English (Table 1).

Table 1: Participant demographics.

Age group (yr)	***Participants (n)***	**%**
Note: Mean age (SD) = 46.6 (14.4)		
18 – 35	2837	27.4
36 – 50	2897	28.0
51 – 65	3698	35.7
66 – 79	897	8.7
80+	33	0.3
Country/region of birth		
Australia	8379	81.3
UK/Ireland	801	7.8
Asia	362	3.5
Europe	260	2.5
New Zealand	253	2.5
The Americas	139	1.3
Africa	100	1.0
Oceania	14	0.1
Aboriginal or Torres Strait Islander	142	1.4
Years in Australia if born overseas	*n=1973*	
<1 year	23	1.2
1 - 5 years	188	9.5
> 6 years	1762	89.3
English competency		
Understand and speak English very well	10250	99.0
Understand and speak English fairly well	90	0.9
Find it difficult to understand and speak English	9	0.1
English spoken at home		
Yes	10,170	98.0

3.1.6 Education and employment

Women were typically educated at tertiary level (67.4%). A minority received a technical/trade school certificate (11.3%), whilst 14.7% identified completing high school as their highest level of education (Table 3). Employment status was classified into 6 categories, with the consideration of both paid and unpaid working duties (Table 3). Nearly half of surveyed women undertook full-time paid work (46.5%), with only 6.2% undertaking home duties on a full-time basis. Retirees comprised of 11.1% of respondents, whilst 2.0% of women were unemployed.

3.1.7 Marital status

Approximately half of those surveyed reported being married (53.2%), whilst 14.6% identified as being de facto/living together and 7.1% divorced. Of all women, 64.3% have 1 child or more (Table 4).

Table 2: Location of survey participants (n=10,377).

State	*Participants (n)*	*%*
VIC	4535	43.7
NSW	1966	19.0
ACT	586	5.7
SA	501	4.8
QLD	1220	11.8
WA	1278	12.3
NT	93	0.9
TAS	190	1.8
Geographical remoteness		
Major Cities	7659	74.1
Inner Regional	1857	18.0
Outer Regional	647	6.3
Remote	119	1.2
Very Remote	49	0.5

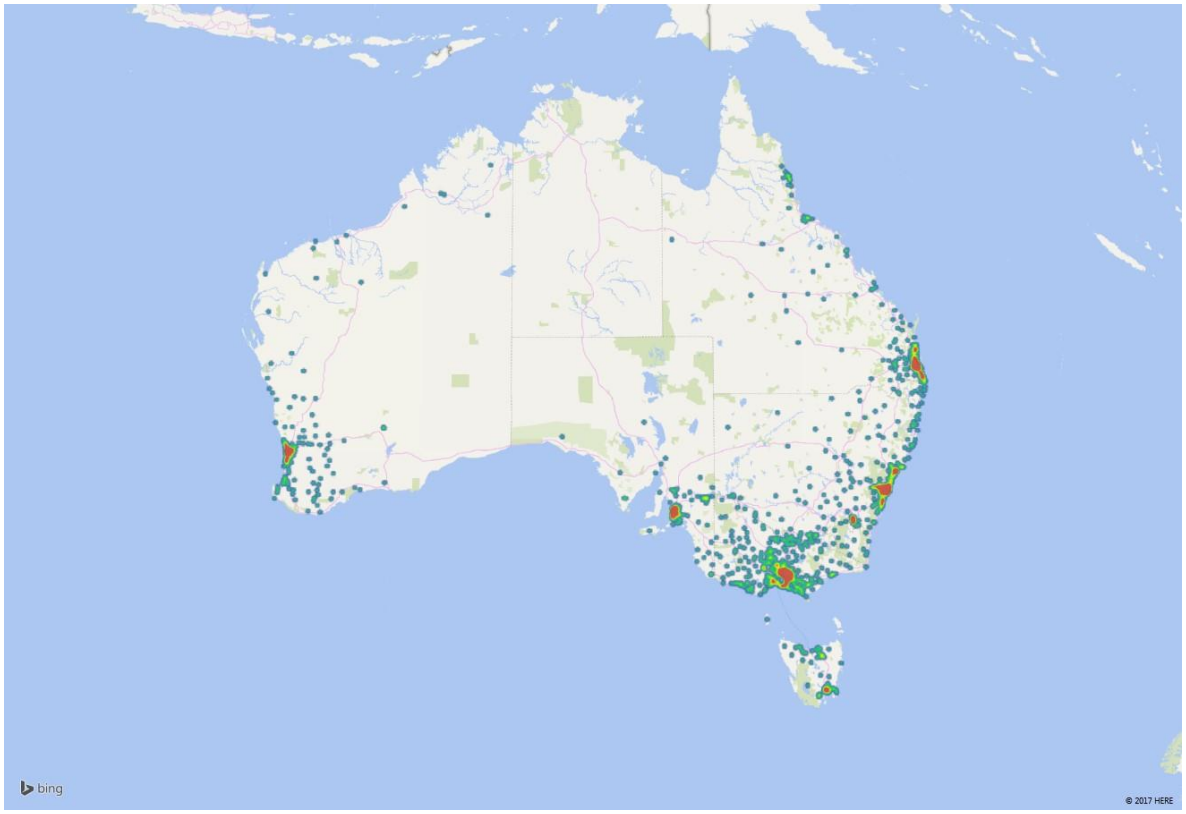

Figure 1: Location of survey participants across Australia.

Table 3: Education and employment status of survey participants.

Education Level	***Participants (n)***	***%***
Never attended school	2	-
Primary school	8	0.1
Some high school	674	6.5
Completed high School	1529	14.7
Technical or trade school certificate	1173	11.3
University or tertiary qualification	6990	67.4
Employment Status		
Full-time	4,812	46.50
Part-time	3,047	29.4
Home duties full-time	640	6.2
Student	496	4.8
Retired	1154	11.1
Unemployed	207	2.0

Table 4: Marital status and women with children.

Marital Status	*Participants (n)*	*%*
Not Married	2022	19.5
Married	5508	53.2
De facto/living together	1516	14.6
Separated	324	3.1
Divorced	734	7.1
Widowed	248	2.4
Women with children		
Yes	6667	64.3

3.2 Health of Australian women

3.2.1 Perceived health status

Table 5: Perceived personal health status.

Description of Overall Health	*Participants (n)*	*%*
Excellent	1531	15.2
Very good	4081	40.5
Good	3779	37.5
Poor	638	6.3
Very poor	49	0.5
Current Weight		
Underweight	155	1.5
About the right weight	3636	36.1
Slightly overweight	4152	41.2
Quite overweight	2123	21.1

Almost half of the participants described their overall health as ‘very good’ and their current weight as ‘slightly overweight’.

Of interest:

- Women of older age, who obtained a higher level of education, were more likely to rate themselves as being healthier than younger women who were less educated. The degree of geographical remoteness did not impact perceived overall health status.
- Women were more likely to rank themselves as being overweight if they were older or lived in a major city of Australia compared to younger women or those who lived in metropolitan areas.
- Tertiary educated females more commonly ranked themselves as being within a healthy weight range than those who were not tertiary educated.

3.2.2. Physical Activity

Table 6: Perceived completed levels of moderate physical activity per week.

At least 2.5 hours of moderate PA per week	*Participants (n)*	*%*
Yes	4631	46.0
Yes, on most weeks	2192	21.8
Yes, on some weeks	1598	15.9
No	1637	16.3

Over half of women surveyed responded as not participating in constituent moderate physical activity of 2.5 hours per week.

3.2.3 Barriers to physical activity

Table 7: Perceived barriers to physical activity.

Barriers to physical activity	*Mean**	*(SD)*
Too tired	2.7	(1.0)
Difficult to find time	2.5	(1.0)
Hard to find someone to be active with	2.5	(1.0)
Lack of motivation	2.2	(1.0)
Embarrassed about self-image when active	2.0	(1.0)
Not very good at exercise	2.0	(0.9)
The weather	2.0	(0.9)
Do not enjoy being active	1.8	(0.9)
Concerned about getting injured during exercise	1.8	(0.9)
Feel unsafe being active in the local neighbourhood	1.8	(0.9)
Not a priority	1.7	(0.8)
Limited local areas to be active in	1.6	(0.9)

* Mean score out of 10

Women identified several barriers to undertaking regular physical activity (Table 7). Being too tired was the most significant barrier, closely followed by lack of time and finding someone to be active with. The least influential barriers included a lack of recreational areas in the local community and lack of priority to be active.

Of interest:

- There was no relationship found between level of education and those who participated in higher levels of moderate physical activity.
- Older women and those living in metropolitan areas were more likely to report undertaking 2.5 hours of moderate physical activity per week.
- Geographical location was associated with physical activity. Women living in more remote regions participated in less physical activity.
- Women who did not enjoy being active were half as likely to participate in 2.5 hours of moderate physical activity per week compared to women who stated that they enjoyed physical activity.
- Marital status was not associated with engagement in regular moderate intensity physical activity among women in Australia.
- Women who reported taking part in 2.5 hours of moderate physical activity per week were more likely to know many people in their local community and have an increased overall social network compared to women who were less active.
- Participants who perceived themselves as being 'slightly' or 'quite' overweight were four times more likely to be embarrassed about their self-image when being physically active compared to women in Australia who identified as being 'about the right weight'.
- Lack of perceived safety in the local neighbourhood became more of a barrier to undertaking physical activity as local socioeconomic status reduced. Women living in areas of highest socioeconomic levels were the least concerned about their safety in their local area, less than those living in moderate areas of socioeconomic disadvantage.
- Knowledge of cardiovascular disease risk factors among participants was not associated with reported levels of regular moderate physical activity per week.

3.2.4 Physical activity according to Australian state and territory

Table 8: Women participating in 2.5 hours of moderate physical activity per week according to Australian state and territory.

	VIC	*NSW*	*QLD*	*SA*	*NT*	*WA*	*TAS*	*ACT*
Participants (n)	4535	1966	1220	501	93	1278	190	586
≥2.5 hrs moderate physical activity/week (%)	48.7	42.6	47.7	43.9	50.0	38.5	48.9	50.3

State of residence was significantly associated with overall participation in 2.5 hours of moderate physical activity per week, with Western Australian women participating in less physical activity than other states. Women residing in the Australian Capital Territory and Northern Territory were more likely to participate in 2.5 hours of physical activity (Table 8).

3.2.5 Smoking status

Table 9: Regular smoking status identified by participants.

Smoking status	*Participants (n)*	*%*
Yes	573	5.7
No	9480	94.3

The majority of participants were not cigarette smokers as only 5.7% acknowledged being regular cigarette smokers (Table 9).

3.2.6 Personal health awareness and knowledge

Table 10: Personal health awareness and health knowledge.

Personal health awareness	*Correct response (n)*	*%*
Current knowledge of blood pressure	6063	60.3
Previously diagnosed with depression or anxiety by a medical doctor or psychologist	4158	41.3
Current knowledge of cholesterol level	4112	40.8
Health knowledge regarding heart attack and stroke risk factors		
Smoking cigarettes	9180	91.1
Low blood pressure	1886	18.7
Diabetes	6983	69.3
Exercising too often	688	6.8
Being overweight	9640	95.6

Blood pressure was the most commonly known personal health measure among women, with 60% of women stating that they knew their current blood pressure.

Nearly half of participants (41.3%) reported having been professionally diagnosed with anxiety or depression (Table 10).

Overall, women were able to identify that cigarette smoking, having diabetes and being overweight are important risk factors for heart attack or stroke. However, nearly a quarter of those surveyed wrongly identified low blood pressure as a risk factor.

Of interest:

- The degree of geographical remoteness was not associated with women's knowledge of risk factors associated with heart attack and stroke.
- Education level and age were significantly associated with identifying heart attack and stroke risk factors, with older women and those holding a higher

level of education being more knowledgeable of factors than women who had not completed high school or who were younger.

3.2.7 Mental health: Experienced levels of anxiety

Generalised Anxiety Disorder (GAD) 7-item questionnaire was used to assess symptoms of anxiety in the surveyed population over the past two weeks. A score of 5, 10 and 15 are indicative of mild, moderate or severe anxiety respectively. *N=10,094*

Table 11: Experienced anxiety in the past two weeks (0 = not at all, 1 = nearly every day).

Anxiety symptom	*Mean* (SD)*				
Age (yr)	**18-35**	**36-50**	**51-65**	**66-79**	**80+**
Feeling nervous, anxious or on edge	1.0 (0.9)	0.9 (0.9)	0.7 (0.8)	0.5 (0.7)	0.4 (0.7)
Not being able to stop/ control worrying	0.9 (0.9)	0.7 (0.9)	0.6 (0.8)	0.4 (0.7)	0.3 (0.5)
Extensive worrying about different things	1.1 (0.9)	0.9 (0.9)	0.8 (0.8)	0.6 (0.7)	0.4 (0.6)
Trouble relaxing	1.1 (0.9)	0.9 (0.9)	0.7 (0.8)	0.5 (0.7)	0.5 (0.7)
Extreme restless	0.7 (0.9)	0.5 (0.8)	0.4 (0.7)	0.3 (0.5)	0.2 (0.7)
Easily annoyed/irritated	1.2 (0.9)	1.1 (0.9)	0.7 (0.8)	0.5 (0.7)	0.4 (0.6)
Afraid that something awful might happen	0.7 (0.9)	0.5 (0.8)	0.4 (0.7)	0.3 (0.6)	0.4 (0.9)

* Mean score out of 3

Table 12: Women identified as experiencing moderate anxiety (GAD summed score of 10+).

	Participants (n)	*%*
GAD-7 summed score of 10+, indicating moderate anxiety	1605	15.9

Table 13: Generalised Anxiety Disorder (GAD) score according to participant age group.

Age (yr)	*Mean* (SD)*	*Summed GAD score*
18-35	6.7 (5.3)	660
36-50	5.6 (4.8)	474
51-65	4.3 (4.4)	422
66-79	3.1 (3.5)	47
80+	2.7 (3.3)	1

* Mean score out of 21

Of interest:

- Overall mean GAD score was 5.2, indicating respondents were experiencing mild levels of anxiety.
- Approximately 16% of women were identified as being moderately anxious over the last two weeks.
- Severity of anxiety decreased with each increase in age group. Women aged 18-35 years were the most anxious age group among women in Australia, experiencing 'mild' levels of anxiety.
- Women most commonly 'become easily annoyed or irritated', 'worry too much about different things' and 'have trouble relaxing', identifying these as the 3 most common experienced symptoms of anxiety.
- Women who were older and tertiary educated were less likely to experience moderate levels of anxiety than younger, less educated women.
- Levels of anxiety did not differ according to geographical remoteness, meaning on average women living in major cities experienced the same level of anxiety as women residing in rural or remote areas of Australia.
- Women who perceived themselves as being overweight were more likely to be diagnosed with anxiety, as well as reported moderate levels of anxiety compared to non-overweight women across Australia.

3.2.8 Effect of geographical location and physical activity on overall anxiety

Table 15: Physical activity and anxiety according to each state and territory.

	VIC	*NSW*	*QLD*	*SA*	*NT*	*WA*	*TAS*	*ACT*
Participants (n)	4535	1966	1220	501	93	1278	190	586
≥ 2.5 hours moderate physical activity/week (%)	48.7	42.6	47.7	43.9	50.0	38.5	48.9	50.3
Moderate anxiety (%)	14.7	17.9	17.1	13.6	12.9	17.0	16.4	16.7
Overall GAD score mean (SD)	5.0 (4.7)	5.4 (5.2)	5.4 (5.0)	4.8 (4.4)	4.6 (4.6)	5.2 (4.7)	5.5 (5.1)	5.4 (4.8)

A greater proportion of women are active and participating in 2.5 hours of physical activity per week in the Australian Capital Territory and Northern Territory, with the least amount of women being active from Western Australia and New South Wales (Table 15). Interestingly, levels of anxiety were not associated with levels of physical activity undertaken.

Table 16: Physical activity and anxiety according to geographical remoteness.

	Regional/remote	*Major cities*
Participants (n)	2672	7659
≥2.5 hours moderate physical activity, weekly (%)	43.6	46.9
Moderate anxiety (%)	15.6	16.0
Overall GAD score mean (SD)	5.1 (4.8)	5.2 (4.8)

Women residing in metropolitan areas across Australia were more likely to participate in 2.5 hours of moderate physical activity per week than women from regional or remote areas.

3.3 Health needs of Australian women

3.3.1 Medical services

Table 17: Medical services usage and preference.

Number of annual doctor visits (for own health)	*Participants (n)*	*%*
0	444	4.6
1-2	3331	34.9
3-5	3539	37.0
6-10	1396	14.6
10+	846	8.9
Gender preference of doctor		
Female	6513	68.2
Male	61	0.6
No preference	2975	31.2
Confidence in asking questions and discussing health issues with own doctor		
Totally confident	5509	57.7
Somewhat confident	3296	34.5
Not very confident	642	6.7
Not confident at all	108	1.1

Of interest

Age was not associated with the number of times women visited doctors annually, however, their education level and geographical remoteness were significant influences. Females with a higher level of education reported less annual doctor visits than those who had not completed high school.

3.3.2 Health checks

Table 18: Health checks completed in the last 5 years.

Health check	*Participants (n)*	*%*
Bowel cancer screening	3371	36.4
Faecal occult blood test (FOBT)	1970	23.7
Breast cancer screening	4467	48.4
Mammogram/ultrasound	4979	53.6
Cervical cancer screening	2955	34.8
Pap smear	7446	79.4
Blood pressure	8799	93.3
Cholesterol	6280	68.8
Sexual health screen (STIs)	2053	23.6
Skin checks	4642	50.6
Blood sugars/diabetes	5777	63.9

The top five most common health checks undertaken in the last 5 years were blood pressure (93.3%), Pap smear (79.4%), cholesterol (68.8%), blood sugar (63.9%), and mammogram and ultrasound (53.6%). Sexual health screens were the most infrequently completed health checks within the last 5 years (23.6%) across all age groups, yet also the least requested health topic information (Table 20).

Table 19: Percentage of completed health checks within the last 5 years according to age group.

Health check	*Age group Participants n (%)*				
	18-35	**36-50**	**51-65**	**66-79**	**80+**
Bowel cancer screening	103 (4.1)	346 (13.3)	2316 (69.1)	584 (75.5)	17 (70.8)
Faecal occult blood test (FOBT)	119 (5.0)	223 (9.1)	1254 (44.4)	363 (55.7)	8 (38.1)
Breast cancer screening	280 (11.2)	952 (36.3)	2620 (78.9)	604 (79.4)	8 (33.3)
Mammogram/ ultrasound	436 (17.5)	1069 (40.7)	2825 (84.4)	634 (81.6)	10 (40.0)
Cervical cancer screening	648 (27.1)	799 (32.3)	1308 (44.9)	196 (28.9)	1 (4.5)
Pap smear	1879 (74.4)	2327 (87.0)	2736 (81.1)	492 (64.7)	4 (16.7)
Blood pressure	2177 (86.9)	2460 (92.3)	3335 (97.6)	791 (99.0)	24 (92.3)
Cholesterol	866 (36.2)	1671 (64.6)	2990 (89.5)	723 (93.4)	20 (87.0)
Sexual health screen (STIs)	1187 (47.9)	593 (23.2)	242 (8.1)	27 (4.0)	0 (0.0)
Skin checks	791 (31.9)	1251 (47.9)	2029 (62.0)	553 (72.2)	15 (60.0)
Blood sugars /diabetes	1067 43.6)	1577 (61.0)	2483 (77.1)	621 (82.9)	21 (84.0)

As expected, 51-65 year-olds reported having mammograms and/or Breast Cancer screening within the last 5 years. Pap smears were most commonly undertaken in women under the age of 65. Whilst blood pressure was the most common health check among women aged 80 years or older (Table 19).

3.3.3 Awareness of different health topics

Table 20: Most commonly requested health topic information.

Health topic	*Participants (n)*	*%*
Healthy eating/nutrition	4260	46.6
Mindfulness/meditation	4229	46.1
Sleep/fatigue	4069	44.2
Memory/concentration	3687	40.3
Weight management	3603	39.4
Stress management	3540	38.8
Physical activity/exercise	3532	38.8
Bone health/osteoporosis	3399	37.0
Natural therapies/supplements	3328	36.6
Life/work balance	3173	35.0
Menopause	2866	31.3
Bowel health	2627	28.9
Breast health	2621	28.9
Anxiety/worry	2511	27.4
Cholesterol levels	2030	22.5
Cardiovascular disease	1853	20.5
Depression	1760	19.5
Blood pressure	1696	18.7
Cancer	1671	18.5
Diabetes	1401	15.5
Polycystic ovary syndrome	1365	15.2
Painful sex	1246	13.9
Periods	1085	12.1
Endometriosis	1068	11.8
Sexuality	771	8.7
Prescription drug use	667	7.5
Falling pregnant	615	6.9
Contraception	600	6.7
IVF	529	5.9
Sexually transmitted infections	408	4.6
Illegal drug use	229	2.6
Tobacco smoking	193	2.2

As outlined in table 20, the top 5 most commonly requested health information topics by women were:

1. Healthy eating/nutrition (46.6%)
2. Mindfulness (46.1%)

3. Sleep/fatigue (44.2%)
4. Memory/concentration (40.3%)
5. Weight management (39.4%)

3.3.4 Insights into health topics that women were most concerned about.

Figure 2: Most important health topics women are most concerned about.

The top 5 health conditions that all women were most concerned about were:

1. Menopause (21.2%)
2. Cardiovascular (heart) disease (15.9%)
3. Breast cancer (10.9%)
4. Bowel health (10.7%)
5. Painful sex (7.9%)

However, when age was taken into consideration, 18-50 year-olds had significantly different health concerns:

1. Breast cancer
2. Bowel health
3. Fertility
4. Endometriosis
5. Period pain

3.3.5 Perceived reliability of health information sources

Table 21: Sources of health information identified as trustworthy and reliable.

Health information Source	*Participants (n)*	*%*
Internet search using Google or similar	4640	49.5
Government health websites	8866	95.1
Health information flyers at medical centres	8744	93.4
Health apps on mobile devices	4594	50.6
Health professionals (doctor, specialist, allied health, nurse)	9149	97.5
Social Media (Facebook, Twitter, Instagram...)	734	7.9
Independent health organisations (e.g. Jean Hailes)	8892	95.5
Commercial organisations (e.g. health insurance funds)	4892	52.8
Television shows	1918	20.6
Magazines (e.g. Women's Weekly)	1655	17.9

Health professionals, independent health organisations, government health websites, and health information flyers at medical centres were perceived as the most trustworthy and reliable sources of health information obtained by women, while social media was perceived as the least reliable source for obtaining health information.

3.3.6 Website and social media use for health knowledge

Table 22: Social media use and resources of health information.

Use of social media (e.g. Twitter, Instagram, Facebook)	***Participants (n)***	***%***
Daily	6088	66.7
Couple of times a week	1004	11.0
Occasionally (e.g. once a week)	401	4.4
Rarely (e.g. once a fortnight)	440	4.8
Not at all	1193	13.1
Preferred method to attain women's health information		
Online (e.g. websites)	4558	52.6
Videos or podcasts	427	4.9
Hardcopy print materials (e.g. brochures, booklets)	2240	25.9
Small local community talks/seminars	396	4.6
Larger group gatherings (e.g. conferences, exhibitions)	168	1.9
Online group forums (e.g. webinars)	111	1.3
Social media (e.g. Facebook)	442	5.1
Telephone contact	111	1.3
Apps (on mobile devices)	209	2.4
Method used most to access health information on line		
Mobile phone	3443	38.0
iPad (or similar device)	2369	26.1
Desktop or Laptop	3153	34.8
Other	99	1.1

Participants identified with common use of social media (e.g. Twitter, Instagram and Facebook) in everyday life. Accessing women's health information on line and through hardcopy printed materials were identified as most preferred, whilst telephone contact and online group forums (e.g. webinars) were equally the least preferred method among women. Mobile phone, followed by desktop or laptop, were outlined as the most desired methods to access health information on line (Table 22).

Table 23: Top 10 most commonly used websites to source health information.

Ranking	*Website*
1	Better Health Channel
2	Jean Hailes for Women's Health
3	Mayo Clinic
4	Women's Health
5	Wikipedia
6	Google
7	Web MD
8	VIC Health
9	Health Direct
10	Health.gov

The Better Health Channel was the most popular website used to source health information by women across Australia, followed by Jean Hailes for Women's Health and the Mayo Clinic. Of concern, Wikipedia and Google were identified as regularly used forms of health information sources to a greater extent than VIC Health and the Australian Government Health Department website (Table 23).

3.3.7 Preferred information sourcing

Table 24: Percentage of participants outlining preferred information sourcing according to age group.

Method	*Age group, %*					
	18-35	**36-50**	**51-65**	**66-79**	**80+**	**Total**
Non-online	20.59	29.12	41.94	56.63	65.00	33.64
Online	79.41	70.88	58.06	43.37	35.00	66.36

Of interest:

- Age and education significantly influenced the preferred method of accessing health information. Women who were younger or tertiary educated preferred to receive health information through online methods (e.g. health mobile applications, websites and social media) whilst non-online methods (e.g. health professionals, independent community health organisations and flyers) were preferred by women of older age groups, or by women who had not finished high school or were non-tertiary educated but finished high school (Table 24).
- Awareness and knowledge of where to access health services (e.g. family planning, child health centres) and where to access reliable information on chronic disease, did not differ between women born in or out of Australia. Yet Australian born women were more likely to know where to find reliable information on mental health.

3.3.8 Barriers to accessing healthcare

Table 25: Access to healthcare.

Prompts	*Positive responses (n)*	*%*
Attending appointments for health checks	6534	71.4
Access to a doctor or health services	8107	88.6
Access health services such as family planning and child health centres	7411	81.0
Attending health programs or receiving health services in the local community	7573	82.7
Discussing health issues with doctor	8399	91.8
Understanding information provided by doctor	8859	96.8
Using technology such as computers, digital tablets, mobile phones	8842	96.6
Enough time to exercise	5395	58.9
Access to reliable information on heart disease	7467	81.6
Access to reliable information on mental health	7806	85.3
Friends in the local community	5815	63.5
Knowledge of those in the local community	5796	63.3

As outlined in Table 25, approximately 60% of women did not find enough time in their day to engage in daily physical activity. Approximately 35% of women identified as not having many friends or knowing a lot of people in their local community, which might be a barrier to accessing healthcare.

Most women felt comfortable using technology such as computers, digital tablets and mobile phones to access their health information as required. Upon visitation to their local general practitioner, allied health professional or medical specialist, most women outlined that they understood most of the information provided to them, and felt comfortable discussing their health issues. Approximately 20% of women were unaware of where to access health services (such as family planning and child health centres), and couldn't afford to attend health programs or receive health services.

Of interest:

- Being of Aboriginal or Torres-Strait Islander descent did not influence a women's ability to afford and attend health programs or receive health services in their local community.
- Age had a significant impact on the ability to access and afford local health services and programs, with women aged 18 – 35 years being the least likely to afford healthcare compared to all other age groups.
- Women found it much harder to access health services if they did not live in a major city.

3.3.9 Women's health issues

Table 26: Top 5 most important health issues currently impacting the health of women aged 18+ years.

Ranking	*Health Issue*
1	Cancer
2	Mental Health (anxiety and stress)
3	Weight (weight management)
4	Obesity
5	Depression

Figure 3: Top 5 most identified important health issues impacting women's health at present.

3.3.10 Behaviour changes to improve overall personal health

Table 27: Top 5 behaviour changes identified by women that should be done to improve their personal health.

Ranking	*Behaviour Change*
1	Exercise
2	Lose weight
3	Consume a more nutritious diet
4	Rest, relax and worry less
5	Have more time to myself (by working less)

Figure 4: Top 5 behaviour changes to improve women's current status.

3.4 Awareness of Jean Hailes for Women's Health Foundation

Table 28: Sources used to raise awareness of Jean Hailes.

	Participants (n)	*%*
Knowledge of Jean Hailes prior to survey completion	4036	44.1
Sources used for Jean Hailes awareness		
Doctor / Specialist at Jean Hailes	514	12.7
Flyer / pamphlet	859	21.3
Podcast / Webcast	230	5.7
Conference presentation	409	10.1
Website	1542	38.2
Friend/family	797	19.7
Jean Hailes Resource provided by General Practitioner	389	9.6
Social media	589	14.6
Colleague / workplace	1014	25.1
Email	624	15.5

Nearly half of the surveyed participants were aware of Jean Hailes prior to completing the survey. The Jean Hailes website (38.2%), a colleague/workplace (25.1%), and use of a flyer/pamphlet (21.3%) were the top 3 resources reported to alert women about Jean Hailes and the services it provides.

Survey Limitations

It must be noted that there were several limitations associated with this survey.

Firstly, participants must have been literate in English in order to complete the survey, unless interpreters were available at the time of completion (which were not provided or funded by Jean Hailes). Additionally, the completion of this survey on line would have required additional computer literacy skills, implying further restriction on the sampled population.

Finally, participants who consented to take part were more likely to be more motivated, health conscious and aware of their health needs, and hence the results of this survey may not necessarily represent the health needs and status of women in the general Australian population.

Future studies recommend an equal proportion of online and paper-based surveys that are available in several languages other than English, with access to a reliable interpreter when required to improve the diversity and representation of the sampled population.

Conclusions/Future Directions

This survey has provided a greater understanding of the health information needs and health behaviour of women in Australia. The health needs of different life stages have been highlighted in the results. For example, women over the age of 50 had different health concerns and also different ways that they would like health information delivered as compared to those aged 18-35 years. This suggests a need for tailoring of information and delivery across life stages.

An important finding was that women seemed to be knowledgeable overall in relation to the risk factors associated with conditions such as cardiovascular disease. However, the majority of women were not participating in recommended levels of physical activity each week and were finding it difficult to maintain a healthy weight. This suggests the need to support women to make healthy choices and change lifestyle behaviours where required. The survey findings related to the barriers women face in being physically active and accessing health care will inform the development of strategies to support women to better enable behaviour change.

Another important finding highlighted the need for better support among women for the prevention and management of depression and anxiety, particularly in the 18-35 year old age range. Women acknowledged the need for support to manage their anxiety as evidenced by one of the survey's most commonly requested health topics: mindfulness and meditation.

Finally, although cancer was highlighted as a major concern for women, it is interesting that women did not recognise cardiovascular disease as a major health concern, considering that this chronic disease is the major cause of mortality in women in Australia. However, women were able to identify several modifiable risk factors for cardiovascular disease, such as smoking and high cholesterol levels, and identified the need for support to make positive changes to their own lives.

Overall, women in Australia have identified several key areas for future focus, including the need for support for behaviour change where required.

APPENDIX

Appendix A: GAD-7 survey questionnaire and responses according to age group as experienced in the previous two weeks

	Participants n (%)				
	18-35	**36-50**	**51-65**	**66-79**	**80+**
Feeling nervous, anxious or on the edge					
Not at all	806 (29.6)	1042 (36.8)	1705 (47.1)	501 (58.5)	21 (70.0)
On several days	1318 (48.3)	1325 (46.8)	1491 (41.2)	298 (34.8)	7 (23.3)
More than 7 days	308 (11.3)	242 (8.6)	212 (5.9)	30 (3.5)	1 (3.3)
Nearly every day	295 (10.8)	220 (7.8)	214 (5.9)	28 (3.3)	1 (3.3)
Not being able to stop or control worrying					
Not at all	1129 (41.4)	1412 (49.9)	2092 (57.8)	546 (63.7)	23 (76.7)
On several days	1034 (37.9)	1005 (35.5)	1154 (31.9)	265 (30.9)	6 (20.0)
More than 7 days	310 (11.4)	198 (7.0)	195 (5.4)	26 (3.0)	1 (3.3)
Nearly every day	254 (9.3)	214 (7.6)	180 (5.0)	20 (2.3)	0 (0.0)
Worrying too much about different things					
Not at all	703 (25.8)	938 (33.2)	1478 (40.8)	447 (52.2)	19 (63.3)
On several days	1281 (47.0)	1350 (47.7)	1658 (45.8)	348 (40.6)	9 (30.0)
More than 7 days	408 (15.0)	291 (10.3)	264 (7.3)	42 (4.9)	2 (6.7)
Nearly every day	335 (12.3)	250 (8.8)	221 (6.1)	20 (2.3)	0 (0.0)
Trouble relaxing					
Not at all	790 (29.0)	940 (33.2)	1625 (44.9)	475 (55.4)	17 (56.7)
On several days	1240 (45.5)	1337 (47.3)	1507 (41.6)	329 (38.4)	11 (36.7)
More than 7 days	403 (14.8)	313 (11.1)	288 (8.0)	31 (3.6)	1 (3.3)
Nearly every day	294 (10.8)	239 (8.4)	202 (5.6)	22 (2.6)	1 (3.3)
Being so restless that it is hard to sit still					
Not at all	1455 (53.4)	1799 (63.6)	2586 (71.4)	672 (78.5)	26 (86.7)
On several days	860 (31.5)	749 (26.5)	771 (21.3)	155 (18.1)	2 (6.7)
More than 7 days	268 (9.8)	177 (6.3)	176 (4.9)	21 (2.5)	1 (3.3)
Nearly every day	143 (5.2)	104 (3.7)	89 (2.5)	8 (0.9)	1 (3.3)
Becoming easily annoyed or irritated					
Not at all	621 (22.8)	725 (25.6)	1596 (44.1)	492 (57.4)	19 (63.3)
On several days	1315 (48.2)	1451 (51.3)	1580 (43.6)	311 (36.3)	9 (30.0)
More than 7 days	490 (18.0)	424 (15.0)	294 (8.1)	36 (4.2)	2 (6.7)
Nearly every day	301 (11.0)	229 (8.1)	152 (4.2)	18 (2.1)	0 (0.0)
Feeling afraid as if something awful might happen					
Not at all	1500 (55.0)	1822 (64.4)	2536 (70.0)	658 (76.8)	24 (80.0)
On several days	768 (28.2)	708 (25.0)	813 (22.4)	163 (19.0)	3 (10.0)
More than 7 days	276 (10.1)	178 (6.3)	158 (4.4)	20 (2.3)	1 (3.3)
Nearly every day	183 (6.7)	121 (4.3)	115 (3.2)	16 (1.9)	2 (6.7)

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