

**GIPPSLAND
WOMEN'S
HEALTH**



HEALTHY WOMEN HEALTHY GIPPSLAND

*The State of Women's
Health and Safety
in Gippsland*



2025 REPORT CARD

Authors:

Kate Johnston-Ataata¹

Kate Graham¹

Lauren Zappa²

Bec Steinhoff¹

Hayley Mitchell¹

¹Gippsland Women's Health

²Lauren Zappa Consulting

Enquiries:

Kate Graham

Chief Executive Officer

Gippsland Women's Health

Suite 6

81 Queen Street

Warragul VIC 3820

Suggested citation:

Johnston-Ataata K, Graham K, Zappa L, Steinhoff B and Mitchell H. (2025) *Healthy Women, Healthy Gippsland – The State of Women's Health and Safety in Gippsland 2025 Report Card*. Gippsland Women's Health. Warragul. Victoria.

Design: Gippsland Women's Health Communications team – Eryn Levey, Elissa Duck and Alex Brown

© Gippsland Women's Health 2025 Suite 6, 81 Queen Street,
Warragul Victoria 3820, Australia admin@gwh.asn.au

Published November 2025

Disclaimer: Every effort has been made to ensure the information contained in this publication is accurate and current at the date of printing.



GWH acknowledges
the support of the
Victorian Government



ACKNOWLEDGEMENTS

Acknowledgement of Country

Gippsland Women's Health acknowledges Aboriginal and Torres Strait Islander people as the Traditional Owners of Country and pay our respects to Elders past and present. We acknowledge the Gunaikurnai, Bunurong, Bidwell, Ngarigo Monero and Jaithmathang as the Traditional Owners of the land and waters now known as Gippsland and acknowledge that they have never ceded sovereignty.

Acknowledgement of Victim-Survivors of Gendered and Family Violence

Gippsland Women's Health acknowledge and pay respects to the women, gender diverse people and children who have died as a result of gendered and family violence and those who continue to live with violence.



Acknowledgement of Contributors

This report would not have been possible without the support and contributions of many people. Gippsland Women's Health (GWH) would like to thank the 197 women and gender diverse people from across Gippsland who shared their experiences, perspectives and insights via the *Healthy Women, Healthy Gippsland* online survey and focus groups. We would also like to thank the organisations who assisted with the focus groups, including YooWINna Wurnalung Aboriginal Healing Service, Wonthaggi Neighbourhood House, Distinctive Options Noweyung, and Sale Neighbourhood House. Thanks also go to our four key informants Kim Adams, Catherine Bateman, Andi Connell and Susanne Lampitt for their insightful contributions.

Many people and organisations provided support, advice and assistance to the project including providing access to data, advertising the online survey and focus groups, and providing background context. These include staff working on municipal health and wellbeing plans in all 6 Gippsland local government areas (LGAs), Jenny Ward, Evidence and Analysis Officer, Women's Health Victoria, staff from Gippsland Region Public Health Unit (GRPHU) and Gippsland Primary Health Network (GPHN), Federation University's Collaborative Evaluation and Research Centre (CERC), Tiana Felmingham, Dr Nicolette Snowden, Jackson Fairchild and Matt Healy. Appreciation is also extended to our external reviewers Equity Economics and special thanks to Dr Julia Heslop and Hayley Sestokas for their contributions.

At GWH, almost every staff member contributed to the project in a myriad of invaluable ways – everything from helping with recruitment of participants to data analysis to designing, reviewing and proof-reading the report.

Finally, GWH would like to thank the Victorian Government for their funding support and support for the health and safety of all Victorian women and gender diverse people.

First Nations imagery disclaimer

Aboriginal and Torres Strait Islander readers are advised that this publication may contain images of people who have passed away. Viewer discretion is advised.

Some images in this report feature places of cultural and spiritual significance to First Nations Peoples, including sites such as the Den of Nargun, Tarra-Bulga National Park, Wilsons Promontory National Park and Mount Baw Baw. We acknowledge and respect their ongoing cultural importance. .

Photographer Credits

Eryn Levey

Via Unsplash:

Zoe Askew, Billy Joachim, Damien Tait, Max Smith, Jesse Bauer, Weo Ping Khoo, Myrtle Schilling, Beth Hope, Pat Whelen, Troy Mortier, Ashwin Vaswani, Andra C Taylor Jr and CDC

Via Canva Pro:

Chris Putnam, Mailson Pignata, Wayne Quilliam, Annakraynova, RDNE Stock project, Tharg, Halfpoint, Merrysky, Crystal Sings, Jayden Becker, Vikki Marshall and Karola G

Via Flickr:

Richard Leonard Words & Pictures

Via Pexels:

Richard Pan, Kampus Production, Leo Burnett, Shane, JÉSHOOTS, Karolina Grabowska, Yan Krukau, Polina Tankilevitch, Julia Avamotive, Jeremy Wong, Rosemary Ketchum, Cottonbro Studio and Elena Sazonova

Via Getty Images for Canva Pro:

Mountlynx, Whitebalance.space, Stock_Colors, SDI Productions, Thurtell, Cliff Booth, Bobtokyoharris, Tsvbrav, Wirestock, Lleerogers, Michelle Bonardi and Tracie Louise.

A Note on Language

Gippsland Women's Health (GWH) is a for-purpose organisation working across communities supporting positive health and wellbeing outcomes; and freedom from violence and gender equity for all women, girls and gender diverse people in Gippsland. This includes cis and transgender women, nonbinary people, and anyone whose identity doesn't fit within the gender binary¹.

Through this report, we use the terms 'women and gender diverse people', 'women' and 'females' interchangeably, and sometimes depending on context. For example, most publicly available statistical data reports data disaggregated by binary sex only and so when reproducing this data we report female and/or male data. As organisations increasingly collect data based on both sex and gender, including the 2026 Australian Census, GWH looks forward to being able to better report on the health, wellbeing and safety of trans and gender diverse Gippslanders in future.

In this report we also use the terms 'gendered violence', 'family violence' and 'sexual violence', each of which have overlapping but distinct meanings.

- Gendered violence refers to violence directed against a person because of their gender or that disproportionately affects people of a particular gender – most commonly women, girls, gender diverse people and LGBTQIA+ community members. It includes physical, mental or sexual violence, threats of such violence, coercion and other deprivations of liberty (UN Women Australia 2025; eSafety Commissioner 2025).
- Family violence refers to 'violent or threatening behaviour, or any other form of behaviour that coerces or controls a family member or causes that family member to be fearful' (OurWatch 2025)
- Sexual violence means 'sexual activity where consent is not obtained or freely given. It occurs any time a person is forced, coerced or manipulated into any unwanted sexual activity, such as touching, sexual harassment and intimidation, forced marriage, trafficking for the purpose of sexual exploitation, sexual abuse, sexual assault, and rape.' (OurWatch 2025)

While family violence and sexual violence also disproportionately impacts women, girls and gender diverse people, men and boys are also affected.

CONTENTS

ACKNOWLEDGEMENTS	4
Acknowledgement of Country	4
Acknowledgement of Victim-Survivors of Gendered and Family Violence	4
Acknowledgement of Contributors	4
First Nations imagery disclaimer	5
Photographer Credits	5
A Note on Language	5
CONTENTS	6
LIST OF FIGURES, BOXES AND TABLES	10
ACRONYMS	13
CEO MESSAGE	14
EXECUTIVE SUMMARY	16
Introduction	17
Background	18
About Gippsland	18
Gippsland's climate change and energy transition – an opportunity for a 'gender just' transition	18
Research Approach and Participants	20
Key findings	22
Health Service Access and Continuity of Care	22
Family and Gendered Violence	25
Women's Economic Participation and Leadership	27
Climate Change and the New Energy Transition	28
Key Recommendations	30
1. Improving Gippsland Women and Gender Diverse People's Health and Wellbeing	31
2. Preventing Gendered and Family Violence in Gippsland and Supporting Victim-Survivors	33
3. Supporting Gippsland Women's Adaptation to Climate Change and Clean Energy Transition Leadership	33
4. Increasing Gippsland Women's Economic Participation and Leadership	34
5. Embedding Inclusive Regional Planning	34
1. INTRODUCTION	36
1.1 About This Report Card	37
1.2 Context: Gippsland in Times of Rapid Change	38
Climate Change and Related Disasters	39
Gippsland's Economy in Transition	40
Planning for a 'Gender Just' Clean Energy Transition in Gippsland	40
1.3 Working in Partnership	42
Victorian Government	42
Regional Partnerships	42

2. ABOUT GIPPSLAND	44
2.1 First Peoples	45
2.2 European Colonisation, Settlement and Economic Development of Gippsland	46
2.3 Gippsland's LGAs	47
2.4 Socio-economic Overview	49
SEIFA Data	49
Homelessness	50
Educational Attainment	51
2.5 Underserved Communities in Gippsland	52
Women Living in Regional and Remote Areas	53
First Nations Women	54
LGBTQIA+ Community Members	55
Migrant, Refugee and Minority Ethnocultural Background Women	56
Women with Disabilities	58
Older Women	59
3. WOMEN'S HEALTH AND ACCESS TO HEALTH CARE IN GIPPSLAND	60
3.1 Accessing Health Care – Enablers and Barriers, Quality and Availability	62
Key Finding 1: <i>There are persistent challenges with accessing health care for women and gender diverse people in our region</i>	62
Key Finding 2: <i>Service gaps exist across the health system for most women and gender diverse people living in Gippsland, with particular gaps in availability of primary care, women's health, child health, aged care, mental health, and medical specialists.</i>	72
Key Finding 3: <i>Women in Gippsland experience significant variability in health care quality. Whilst some positive experiences are reported, there are consistent challenges with continuity of care, health professional knowledge gaps, and a lack of inclusive and respectful care</i>	78
Key finding 4: <i>Health care access and quality issues have gendered impacts – poor access to quality healthcare impacts women's and gender diverse people's health and wellbeing</i>	84
3.2 Health Promotion and Prevention	89
Key Finding 5: <i>Women in Gippsland want more control over their own health through health promotion, education and preventive health</i>	89
3.3 Gippsland Women's Health Status and Inequities	99
Key Finding 6: <i>Women in Gippsland experience poorer health outcomes than both other Victorian women and Gippsland men in a range of areas. Key health inequities experienced by women in Gippsland exist in relation to mental health, sexual and reproductive health, chronic disease, and cancer.</i>	99
4. GENDERED AND FAMILY VIOLENCE IN GIPPSLAND	110
Key Finding 7: <i>Gendered violence is a critical and persistent issue for women in Gippsland, with rates among the highest in the state and at record levels in some parts of the region</i>	111
Key Finding 8: <i>Women and gender diverse people have variable experiences with the quality and availability of family and sexual violence support services</i>	118
Key Finding 9: <i>Women in Gippsland need more effective housing and criminal justice system responses to family violence in their community</i>	120
Key Finding 10: <i>Women and gender diverse people in Gippsland continue to experience harmful community attitudes and norms and want continued and expanded efforts to prevent gendered violence</i>	124
5. WOMEN'S ECONOMIC PARTICIPATION	130
Key Finding 11: <i>Women in Gippsland face higher economic disadvantage relative to men and are underrepresented in leadership positions</i>	131

6. GENDER AND CLIMATE CHANGE ADAPTATION, DISASTERS AND EMERGENCIES 136

Key Finding 12: *Women and gender diverse people in Gippsland experience gendered impacts in times of disaster and are often excluded from disaster planning* 137

Key Finding 13: *Challenges accessing disaster recovery support across the region disproportionately impact women* 139

Key Finding 14: *Women are at risk of being left behind in Gippsland's clean energy transition, but a 'gender just' energy transition can mitigate the impacts* 140

REFERENCES 142

ENDNOTES 145

APPENDIX 1: RESEARCH APPROACH 146

Publicly Available Statistics 146

Community Online Survey 146

Community Focus Groups 147

Key informant interviews 148

Analysis 148

Ethical considerations 148

Limitations 148

APPENDIX 2: WHO WE HEARD FROM 150

Community Members 150

Key Informants 152



LIST OF FIGURES, BOXES AND TABLES

2. ABOUT GIPPSLAND

	Fig. 1: Map of Recognised Aboriginal Parties' boundaries in Victoria (2025)	45
	Fig. 2: Proportion of Gippsland Aboriginal and Torres Strait Islander population by LGA (2021)	45
	Fig. 3: Map of Gippsland LGAs	47
	Table 1: Gippsland LGAs – Estimated population and population growth, area and population density (2024)	48
	Fig. 4: Lifetime Total Fertility Rate (TFR): Gippsland LGAs vs Victoria (2014 – 2023)	48
	Fig. 5: Gippsland LGAs: SEIFA scores and IRSAD ranking in Victoria (2021)	49
	Fig. 6: Map showing homelessness rate per 10,000 (females and males): Gippsland LGAs (2024)	50
	Fig. 7: Proportion of dwellings unoccupied on Census night: Gippsland LGAs vs Victoria (2021)	50
	Fig. 8: Proportion of population who have attained Year 12 or equivalent (females): Gippsland LGAs vs Victoria (2011 – 2021)	51
	Fig. 9: Proportion of population who have attained Year 12 or equivalent (females and males): Gippsland LGAs vs Victoria (2021)	51
	Box 1: What is structural inequality?	52
	Fig. 10: Map of Gippsland showing LGAs and Remoteness Areas	53
	Fig. 11: Proportion of population identifying as Aboriginal or Torres Strait Islander (females): Gippsland LGAs vs Victoria (2021)	54
	Table 2: Top five countries of birth (excluding Australia): Gippsland LGAs vs Victoria (2021)	57
	Fig. 12: Proportion of population born in Australia (females): Gippsland LGAs vs Victoria (2021)	57
	Fig. 13: Proportion of population needing assistance with core activity (females): Gippsland LGAs vs Victoria (2021)	58
	Fig. 14: Female population by age bracket: Gippsland LGAs vs regional Victoria (2021)	59
	Fig. 15: Proportion of population aged 75 years and over and living alone (females and males): Gippsland LGAs vs Victoria (2021)	59

3. WOMEN'S HEALTH AND ACCESS TO HEALTH CARE IN GIPPSLAND

	Box 2: Presenting participants' quotes	61
	Fig. 16: Waited longer than acceptable to see a GP (%) - females: Gippsland LGAs vs Victoria (2023)	70
	Fig. 17: Did not see a GP when needed (%) - females: Gippsland LGAs vs Victoria (2023)	70
	Box 3: How GWH is helping improve access to women's health care in Gippsland	71
	Fig. 18: How often survey respondents travel outside Gippsland for health care (2025)	72
	Fig. 19: Proportion of survey respondents who travel outside Gippsland for health care by LGA of residence (2025)	72
	Fig. 20: Services survey respondents travelled outside Gippsland to access (2025)	73
	Fig. 21: Medication Abortion - Rate per 1,000 by prescriber location (females): Gippsland LGAs vs Victoria (2017 - 2023)	75
	Fig. 22: Medication Abortion - Rate per 1,000 by pharmacy location (females): Gippsland LGAs vs Victoria (2017 - 2023)	75
	Fig. 23: Medication abortion provision in Gippsland: Rate per 1,000 patient location vs prescribing (2023)	76
	Fig. 24: Medication abortion in Gippsland: Rate per 1,000 patient location vs dispensing (2023)	77
	Box 4: How GWH is helping build Gippsland health professionals' capacity in gender-responsive healthcare	81
	Fig. 25: Proportion of people who feel lonely (females and males): Gippsland LGAs vs Victoria (2023)	88
	Box 5: How GWH is supporting preventative healthcare for women and gender diverse people in Gippsland	91
	Box 6: What are the social determinants of health?	92

	Fig. 26: Proportion of adults at increased risk of alcohol-related harm (females vs males): Gippsland LGAs vs Victoria (2023)	95
	Fig. 27: Proportion of adults who are daily tobacco smokers / e-cigarette users (females) - Gippsland LGAs vs Victoria (2023)	95
	Fig. 28: Proportion of adults who do not meet recommended fruit and vegetable consumption guidelines (females): Gippsland LGAs vs Victoria (2023)	96
	Fig. 29: Proportion of adults who sat for 7 or more hours a day on a weekday (females): Gippsland LGAs vs Victoria (2023)	96
	Fig. 30: Breast screening – 2-year participation %: Gippsland LGAs vs Victoria (2016 – 2024)	97
	Fig. 32: Cervical screening – 5-year coverage %: Gippsland LGAs vs Victoria (2023)	97
	Fig. 31: Bowel screening – 2-year participation %: Gippsland LGAs vs Victoria (2016 – 2023)	97
	Box 7: How GWH is helping improve women and gender diverse people's health literacy and awareness of services in Gippsland	98
	Box 8: Remoteness classifications in Gippsland	99
	Fig. 33: Health workforce ratios by MMM area, Australia (2023)	100
	Fig. 34: Rate of age-standardised premature deaths compared with major cities (2023)	100
	Fig. 35: Mental health conditions ever diagnosed per 10,000 (female and male): Gippsland LGAs vs Victoria (2021)	101
	Fig. 36: Proportion of population who sought professional help for a mental health problem in last 12 months (females and males): Gippsland LGAs vs Victoria (2023)	101
	Fig. 38: Hospitalisation for self-harm - rate per 1,000 (females and males): Gippsland LGAs (2021)	102
	Fig. 37: Hospitalisation for self-harm – rate per 1,000 (females): Gippsland LGAs vs Victoria (2016 - 2021)	102
	Fig. 39: Chlamydia, gonorrhoea and syphilis - rate per 1,000 (females): Gippsland regional vs Victorian state estimates (2014 - 2023)	103
	Fig. 40: Endometriosis – rate per 1,000 (females): Gippsland LGAs vs Victoria (2022)	103
	Fig. 41: Hysterectomy – rate per 1,000 (females): Gippsland LGAs vs Victoria (2022)	104
	Fig. 42: Adolescent Birth – 2-year rate per 1,000 people: Gippsland LGAs vs Victoria (2012 – 2020)	104
	Fig. 43: Map showing arthritis – rate per 10,000 (females and males): Gippsland LGAs (2021)	105
	Fig. 44: Map showing asthma – rate per 10,000 (females and males): Gippsland LGAs (2021)	105
	Fig. 45: Map showing dementia – rate per 10,000 (females and males): Gippsland LGAs (2021)	106
	Fig. 46: Arthritis, asthma, dementia, diabetes and heart disease rate per 10,000 (female): Gippsland LGAs vs Victoria (2021)	106
	Fig. 47: Estimated 5-year ASR rate of breast, bowel, lung, melanoma and uterine cancers per 100,000 (females): Gippsland vs Victoria (2023)	107
	Table 3: Relative likelihood of being diagnosed with and dying from key cancers: Gippsland vs Victorian women (2001 – 2023)	108

4. GENDERED AND FAMILY VIOLENCE IN GIPPSLAND

	Fig. 48: Rate per 10,000 of family violence incidents (female AFM): Gippsland LGAs vs Victoria (2024)	113
	Fig. 50: Rate per 10,000 of family violence incidents (female AFM, child present): Gippsland LGAs vs Victoria (2024)	113
	Fig. 49: Rate per 10,000 of family violence incidents (female, First Nations AFM): Gippsland LGAs vs Victoria (2024)	113
	Fig. 51: Rate per 10,000 of family violence (female AFM): Gippsland LGAs vs Victoria (2024) - Selected indicators	113
	Fig. 52: Rate per 10,000 of family violence incidents (female AFM): Gippsland LGAs vs Victoria (2014 - 2024)	114
	Fig. 53: Rate per 10,000 of family violence incidents (female, First Nations AFM): Gippsland LGAs vs Victoria (2021 - 2024)	114
	Fig. 54: Rate of family violence incidents (female AFM, child present) per 10,000: Gippsland LGAs vs Victoria (2018 - 2024)	115
	Fig. 55: Rates of sexual violence and stalking, harassment and threatening behaviours (female victim) per 10,000: Gippsland LGAs vs Victoria (2024)	116
	Fig. 56: Rate of sexual violence incidents (female victim) per 10,000 - Gippsland LGAs vs Victoria (2014 - 2024)	117
	Fig. 57: Rates of stalking, harassment and threatening behaviours (female victim): Gippsland LGAs vs Victoria (2014 - 2024)	117
	Box 9: How GWH is helping prevent gendered violence in Gippsland	129

5. WOMEN'S ECONOMIC PARTICIPATION

	Fig. 58: Proportion of population earning above the minimum wage (females and males): Gippsland LGAs vs Victoria (2021)	131
	Fig. 59: Proportion of population earning above the minimum wage (females): Gippsland LGAs vs Victoria (2011 – 2021)	131
	Fig. 60: Proportion of population in full-time vs part-time work vs unemployed (females): Gippsland LGAs vs Victoria (2021)	132
	Fig. 61: Proportion of population in full-time vs part-time work vs unemployed (males): Gippsland LGAs vs Victoria (2021)	132
	Fig. 62: Proportion of population undertaking 15+ hours per week of unpaid work (females and males): Gippsland LGAs vs Victoria (2021)	133
	Fig. 63: Proportion of population undertaking informal caregiving (females and males): Gippsland LGAs vs Victoria (2021)	133
	Fig. 64: Proportion of CEOs, General Managers and Legislators (females and males): Gippsland LGAs vs Victoria (2011 – 2021)	134
	Fig. 66: Proportion of female local councillors: Gippsland LGAs vs Victoria (2012 – 2024)	135
	Fig. 65: Proportion of Council CEOs (female): Gippsland region vs Victoria (2015 – 2025)	135

6. GENDER AND CLIMATE CHANGE ADAPTATION, DISASTERS AND EMERGENCIES

	Box 10: What GWH is doing to support women and gender diverse people to adapt to climate change and the energy transition	141
---	--	-----

APPENDIX 2: WHO WE HEARD FROM

	Fig. 67: HWHG 2025 Report Card – community member participants	150
	Fig. 68: HWHG 2025 Report Card community participants – age distribution	150
	Fig. 69: HWHG 2025 Report Card participants – LGA of residence	150
	Fig. 70: HWHG 2025 Report Card community participants – primary activity (work, study, domestic duties, volunteering)	151
	Fig. 71: HWHG 2025 Report Card community participants – caregiving responsibilities	151
	Fig. 72: HWHG 2025 Report Card community participants – relationship status	151

ACRONYMS

ACCHO:	Aboriginal Community Controlled Health Organisation
ACCO:	Aboriginal Community Controlled Organisation
ADHD:	Attention Deficit Hyperactivity Disorder
ASGS:	Australian Statistical Geography Standard
BSP:	Behaviour Support Practitioner
CAMS:	Child and Adolescent Mental Health Service
COPD:	Chronic Obstructive Pulmonary Disease
CT scan:	Computed Tomography scan (also known as a CAT scan)
CTG:	Closing the Gap PBS Co-Payment Program
ENT:	Ear, Nose and Throat
GFVA:	Gippsland Family Violence Alliance
GP:	General Practitioner
GWH:	Gippsland Women's Health
ITC:	Integrated Team Care program
IUD:	Intrauterine Device
IVF:	In Vitro Fertilisation
LCHS:	Latrobe Community Health Service
LGA:	Local Government Area
LGBTQIA+:	Lesbian, Gay, Bisexual, Transgender, Queer / Questioning, Intersex and Asexual. The plus sign indicates diverse terms and identities that are not captured by these categories (e.g., non-binary, sistergirl, brotherboy, aromantic, pansexual).
LRH:	Latrobe Regional Hospital
MARAM:	Multi-Agency Risk Assessment and Management framework
MBS:	Medicare Benefit Scheme
MRI scan:	Magnetic Resonance Imaging scan
NDIS:	National Disability Insurance Scheme
OT:	Occupational Therapist
PBS:	Pharmaceutical Benefit Scheme
PCOS:	Polycystic Ovary Syndrome
PIP:	Practice Incentives Program
PHN:	Primary Health Network
RA:	Remoteness Area (ASGS measure of remoteness)
SEWB:	Social and Emotional Wellbeing
SRH:	Sexual and Reproductive Health
WHSN:	Women's Health Services Network

CEO MESSAGE

On behalf of Gippsland Women's Health, I am proud to present the *Healthy Women, Healthy Gippsland – The State of Women's Health and Safety in Gippsland 2025* Report Card.

Place-based consultation was at the core of this project as it is with all GWH work. Gippsland is not a homogenous region and deeply understanding local experiences and stories has been critical in building a report that elevates women and gender diverse people's lived experience in conjunction with a comprehensive range of quantitative data.

This report would not have been possible without the lived experience contributions from almost 200 women and gender diverse individuals across Gippsland who shared their stories and insights with courage and passion. For many individuals, this included sharing traumatic events related to violence at home, in the community, and in workplaces. And for a significant number of other participants, it included sharing negative experiences within our health system that have had far-reaching consequences. My deep appreciation and gratitude are extended to each one of those who contributed; our aim is that this report will continue to drive positive change across our region.

I am also indebted to the team at GWH and our external partners and stakeholders for their assistance and contributions.

This evidence-informed report has been prepared with enormous care and consideration by Dr Kate Johnston-Ataata, Research Lead at GWH, with support from consultant Lauren Zappa, GWH staff members Bec Steinhoff and Hayley Mitchell as well as other members of the team. My greatest thanks to Kate and colleagues for their expertise and passion for this work. They have collated data and crafted a story that provides a deep and detailed understanding of women's health and safety in Gippsland and highlights important initiatives, the impact of those initiatives, and recommendations for systemic change.

The *2025 Healthy Women, Healthy Gippsland* report tragically highlights the continued devastation on individuals, families and communities wrought by gendered and family violence in Gippsland. The most recent estimate of the cost of responding to Victoria Police-reported family violence was more than \$320 million per year – an unacceptable cost (KPMG 2017). The catastrophic cost to women, children and gender diverse people, however, cannot be measured in dollars.

Also starkly reflected in stories and data throughout this report is the conscious and unconscious bias and discrimination women and gender diverse people experience when accessing health care. Medical misogyny permeates the health system right across Australia as the 2024 #EndGenderBias Survey conducted by the National Women's Health Advisory Council found.

It is an indictment that four out of five women surveyed for our research reported that they left the region to seek health services. Women's health was the most common reason – by a large margin – for accessing services outside of Gippsland. It is encouraging to see increased access to medical abortion in LGAs where Victorian Government-funded Sexual Reproductive Health (SRH) hubs have been established in Gippsland. However, demand still exceeds supply, and data presented indicates that many abortion-seekers are still needing to travel outside their local area to access services.

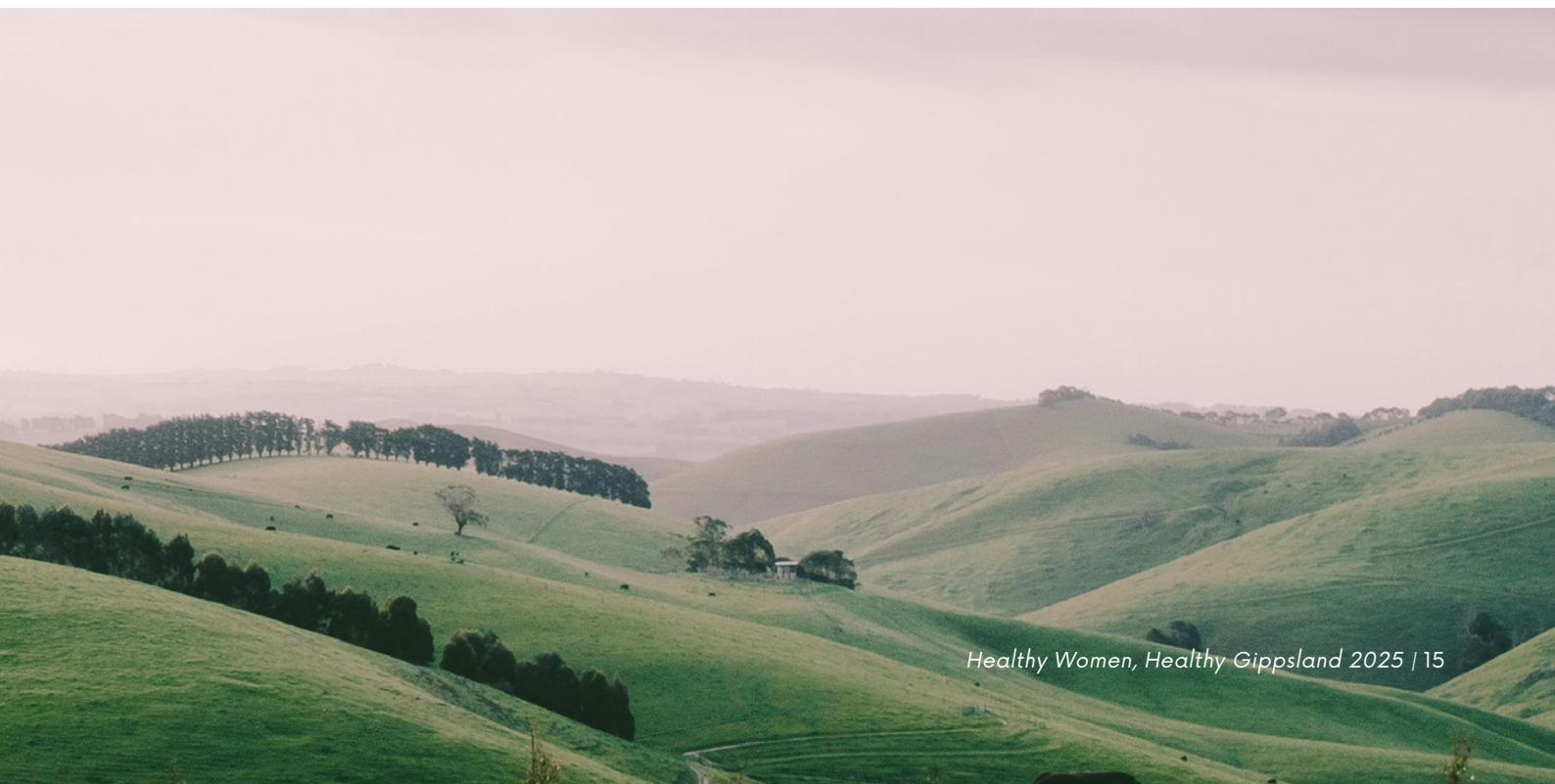
In a call to action for better coordination between hospitals, health services and health promotion organisations, women and gender diverse individuals also spoke in detail about “not knowing what you don't know” - lacking access to information or the knowledge to navigate the system to make informed decisions about their own health, wellbeing and safety.

The backdrop to the report is climate change, climate-related disasters and the clean energy transition, which are already having a significant impact on Gippsland and risk deepening gender inequity and further straining under-resourced services. Although questions were not specifically asked in the research about the clean energy transition, the report highlights the urgent need for coordinated action, improved service delivery, and inclusive decision-making to realise the

opportunity offered by climate change adaptation and the energy transition. This in turn can level the playing field between Gippsland women, men and gender diverse people and ensure a healthier, safer and more sustainable future for our region.

Gippsland Women's Health recognises the significant contribution the Victorian Government has made in improving services and access through a significant package of funded women's health initiatives including but not limited to multidisciplinary women's health clinics, mobile women's health clinics, virtual clinics and the landmark Inquiry into Women's Pain. The Victorian Government continue to fund primary prevention and family and sexual violence initiatives and services, and their ongoing funding of regional women's health services is a testament to their commitment to improving the lives of women and gender diverse individuals across Victoria.

As this report attests, Gippsland women and gender diverse people remain resilient and flexible in the face of significant adversity. Communities rally together in disasters, develop creative solutions to local problems, and there are strong social connections among women who frequently fill the caregiving and support vacuum left by fragmented or absent services. These community attributes are a powerful asset to be harnessed by those working to improve services and address gender inequality and the social determinants of health.





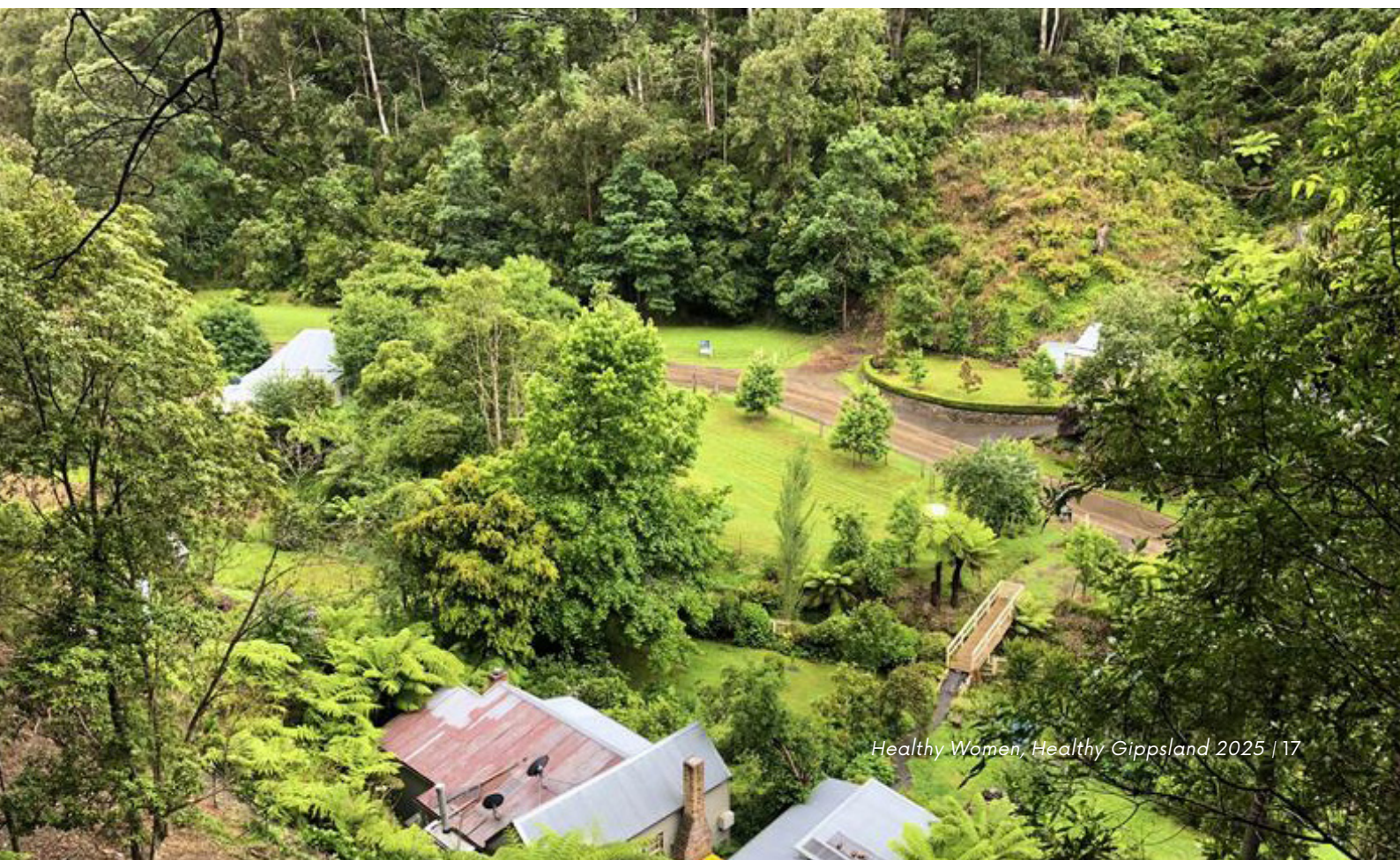
EXECUTIVE SUMMARY

Introduction

Women and gender diverse people in Gippsland face significant health and safety inequities, made worse by geographic isolation, gendered norms and structures at home, in the workplace and in the community, and climate-related disasters.

The first *Healthy Women Healthy Gippsland* Report Card published by Gippsland Women's Health (GWH) in 2023 put a spotlight on regional women's health, wellbeing and safety, driving important conversations and collaborations between GWH and its partners across the region. The *2025 Healthy Women, Healthy Gippsland* Report Card builds on the 2023 report card by presenting comprehensive updated statistical data and in-depth lived experiences based on focus groups, an online survey and key informant interviews involving around 200 women and gender diverse people from across Gippsland.

Not only does the new report bring the voices of Gippsland women and gender diverse people to the conversation about their health and safety needs, it also presents a collection of statistical data disaggregated by sex and reported at the Local Government Area (LGA) level to be updated ongoingly. This repository will support organisations and leaders committed to gender equity and women's health and safety in Gippsland to better monitor and evaluate the impact of their efforts.



Background

About Gippsland

Located in southeastern Victoria, Gippsland is a region of rich cultural heritage, diverse landscapes, and complex social dynamics. It comprises 6 LGAs: Bass Coast, Baw Baw, East Gippsland, South Gippsland, Wellington, and Latrobe. The region is home to several Traditional Owner groups including the Bunurong, Gunaikurnai, Bidwell, Ngarigo Monero, and Jaithmathang peoples, whose connection to Country spans tens of thousands of years.

Following European colonisation and settlement in the 1830s, Gippsland's economy has been shaped by masculinised industries such as mining, forestry, and agriculture, influencing its gender dynamics and workforce patterns. Brown coal and offshore gas were particularly significant resource discoveries, transforming Gippsland into the heart of Victoria's energy production.

Today, the region has over 312,000 residents. Population growth is driven by migration, with birth rates gradually declining. Compared with regional Victoria, Baw Baw and Latrobe have a younger demographic and higher growth rate, while the remaining 4 LGAs have a larger share of older people. Gippsland's cultural diversity is lower than other parts of Victoria and although this is changing, migrant, refugee, and ethnocultural minority people in the region face structural barriers to inclusion and healthcare access.

Socioeconomic disparities are evident across Gippsland. Latrobe, Wellington and East Gippsland rank lower on the SEIFA index, indicating relatively greater disadvantage, a pattern that recurs through much of the demographic, health and violence data. Rates of female homelessness in outer Gippsland are concerningly high, with East Gippsland, Latrobe, and Wellington ranking 4th, 7th, and 9th respectively in Victoria. Educational attainment has improved but still lags the state average. Compared with Gippsland men, women are more likely to have completed Year 12 but more likely to work part-time, earn less, and take on unpaid care work, contributing to economic insecurity.

Women and gender diverse people from underserved communities in Gippsland face additional barriers to accessing health care, family and sexual violence services, and support during disasters, and experience poorer health outcomes and often higher rates of gendered violence. Those in remote communities struggle with

access to health and violence response services. First Nations women experience poorer health outcomes and higher rates of gendered and family violence due to systemic racism and historical trauma. LGBTQIA+ individuals report high levels of discrimination and psychological distress, with regional residents facing fewer inclusive supports.

Migrant, refugee and ethnocultural minority women are vulnerable to exploitation in the workplace and face limited access to services. Women with disabilities encounter physical and systemic barriers to healthcare, and older women face isolation, chronic illness, and financial hardship. At the same time, significant data gaps – about migrant and refugee women and LGBTQIA+ community members in particular – hinder effective policy and service planning and responses.

The challenges faced by Gippsland's women and gender diverse people underscore the need for inclusive, gender-responsive planning. Addressing structural inequality across health, education, employment, and housing is essential to improving wellbeing and ensuring equitable access to services. Gippsland's future depends on recognising and responding to the diverse needs of its communities.

Gippsland's climate change and energy transition – an opportunity for a 'gender just' transition

Gippsland is undergoing a major shift as Victoria transitions from coal and gas to clean energy, with the region designated a Renewable Energy Zone and Australia's first Offshore Wind Zone. While this presents economic and environmental opportunities and supports the state's goal of net zero emissions by 2050, it also risks deepening gender inequities unless carefully managed.

Women and gender diverse people in Gippsland already face significant challenges—limited healthcare access, high rates of gendered violence, and economic insecurity. Climate change and related disasters amplify these issues, disproportionately affecting those in caregiving roles and female-dominated industries like tourism and healthcare. Disaster recovery periods often see spikes in family violence, further compounding vulnerability.

The energy transition will also bring surge workforces—predominantly male—into the region, straining housing, health, and social services. Without inclusive planning, this can exacerbate gendered violence and economic

challenges, particularly for women with disabilities or migrant backgrounds, First Nations women, members of the LGBTQIA+ community, or those experiencing gendered and family violence.

Gippsland has a unique opportunity to lead in equitable climate adaptation. Industry, government, and philanthropy must collaborate to ensure women and gender diverse people are not further disadvantaged. A 'gender just' transition requires gender-responsive policies, inclusive workforce strategies, and investment in care work. Women remain underrepresented in energy, climate science, and leadership roles, despite evidence that their participation leads to better environmental and community outcomes, and despite bearing the brunt of climate impacts. Investing in care work alongside clean energy can create sustainable jobs and support community wellbeing.

By applying a gender lens to planning and implementation, Gippsland can build a resilient, inclusive future—where all community members benefit from the energy transition.



Research Approach and Participants

Data Sources



Statistical data disaggregated by sex and reported at the LGA level from sources such as the **Victorian Women's Health Atlas**, the **Victorian Population Health Survey** and others were collated

How We Gathered Insights



A **10-week online survey** gathered **166 responses**, exploring perceptions and experiences of health and safety.



Focus groups added depth, with 41 participants across eight sessions, including targeted groups for First Nations women, migrant and refugee women, and women with disabilities.



Ten people participated in both the survey and a focus group, **bringing the total number of community member participants to 197**



Interviews with 4 key informants – experts in chronic illness, gendered and family violence, mental health, and sexual and reproductive health – enriched the report with professional perspectives on regional health and safety challenges.

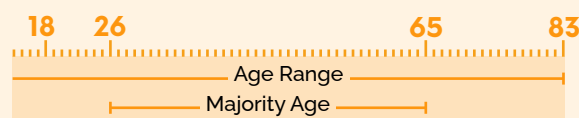
The *Healthy Women Healthy Gippsland 2025* Report Card centres the voices of Gippsland women and gender diverse people through a mixed methods approach combining qualitative and quantitative data. Insights were drawn from publicly available statistics, a community survey, focus groups, and key informant interviews.

Data analysis involved thematic coding of open-ended responses and transcripts, identifying patterns, and refining themes across methods. Ethical considerations included participant reimbursement, data de-identification, and secure storage.

Community Voices: Who took Part?



Of the **197** community members, most were **women (96.5%)**, while **3.5%** were **non-binary**.



Participants ranged from under 18 to 83 years, with most aged between 26 and 65, and they were evenly spread across Gippsland's 6 LGAs.



Nearly half had caregiving responsibilities, and **70%** were partnered.



Three in four participants were engaged in paid work as their primary activity, the remaining undertaking study, domestic duties, or volunteering.



The sample was not intended to be statistically representative, but to **offer rich insights into the lived experiences of Gippsland women and gender diverse people**, highlighting systemic barriers and opportunities for change.



Key findings

Findings reveal persistent disparities facing Gippsland women and gender diverse people – in healthcare access, quality, and service availability and family and sexual violence rates that are among the highest in the state. Despite important inroads achieved through Victorian Government initiatives and our work at Gippsland Women's Health *(to learn about our current range of activities and initiatives, see Boxes 3 – 5, 7, and 9 – 10 in the report)*, many women still travel outside the region for essential health services and experience systemic gender bias, and rates of gendered and family violence continue to rise. Gippsland women and gender diverse people remain disproportionately impacted by climate change and the clean energy transition while being excluded from decision-making opportunities on these issues.

Health Service Access and Continuity of Care



Key finding 1

There are persistent challenges with accessing health care for women and gender diverse people in our region

Women and gender diverse people in Gippsland face significant challenges in accessing appropriate and timely healthcare. **Affordability, lengthy wait lists, and the complexity of navigating healthcare services** are major concerns, along with **stigma and privacy in small communities**. These challenges are compounded by **geographic isolation, unreliable transport, and limited telehealth viability** due to poor connectivity and unsuitability for certain health needs. Women report financial strain, limited service options, and difficulty coordinating care across multiple providers.

Key finding 2

Service gaps exist across the health system for most women and gender diverse people living in Gippsland, with particular gaps in availability of primary care, women's health, child health, aged care, mental health, and medical specialists

A large majority of women surveyed (4 out of 5) report travelling outside the region for health services, highlighting systemic gaps in local service provision. **Women's health is the most common form of care sought outside Gippsland**, along with mental health, dental care, and specialist care. **Mental health services are strained**, with **long wait times, affordability challenges, and limited service availability**, whether in-person or via telehealth. These pressures are pushing women and gender diverse people to either attempt to access limited public mental health inpatient services or, more commonly, to forego care.

Key finding 3

Women in Gippsland experience significant variability in health care quality. Whilst some positive experiences are reported, there are consistent challenges with continuity of care, health professional knowledge gaps, and a lack of inclusive and respectful care

Organised, effective health services and knowledgeable, respectful health practitioners exist in Gippsland and are **highly valued**. However, **continuity of care** is severely disrupted by **frequent turnover of medical practitioners**, leading to fragmented care, poor follow-up, and the emotional burden of repeatedly recounting medical histories – especially for those with chronic conditions.

Gender bias and medical misogyny are prevalent, with women frequently **feeling dismissed or disbelieved**, particularly regarding symptoms related to sexual and reproductive health concerns. In combination with **health professional knowledge gaps**, these experiences can and have contributed to **delayed or incorrect diagnoses and inappropriate treatment**.

Women from underserved communities face additional barriers related to **discrimination and lack of culturally safe, inclusive or accessible services**, including First Nations women, migrant and refugee women, women with a disability and those in the LGBTQIA+ community.

Key finding 4

Health care access and quality issues have gendered impacts – poor access to quality healthcare impacts women's and gender diverse people's health and wellbeing

Women and gender diverse people face significant **emotional, financial, and logistical burdens when trying to access timely and quality healthcare**, particularly for time-sensitive or extended care. Impacts range from inconvenience (e.g., repeatedly having to follow up on referrals) to compromises to women's health or lives (e.g., cancelling life-saving treatments like chemotherapy due to unaffordable travel costs).

Poor health and community service access exacerbates social isolation in regional areas like Gippsland, leading to mental health challenges, with women from underserved communities particularly impacted. Women who are **unpaid caregivers** often take on **greater responsibilities in the absence of adequate health care services**. Lack of formal support for caregiving further increases the burden, leaving carers facing burnout while managing complex care responsibilities, with many **relying solely on informal networks** and struggling to access services due to **cost, availability, and scheduling barriers**.

Key finding 5

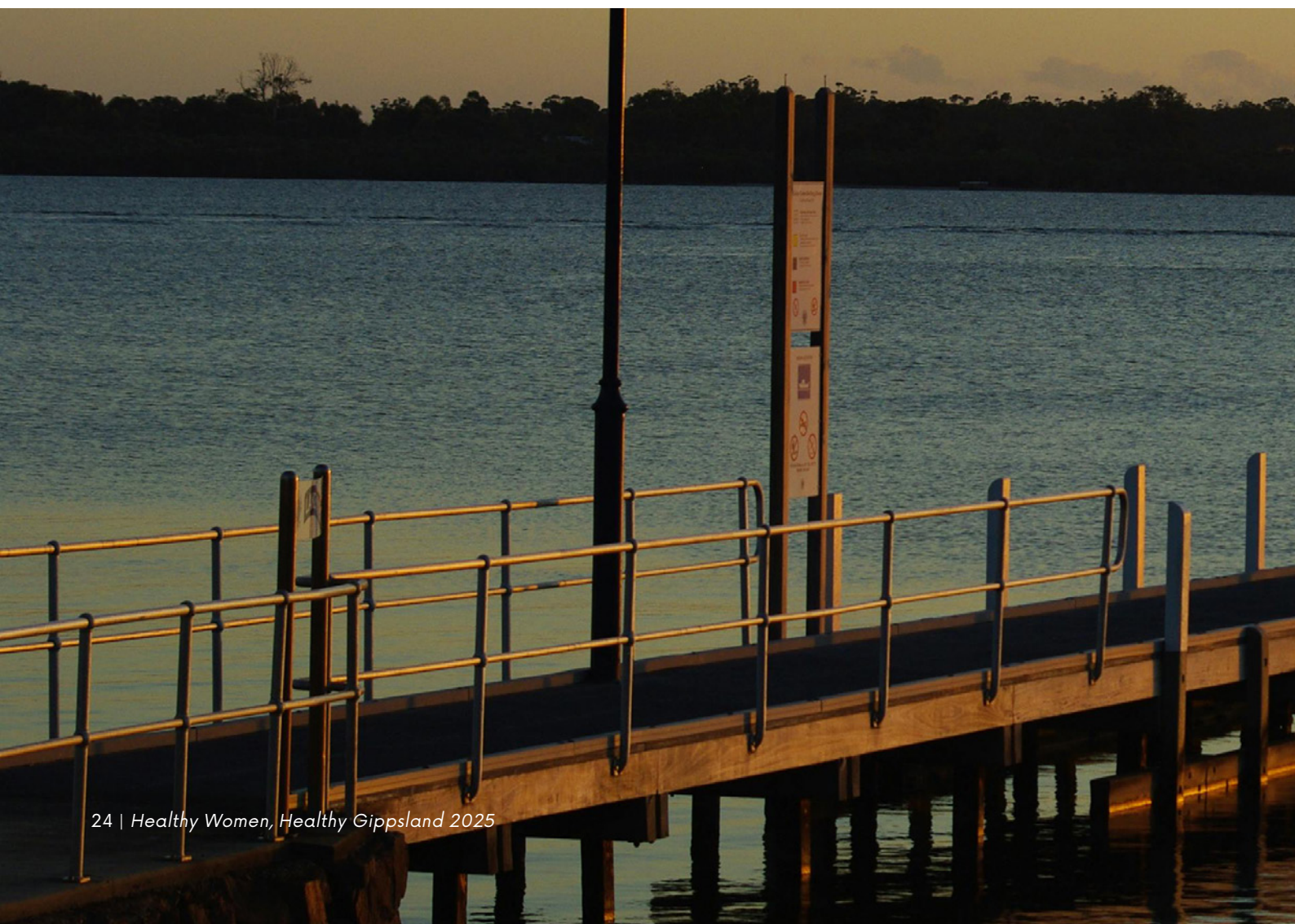
Women in Gippsland want more control over their own health through health promotion, education and preventive health

Broader social determinants, including **extremely high rates of alcohol use among men in Gippsland, challenges around healthy eating and physical activity, and significant health literacy gaps**, exacerbate health inequities and compromise safety. Although women and gender diverse people **find preventative care and health promotion activities useful** in helping them better manage their health, such initiatives are **underfunded and undervalued**, with practitioners and health services showing limited engagement in proactive health approaches.

Key finding 6

Women in Gippsland experience poorer health outcomes than both other Victorian women and Gippsland men in a range of areas. Key health inequities experienced by women in Gippsland exist in relation to mental health, sexual and reproductive health, chronic disease, and cancer.

Outcomes for Gippsland women are **notably poorer than for Victorian women and Gippsland men** in particular areas of health, including **mental health**, chronic diseases such as **arthritis and asthma, and cancer**. Gippsland women are more likely to be diagnosed with bowel and lung cancer and melanoma (up to 47%) and are more likely to die from these cancers (up to 60%, or 70% for ovarian cancer). Compared with Victorian women overall, Gippsland women also have **greater exposure to alcohol and tobacco-related risks**.



Family and Gendered Violence

Key finding 7

Gendered and family violence is a critical and persistent issue for women in Gippsland, with rates among the highest in the state and at record levels in some parts of the region

Gippsland women and gender diverse people are aware that gendered and family violence is one of the region's most pressing public health and community safety challenges, with nearly **10,000 reported incidents** in the year to July 2025, including serious assaults and breaches of family violence orders. Additionally, **almost 2,100 sexual offences** were reported, underscoring the severity of the issue. These figures reflect cases reported to Victoria Police only, suggesting the true scale is likely far greater.

The impact is particularly devastating for **First Nations women**, with rates of violence significantly exceeding the state average—**three times higher in East Gippsland, almost three times in Latrobe, and double in Wellington.**

Overall, **East Gippsland, Latrobe and Wellington rank between 1st and 8th in the state** for rate of family violence incidents with a female affected family member (AFM), a First Nations female AFM, and incidents where a child was present, and in 2024 East Gippsland and Latrobe reached their highest rates in the last 10 years.

Key finding 8

Women and gender diverse people in Gippsland have variable experiences with the quality and availability of family and sexual violence support services

Despite the scale of the crisis, **family violence case management and counselling services are severely lacking**, especially in outer Gippsland where the need is greatest. Participants report mixed experiences with family and sexual violence support services in Gippsland—some have found services like The Orange Door respectful and helpful, while others have felt dismissed or blamed, negatively impacting their mental health.

Overall, services are seen as **under-resourced, unevenly distributed, and difficult to access** due to **geography, funding constraints, lack of privacy in small communities, and limited long-term support.** Key gaps identified include programs for people who use violence, therapeutic services, transport and financial assistance, and better coordination with child protection.





Key finding 9

Women in Gippsland need more effective housing and criminal justice system responses to family violence in their community

High rates of **female homelessness in outer Gippsland** are compounded by a **critical shortage of emergency and affordable housing for women experiencing violence** – around half of Victorian women who seek support from specialist homelessness services do so because of family violence. The **scarcity of emergency and affordable housing in Gippsland** makes it very difficult to support women wishing to leave dangerous relationships.

The **criminal justice system** plays a significant role in responding to family and sexual violence, with some participants reporting positive changes such as **improved police protocols and increased support from legal services**. However, many others shared **critical experiences**, highlighting systemic issues like not being **believed, outdated attitudes, and inadequate responses to breaches of Family Violence Intervention Orders (FVIOs)**. Overall, there is a strong call for more consistent, respectful, and effective interventions, especially for repeat offenders and victim-survivors in need of support.

Key finding 10

Women and gender diverse people in Gippsland continue to experience harmful community attitudes and norms and want continued and expanded efforts to prevent gendered and family violence

Deeply entrenched **gendered and conservative community attitudes** continue to normalise violence, discourage reporting and hinder accountability. While there are signs of positive change, the **absence of male leadership and participation** in violence prevention efforts impedes progress and further perpetuates harmful norms and behaviours. Women and gender diverse people value primary prevention initiatives but believe **respectful relationships and gender equality education needs to start as early as possible** in the school system.

Urgent, coordinated action is required across the spectrum—from **prevention and early intervention to crisis response and recovery**. This includes community education in workplaces and community settings as well as schools, the active involvement of men as allies in driving change, and culturally safe and trauma-informed response and recovery services.

Women's Economic Participation and Leadership

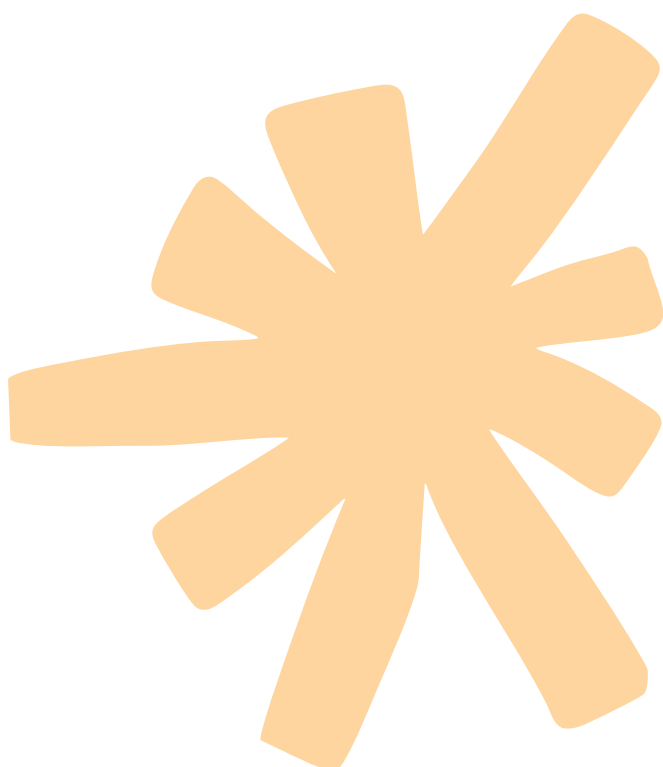
Key finding 11

Women in Gippsland face higher economic disadvantage relative to men and are underrepresented in leadership positions

Despite **higher educational attainment** compared to men, Gippsland women face **lower labour force participation and earnings**, driven by **occupational gender segregation, gender discrimination, and the burden of caregiving responsibilities**.

Women are **over-represented in part-time work**, while men dominate full-time roles, contributing to a persistent **gender wage gap**. Fewer Gippsland women earn above the minimum wage compared to men, reflecting structural barriers to economic advancement.

Leadership representation remains low, with **few women in senior roles across most sectors**, further entrenching gendered power imbalances. These disparities highlight the urgent need for **targeted policy interventions, investment in housing and support services, and community-driven strategies** to promote gender equity, economic participation, and safety for women and gender diverse people in Gippsland.



Climate Change and the New Energy Transition

Key finding 12

Women and gender diverse people in Gippsland experience gendered impacts in times of disaster and are often excluded from disaster planning

The cumulative effects of **bushfires, floods, storms, and the COVID-19 pandemic** have had profound and disproportionate impacts on women and gender diverse people in Gippsland. These climate-related disasters are **not gender neutral**—they exacerbate existing inequalities and create new vulnerabilities.

Such events are linked to **increased rates of family violence, a heavier caregiving load for women, and greater financial strain**, often resulting in **housing insecurity**. Women also face **significant barriers to accessing timely healthcare** during and after disasters, particularly in relation to **sexual and reproductive health services**, which are often deprioritised in emergency response efforts.

Key finding 13

Challenges accessing disaster recovery support across the region disproportionately impact women and gender diverse people

Despite these realities, the **gendered and intersectional impacts** of climate-related disasters have been **largely overlooked in emergency planning and support systems**. This gap in preparedness and response highlights the urgent need for **inclusive, gender-responsive disaster planning**, investment in **accessible health services**, and **community-led recovery strategies** that centre the voices, needs and experiences of women and gender diverse people.

Key finding 14

Women are at risk of being left behind in Gippsland's clean energy transition, but a 'gender just' energy transition can mitigate the impacts

As Gippsland's clean energy transition gathers pace, action by industry, government, philanthropy and research leaders is critical to ensure women and gender diverse Gippslanders have a seat at the table, and that the potential adverse gendered impacts of surge workforces are planned for.

The *Healthy Women Healthy Gippsland 2025* Report Card provides a clear roadmap for stakeholders across all levels of government, health services, and regional organisations to work collaboratively toward a more equitable, inclusive, and healthy Gippsland. The recommendations outlined on the next pages call for sustained investment, gender-responsive planning, and a commitment to systemic change. By embedding gender equity into health, safety, climate adaptation, economic participation, and regional development, Gippsland can lead the way in creating a region where all people—regardless of gender—can thrive.

Now is the time for coordinated action. With the right partnerships, policies, and resources, we can build a future where Gippsland women and gender diverse individuals are healthy, safe, supported, and empowered across every stage of life.



Key Recommendations

Gippsland Women's Health (GWH) plays a critical role in connecting statewide policies on women's health, safety, climate change adaptation, and gender equity to local contexts. Trusted by both government and community, GWH's expertise and partnerships drive meaningful policy and systems-level change.

This report will serve as a foundational tool to guide GWH's work across the region, providing the evidence base to support Gippsland's leaders in ensuring women, girls, and gender diverse individuals are healthy, safe, and able to equitably

participate across their lifespan. We are well-positioned to lead the effort to address the challenges the report uncovers and drive change for a safer, and more equitable future for all Gippsland women, girls and gender diverse people.

The following recommendations, organised around the key findings of the report and aimed at a range of stakeholders, highlight the need for better regional coordination and sustained funding to drive the systemic and cultural change needed.



1. Improving Gippsland Women and Gender Diverse People's Health and Wellbeing

State Government – Victorian Women's Health Program

To bridge the gap in women's healthcare and change the way women and gender diverse people's health issues are treated, the Victorian Government has invested in a significant package of initiatives including multi-disciplinary women's health clinics, the Mobile Women's Health Clinic, the Virtual Women's Health Clinic, Aboriginal Women's Health Clinic, Sexual and Reproductive Health (SRH) Hubs, women's health and wellbeing support groups and programs, uplift funding to the Women's Health Services Network, women's health research initiatives and the groundbreaking Inquiry into Women's Pain. Local women's health services such as GWH are key connectors for many of these funded initiatives, including the mobile women's health clinic and SRH hubs.

1.1. Sustain uplift funding for women's health services to secure current investment in the health, safety and wellbeing of Victoria's women and gender diverse people beyond 2026 and to sustain our services and safeguard the value we generate now and into the future through ongoing and indexed funding rather than time-limited funding.

1.2. Sustain ongoing funding for multidisciplinary women's health clinics in regional centres co-designed with local stakeholders.

1.3. Expand the Mobile Women's Health Clinic to provide increased frequency and reach to more women and gender diverse people living in rural and remote areas.

1.4. Address medical misogyny through funded initiatives for General Practitioners and health professionals that improve contemporary practice, capability, understanding and management of women's mental health and health including pain, perimenopause and menopause, contraception and medical and surgical abortion.

1.5. Increase the reach of comprehensive sexual and reproductive health (SRH) services to enable timely access to contraception, abortion, fertility treatment and perinatal and antenatal health care.

1.6. Sustained funding to grow **local wellbeing support groups** and **service navigation** programs to support Gippsland women's health literacy, knowledge of services and mental health and wellbeing.

1.7. Resource and develop a regional cancer response strategy targeting high mortality and high prevalence cancers among Gippsland women that covers prevention, screening and treatment.

Gippsland's hospitals and health services – Local Health Service Network

Local Health Service Networks group health services within a geographical region and are responsible for supporting collaborative care for their community, as close to home as possible. Networks are responsible for meeting their communities' care needs as close to home as possible; supporting more equitable and consistent care for patients; increasing consistency of quality and safety of care; strengthening workforce attraction, retention and support; and delivering support services at scale.

1.8. Ensure a collaborative approach to the co-design of funded women's health initiatives to ensure they are inclusive of women's needs including the multidisciplinary women's health clinic.

1.9. Strengthen regional audits and gender impact assessments to improve **gender-responsive care**.

1.10. Collaborate on a regional cancer response strategy targeting high mortality and high prevalence cancers among Gippsland women and gender diverse people that covers prevention, screening and treatment.

1.11. As employers with high proportions of female employees, utilise the strength of the Local Health Service Network and GWH to:

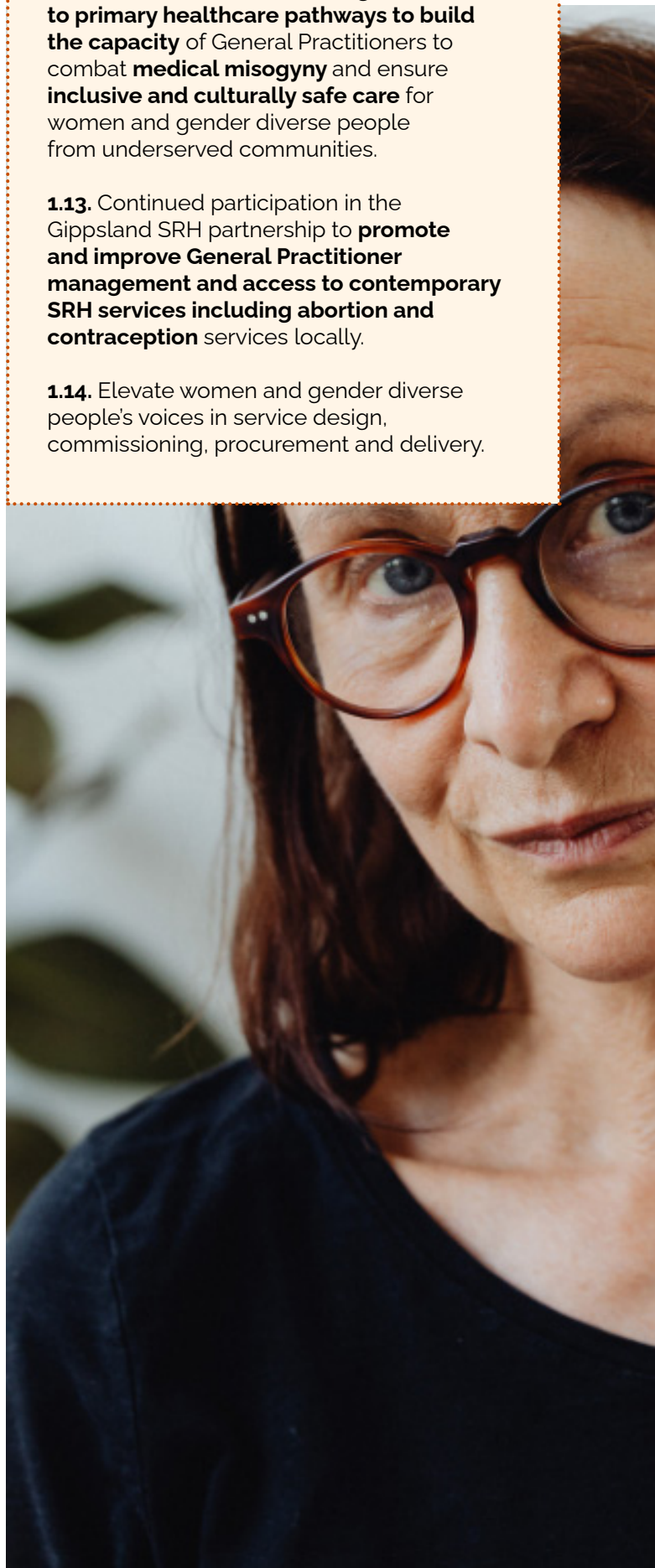
- Develop **leadership pathways** for women in hospitals and health services
- Reduce **sexual harassment and work-related gendered violence** in hospitals and health services
- Address the **gender pay gap** in rural hospitals and health services
- Promote **equitable workforce strategies** to improve retention and women's development.

Australian Government – Gippsland Primary Health Network (GPHN)

1.12. Collaborate with GWH on initiatives that embed an **intersectional gender lens to primary healthcare pathways to build the capacity of General Practitioners to combat **medical misogyny** and ensure **inclusive and culturally safe care** for women and gender diverse people from underserved communities.**

1.13. Continued participation in the Gippsland SRH partnership to **promote and improve General Practitioner management and access to contemporary SRH services including abortion and contraception services locally.**

1.14. Elevate women and gender diverse people's voices in service design, commissioning, procurement and delivery.



2. Preventing Gendered and Family Violence in Gippsland and Supporting Victim-Survivors

State and local government and regional organisations

2.1. Improve **primary prevention of violence against women funding** that recognises and plans appropriately for the disproportionate rate and impact of gendered and family violence in Gippsland.

2.2. Encourage **Gippsland Local Government and regional organisations'** commitment to violence prevention in their communities and workplaces through active leadership and participation in the Respectful Gippsland partnership and associated prevention activities.

2.3. Promote the **Equitable Leadership Program** for male leaders across Gippsland to reduce gender inequities, prevent violence against women and gender diverse people, and elevate women's leadership.

2.4. Support the **Gippsland Family Violence Alliance (GFVA)** call for better resourcing of family violence case management, therapeutic services, men's behaviour change programs and exit pathways.

3. Supporting Gippsland Women's Adaptation to Climate Change and Clean Energy Transition Leadership

New and existing energy providers, Regional Development Victoria, Gippsland Climate Change Network, Local, State and Federal Government, Net Zero Economy Authority

3.1. Local Government and emergency management stakeholders to partner with GWH to apply a **gender lens to climate change and related disaster planning**

3.2. Application of **gender-responsive budgeting** at a State level for emergency management planning including preparedness, response and recovery.

3.3. Energy and supply chain providers operating across Gippsland to commit to **social impact initiatives** benefitting women, girls and gender diverse individuals.

3.4. In consultation with GWH, new energy providers and supply chain to commit to **activating strategies and workplace policies to increase women's workforce participation, retention, safety and leadership opportunities.**

3.5. The Net Zero Economy Authority to continue to engage and consult with GWH and expand consultation to other key health and social services stakeholders to **recognise and promote solutions to the unique position and needs of women and gender diverse people in the Gippsland energy transition.**

4. Increasing Gippsland Women's Economic Participation and Leadership

Local government, industry and regional organisations and leaders

4.1. Consult with GWH to embed strategies, behaviours and workplace policies to **increase women and gender diverse people's workforce participation, retention, safety and leadership opportunities.**

4.2. Provide resources, access and funding to establish and maintain a **women's leadership mentoring program** based on foundations of the GWH Women in Energy Leadership program.

4.3. Establish targets for increasing the **number of women** in leadership roles.

4.4. Create workplace cultures that **value work-life balance** and **support caring responsibilities for all genders.**

5. Embedding Inclusive Regional Planning

State and local government and regional organisations

5.1. Ensure the **Gippsland Regional Plan 2026** and beyond prioritises actions to reduce gender inequities.

5.2. Collaborate to address the **housing crisis in Gippsland**, focusing on women facing violence, older women experiencing homelessness, and the surge workforce.

5.3. Collaborate to strengthen **data collection about and in consultation with underserved communities**, particularly First Nations women, migrant and refugee women, women with disabilities, and Gippsland's LGBTQIA+ community.





1. INTRODUCTION

People living in regional and rural parts of Australia have poorer access to healthcare and poorer health outcomes, with service access and health outcomes declining the further a person lives from a metropolitan city. This inequity is starkly illustrated in *The Forgotten Health Spend report* (Nossal and National Rural Health Alliance 2025), which estimated that **the average health expenditure gap between metropolitan cities and the rest of the country in 2023-24 was over \$1,000 per person**, a reflection of the **'triple rural healthcare disadvantage'** – poor service availability, high cost of service delivery, and social determinants of health.

A similar picture emerges with access to family and sexual violence services, and rates of violence. The further people live from a major population centre, the fewer supports and resources they have, and the higher the rates of family and sexual violence – which means **regional and rural women and gender diverse people are the most impacted, given these forms of violence are highly gendered**.

The region of Gippsland in southeastern Victoria is no exception to these patterns of inequity, as reflected in poor health outcomes and some of the highest rates of family and sexual violence in the state.

1.1 About This Report Card

Gippsland Women's Health (GWH) is a for-purpose organisation working across communities supporting positive health and wellbeing outcomes, freedom from violence and gender equity for all women, girls and gender diverse people in Gippsland. Supported by the Victorian Government and other funding, we are part of the **Victorian Women's Health Services Network (WHSN)** comprising **9 place-based women's health services** across Victoria and **3 statewide services** (Multicultural Centre for Women's Health, Women's Health Victoria, Women with Disabilities Victoria). We apply a gender lens to our 5 priority areas:

- mental health and wellbeing,
- sexual and reproductive health,
- chronic disease,
- prevention of gendered violence, and
- women in a changing environment (climate change).

GWH is trusted by Government and our communities; we connect statewide policies on women's health, safety, climate change adaptation and gender equity to local contexts and are a critical implementer of Government initiatives. Our subject matter expertise, capacity and capability to engage partners can and does have a significant positive impact in driving policy and systems level change.

In 2023 GWH released our first *Healthy Women, Healthy Gippsland – The State of Women's Health and Safety in Gippsland 2022-2023 Report Card* which highlighted devastating disparities in health and safety for Gippsland women and gender diverse people. While the 2023 report provided only a sample snapshot of data and experiences, the evidence it contained drove important discussions and new partnerships across Gippsland.

The 2025 *Healthy Women, Healthy Gippsland Report Card* provides updated, comprehensive, and evidence-informed quantitative and qualitative data. It also provides a robust benchmark to understand longitudinal changes, areas of concern, and progress made on initiatives. The report deepens our understanding of Gippsland women and gender diverse people's health and wellbeing status by elevating their voices and insights into their health and safety needs and available services and supplementing their perspectives with relevant supporting statistics. In so doing it presents updated data we have previously reported on and, concerningly, reveals additional data with profound consequences for women across Gippsland, particularly in terms of cancer prevalence and mortality.

Based on findings from a **community online survey and focus groups** with 197 women and gender diverse people across Gippsland, **key informant interviews**, and publicly available **statistical data** relevant to our priority areas, the 2025 report combines lived experience insights with up-to-date quantitative data – for full details on the research approach, see [Appendix 1](#).

This report will play a foundational role in guiding our work across the region in coming years, by providing the evidence to assist GWH and our partners in ensuring Gippsland women, girls and gender diverse individuals are healthy, safe and able to equitably participate across their lifespan and as the region navigates through the clean energy transition. As an accountability measure, GWH will update the *Healthy Women, Healthy Gippsland Report Card* every few years to monitor progress.

1.2 Context: Gippsland in Times of Rapid Change

Since colonisation, Gippsland's economic development has been built around a highly gendered workforce, including agriculture, fisheries, power stations and mining, paper mills and forestry, and the associated trade sector. This has created an environment where gender inequality has been perpetuated and normalised, resulting in some of the highest rates of gendered and family violence in the state, less than adequate access to women's health and wellbeing services, and alarmingly low rates of women in leadership and employment. Compounding these challenges, the region also has a recent history of devastating climate-related disasters. The cumulative and chronic health, wellbeing and safety impacts have profound implications for Gippsland women and communities in general.

Indeed, climate change adaptation and the impending clean energy transition in Gippsland form the backdrop to this report. Globally women and gender diverse people are disproportionately impacted by climate change and related disasters, but are underrepresented in decision-making around adaptation, mitigation and disaster preparedness. As the findings in this report attest, this is also the case in Gippsland.

Gippsland is facing major change as Victoria transitions from coal-fired power generation and gas to clean energy through the region's designation as a **Renewable Energy Zone** and the **first declared Offshore Wind Zone** in Australia (State Government of Victoria 2025a), in support of Victoria's ambition of achieving net zero greenhouse gas emissions by 2050. However, while Latrobe Valley's remaining coal-fired power stations are expected to close by 2035, it is not clear that renewable alternatives will be operational in time, creating concern about a potential 'energy crunch'.

In the meantime, surge workforces required for large-scale renewable projects will need to be accommodated and managed, while the region simultaneously grapples with workforce shortages in other industries such as health and social care. Coupled with the global climate change emergency and its local and gendered impacts, this transition presents the region with its most significant gendered challenge to date in terms of improving and maintaining women and gender diverse people's health, safety and participation

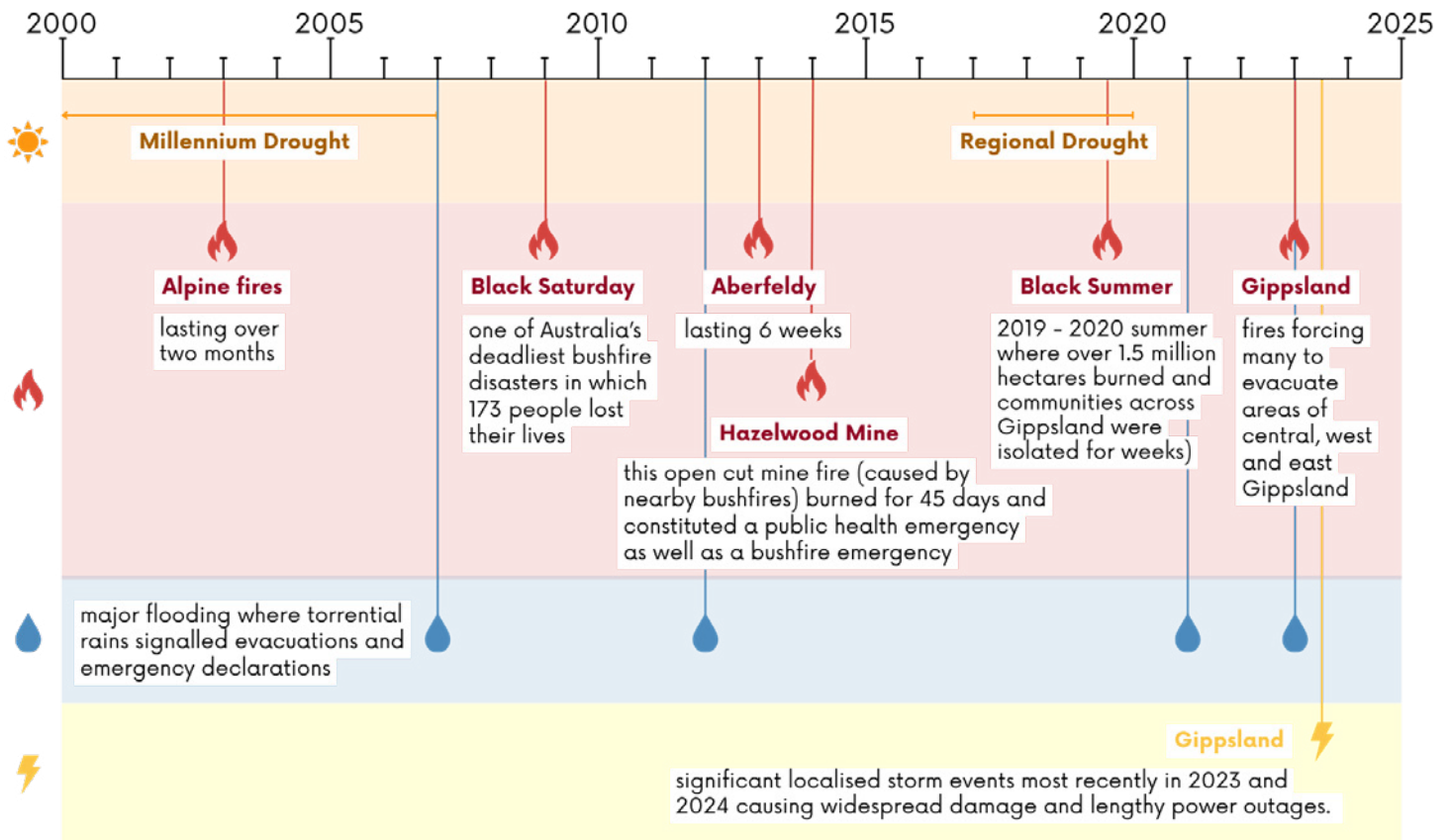
in their communities, workplaces and personal lives. Yet in both industry and policy circles, women are critically underrepresented in decision-making forums (Heslop 2024).

As documented in this report and elsewhere, Gippsland has its own set of existing problems when it comes to gender inequity, socioeconomic challenges and women's participation. Without careful planning, the combined impact of the energy transition, climate change and related disasters will further entrench these problems, bringing additional challenges for women, girls and gender diverse individuals in the region. Alternatively, if the challenges for women associated with both climate change and existing patterns of gender inequity in Gippsland are factored in, the energy transition presents the region with a once-in-a-generation opportunity to transform gender roles and position the region for a more gender equitable future – part of a 'gender just' transition that centres gender as part of ensuring an inclusive and equitable decarbonisation process (Taylor et. al. 2024; Walk 2023).



Climate Change and Related Disasters

As the timeline below illustrates, the Gippsland region has experienced significant climate-related and other disasters over the past 25 years, including extended droughts, catastrophic bushfires, and severe flooding and storm events.



Impact on Women and Gender Diverse People in Gippsland

Climate change is not gender neutral. Women, girls, and gender diverse people in Gippsland face disproportionate impacts, with climate-related disasters compounding existing inequalities across economic, health, and safety domains (WELA 2024; MCWH 2024). Addressing these gendered impacts is essential for equitable climate resilience in Gippsland.

Economic inequities—such as lower workforce participation, unpaid caregiving, and income disparities—are already significant for Gippsland women. Climate change threatens to deepen these gaps. Female-dominated industries like hospitality and tourism are more vulnerable to job losses after disasters, while women in health and care sectors face increased workloads supporting affected communities.

Volunteering during disasters is also gendered. Women's caregiving roles are often undervalued compared to the more visible, male-dominated

emergency response efforts (Orsatti & Dinale 2024). Increased care responsibilities during disasters can force women to reduce paid work, heightening financial insecurity and compromising their wellbeing. Food insecurity and rising living costs further challenge women's ability to maintain healthy lifestyles and adapt to climate change at home.

Health and safety risks are particularly acute in Gippsland, where access to quality healthcare is limited and rates of gendered violence are among the highest in Victoria. Climate-related disruptions worsen mental health, restrict access to sexual and reproductive healthcare, and increase risks during pregnancy, labour and birth, and early parenthood (Women Deliver 2021; WELA 2024).

Gendered and family violence often escalates during disaster recovery. Stress and trauma can intensify existing abuse, while some men's violent behaviour is excused on the basis of post-disaster stress. Women and gender diverse people may also be isolated from support services, leaving them more vulnerable (Orsatti & Dinale 2024).

Gippsland's Economy in Transition

The new energy transition is driven by the need to mitigate climate warming (given the significant contribution made by fossil fuel-based energy generation), as well as retire ageing coal power infrastructure and reduce reliance on depleted fossil fuel sources such as the Gippsland Basin. As vitally important as these objectives are, the shift to renewable energy will result in significant implications for Gippsland, including a workforce surge, particularly during the initial construction phase, and the potential for an energy shortfall.

Across the whole state, the Victorian Government has estimated that almost 25,000 jobs will be created in the process of achieving 50% renewable energy generation by 2030 (State Government of Victoria 2021). However, compressed timeframes such as this typically do not allow time for regional workforce development to enable local recruitment (Briggs et al. 2022). As a result, major infrastructure projects in regional areas often lead to surge workforces – large influxes of predominantly male workers into what become 'boomtowns' – small rural towns that rapidly expand, before contracting again once the project is completed.

An energy shortfall is also a real possibility for the region (and state). With the Latrobe Valley's three coal-fired power stations due to close within the next 5-10 years and declining gas production from the Gippsland Basin, Victoria's energy future is uncertain with a predicted severe shortage of gas as early as 2027 onward. Although the state has significant solar and wind generation potential, it is not clear that alternatives will be operational in time (Tamim Asset Management 2025; Wood 2024). Further compounding this testing set of circumstances are extreme weather events occurring on an annual basis in Victoria (driven by climate change) that are impacting existing energy infrastructure and growing demand for power as a result of digitisation (AI and cloud infrastructure) (Climate Change Authority 2025).

Gippsland has experience with temporary energy supply disruptions – the 1998 Longford gas explosion and 2024 Mirboo North Storm. Not only did the Longford gas plant explosion claim two lives and injure eight other workers, but the resulting catastrophic fire left Victoria without its primary gas supplier for more than 20 days. The shortage impacted over 1.4 million households and nearly 90,000 businesses. For everyday households this meant no gas supply for heating, cooking, and a range of other activities including limited access to LPG for motor vehicles. More recently, Mirboo North in South Gippsland experienced a

catastrophic weather event that killed one person and caused widespread damage to properties, infrastructure and roads. The community was isolated, had no drinkable water, unusable toilets, no electricity or internet and limited phone service.

Impact on Women and Gender Diverse People in Gippsland

The gendered impacts of both surge workforces and the possibility of an energy shortfall are significant. If poorly managed, surge workforces place additional pressure on existing services and housing and create unequal power dynamics – the risk of gendered violence increases, and economic challenges for women are exacerbated (Charman and O'Connor 2023). Given health, education, social services and housing are already stretched in Gippsland, rates of gendered violence are among the highest in the state, and women are more economically disadvantaged relative to men than Victorian women on average, an unplanned influx of workers and their families will likely further reduce service access and housing affordability and amplify existing gendered harms and inequity. Both the Longford and Mirboo events also remind us that energy disruptions are not gender neutral and impact women significantly, particularly those with significant unpaid domestic duties or caring responsibilities, those who work in highly gendered and often inflexible industries such as hospitality and healthcare, and those from underserved communities.

Planning for a 'Gender Just' Clean Energy Transition in Gippsland

'...an apparent gender neutrality in (Gippsland) planning documents in effect privileges masculinised elements of the economy. Current approaches to regional development, at best, reproduce the gendered status quo and, at worst, further re-entrench gender inequality in the region, with consequences for regional labour policy. We conclude that any regional policy that does not account for gendered realities and the lived experiences of women, ultimately fails the (Gippsland) region.'

Farhalla et al. (2020)

Farhalla et al. (2020) highlight that the gender-neutral framing used in Gippsland's planning documents often privileges male-dominated sectors, reinforcing existing inequalities. Without acknowledging gendered realities, regional policies risk failing the communities they aim to serve.

To ensure a 'gender just' energy transition that includes women, gender diverse people and men equally, planning must be gender-responsive. This means involving all stakeholders—government, industry, research, and community sectors—in creating inclusive strategies. Political representation is a strength in Victoria, with 55% of MPs and over half of public service executives being women (VPSC 2024). However, the private sector lags behind: women make up only 35% of clean energy workers nationally, with even fewer in technical and leadership roles, despite evidence that gender-diverse leadership improves financial and environmental outcomes (WELA 2024; Heslop 2024).

Women are also underrepresented in climate science, renewable energy research, and environmental leadership. Yet, at the community level, their leadership has led to more equitable governance and better conservation outcomes. Women tend to consider family and community in decision-making—an essential perspective for inclusive climate solutions.

Despite bearing the brunt of climate impacts, women and gender diverse people face barriers to leadership and participation. Initiatives like Equal by 30, WELA, and Gippsland Women's Health's Women in Energy and Manufacturing Project are working to change this, but more is needed.

Gippsland has an opportunity to lead by embedding gender equity into energy and climate adaptation planning. This includes supporting women's workforce participation, promoting flexible work, and investing in the care economy. A gender lens on workforce ecosystems benefits everyone—ensuring that women and gender diverse people are not further disadvantaged and that Gippsland thrives socially and economically through a fair and inclusive transition.



1.3 Working in Partnership

Victorian Government

GWH acknowledge the significant investment made by the Victorian Government in **women's health services and initiatives** (including specialist multidisciplinary women's health clinics, Sexual Reproductive Health Hubs, the Virtual Women's Health Clinic, Aboriginal Women's Health Clinics, Mobile Women's Health Clinic, the Free Pads and Tampons Initiative, and the recent women's pain inquiry – the first of its kind in Australia), as well as **mental health** (Mental Health and Wellbeing Locals and Mental Health and Wellbeing Connect services) and, in partnership with the Commonwealth Government, **primary care** services (Urgent Care Clinics). These initiatives are already making an important difference.

The Victorian Government has also made important investments in relation to **family and sexual violence** following the 2015 Royal Commission. On **prevention**, these include ongoing support for the primary prevention work of the Victorian WHSN, establishing Respect Victoria in 2018, and introducing Respectful Relationships Education in Victorian schools from 2017. Major reforms to the **family and sexual violence response** sector include the rollout of the Multi-Agency Risk Assessment and Management (MARAM) Framework and The Orange Door network – a community-based point of entry for women, children and young people experiencing family violence.

The Victorian Government has also supported women and gender diverse people to **adapt to climate change** and **participate in the clean energy transition** through funded projects such as the Women in Energy and Manufacturing initiative and the Women Powering Change campaign through the Clean Energy Council.

Regional Partnerships

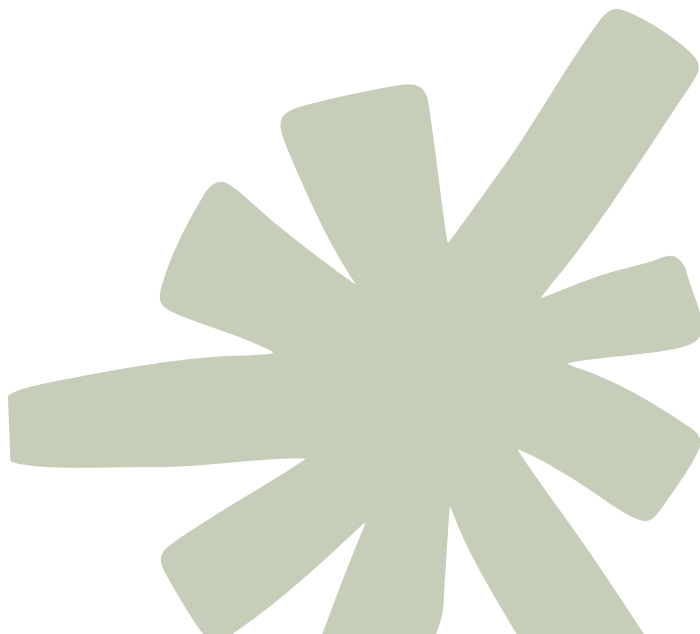
GWH participate in and contribute to significant partnerships across the region including formal networks and regional working groups and committees.

We lead important strategies including the **Respectful Gippsland (prevention of violence) partnership** and the **Sexual and Reproductive Health partnership** – both of which have executive leadership representation from key stakeholders from across the region. GWH not only auspice but are key stakeholders in the **Gippsland Family Violence Alliance (GFVA)** – the regional integrated committee that manages family violence systems reform.

Other partnerships of significance are:

- One Gippsland
- Committee for Gippsland
- Local Health Service Network
- Gippsland Regional Public Health Unit (Primary Care and Population Health Committee)
- Latrobe Regional Hospital Research Partnerships Committee
- Primary Care and Population Health Committee
- Regional Development (Gippsland)
- Food and Fibre Gippsland
- Gippsland Primary Health Network
- Gippsland Environmental Agencies collective
- Gippsland Climate Change Network

GWH also has strong partnerships with TAFE Gippsland, Federation University Gippsland and Gippsland Pride Initiative.





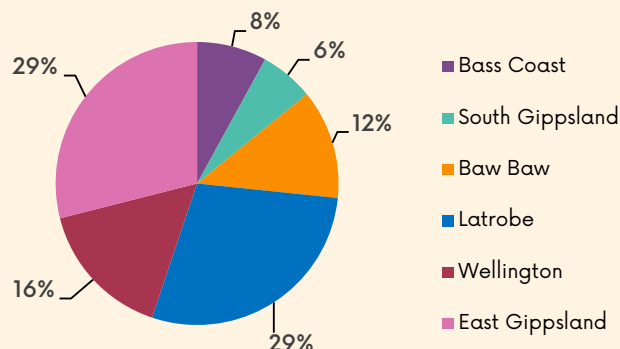


2. ABOUT GIPPSLAND

2.1 First Peoples

For at least 35,000 years, the southeastern Victorian region now known as Gippsland has been home to the Bunurong (or Boonwurrung), Gunaikurnai, Bidwell, Ngarigo Monero and Jaithmathang peoples. Bunurong Country encompasses parts of Bass Coast Shire, Baw Baw and South Gippsland as well as southern Naarm / Melbourne and is believed to have been inhabited for at least 35,000 years (State Government of Victoria 2005b). Gunaikurnai country is the largest geographical area, from Warragul in the east to the Snowy River in the east, and from the Great Dividing Range in the north all the way to the coast. The Gunaikurnai peoples have inhabited the area for an estimated 20,000 years (GLaWAC 2025). In parts of Gippsland, formal recognition of Traditional Ownership is not yet in place (Fig. 1), including the northern and outer eastern parts of East Gippsland which span the Victorian / NSW border – Bidwell, Ngarigo Monero and Jaithmathang Country (EGCMA 2025; Jaithmathang 2025).

Fig. 2: Proportion of Gippsland Aboriginal and Torres Strait Islander population by LGA (2021)



Source: idcommunity demographic resources, Remplan, ABS Census (2021)

Fig. 1: Map of Recognised Aboriginal Parties' boundaries in Victoria (2025)



Source: Aboriginal Cultural Heritage Register and Information System (ACHRIS), 2025

2.2 European Colonisation, Settlement and Economic Development of Gippsland

The first European settlement in the region was established in 1835 on the Bass River (*Weandon Yallock* or *Tullungurn* in *Bunurong* language), but more intensive colonisation did not take place until the 1860s as gold was discovered near places such as Walhalla, Dargo and Omeo.

GWH acknowledges that terms such as 'settlement' and 'colonisation' mask 'forms of genocide, social engineering and legalised relocation' (Paton, Horton and Marsden 2020) that occurred in Gippsland resulting in loss of life, dispossession, disruption of family and cultural relationships and identity, loss of language and cultural practices, and wage theft - the effects of which continue to impact First Nations peoples throughout Gippsland today.

Later, so-called 'black gold' (coal) would prove a far more significant resource discovery – particularly the discovery of one of the world's largest reserves of brown coal in the Latrobe Valley in the 1870s, which set the region on course to become the home of Victoria's electricity industry. Open cut mining was established, and the first power station, Yallourn, commenced operation in 1921. Four further power stations were built from the late 50s onwards as energy demand grew. Today only Yallourn W, Loy Yang A and Loy Yang B are still in operation, albeit not for much longer.

The other landmark fossil fuel resource discovery in the region was the Gippsland Basin – initially the site of Australia's first oil drilling from 1924 – 1945 near Lakes Entrance, and from the 1960s when the exploitation of offshore gas commenced (State Government of Victoria 2025b). Gippsland brown coal and gas have underpinned Victoria's power supply ever since.

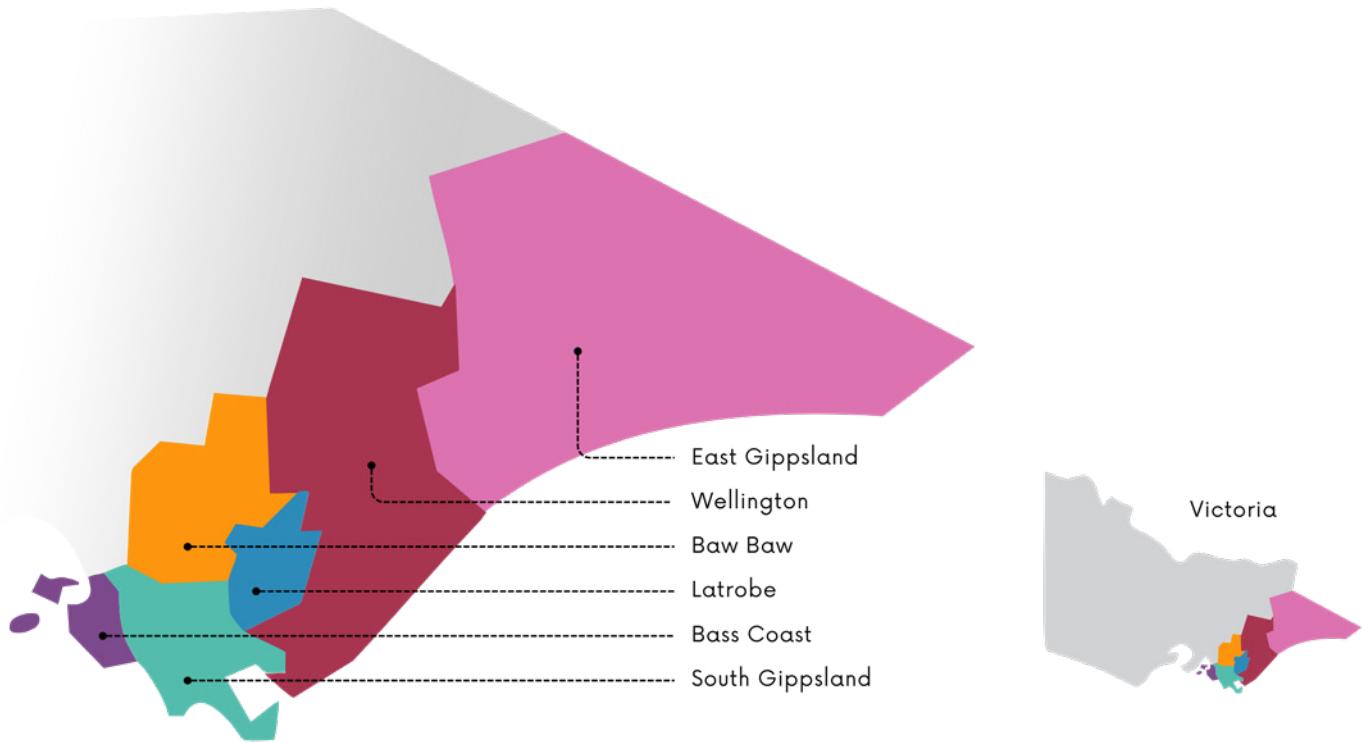
In addition to mining and energy, forestry, agriculture and the associated trade sector also emerged as significant industries in Gippsland, along with health, education, social care and tourism (Regional Development Victoria 2025). The early predominance of masculinised industries centred on natural resource exploitation and commodities shaped Gippsland's workforce and gender culture in ways that reverberate through to the present, including in relation to the forthcoming energy transition as fossil fuel mining and power generation give way to renewable energy.



2.3 Gippsland's LGAs

Administratively, Gippsland comprises 6 LGAs – Bass Coast, Baw Baw, East Gippsland, Latrobe, South Gippsland and Wellington (Fig. 3). Where these place names are used in this report, the reference is to the LGA.

Fig. 3: Map of Gippsland LGAs

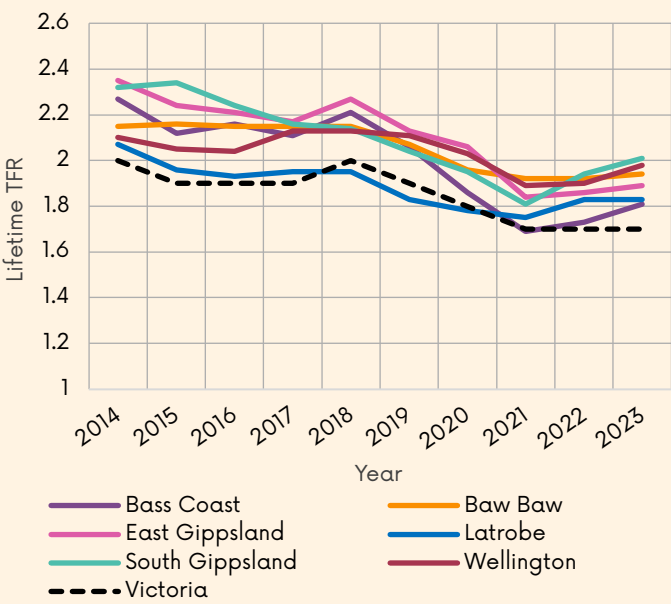


An overview of Gippsland's 2024 estimated population and geographic size by LGA and as a region is provided below. As Table 1 illustrates, Latrobe has both the highest population and is the most densely populated. East Gippsland is the largest LGA, comprising half of the entire region, and Baw Baw had the fastest population growth, closely followed by Bass Coast, both well above the average of 1.2% for regional Victoria (ABS 2025a).

Gippsland's population growth is driven by migration (domestic and international). Birth rates in the region have been gradually falling, as they are across the rest of Victoria (except for some slight increases since 2021).

Regional Australians have a higher Total Fertility Rate (TFR) than those living in metropolitan cities (AIFS 2024), as has been the case throughout most of Gippsland over the last decade (Fig. 4).

Fig. 4: Lifetime Total Fertility Rate (TFR): Gippsland LGAs vs Victoria (2014 – 2023)



Source: Victorian Women's Health Atlas

Table 1: Gippsland LGAs – Estimated population and population growth, area and population density (2024)

LGA and council seat	Population (estimated)	Population – female ²	Population – male	Estimated population growth rate (%)	Area (km ²)	Population density (persons per km2)
Bass Coast (Wonthaggi)	43,557	22,388	21,169	1.94	864	50.41
Baw Baw (Warragul)	61,905	31,757	30,148	2.09	4,025	15.38
East Gippsland (Bairnsdale)	49,422	25,106	24,316	0.50	20,931	2.36
Latrobe (Morwell)	80,524	41,148	39,376	0.78	1,426	56.47
South Gippsland (Leongatha)	31,022	15,697	15,325	0.65	3,295	9.41
Wellington (Sale)	46,533	23,080	23,453	0.90	10,811	4.30
Gippsland	312,963	159,177	153,786	1.14	41,352	7.57

Source: idcommunity demographic resources, Remplan

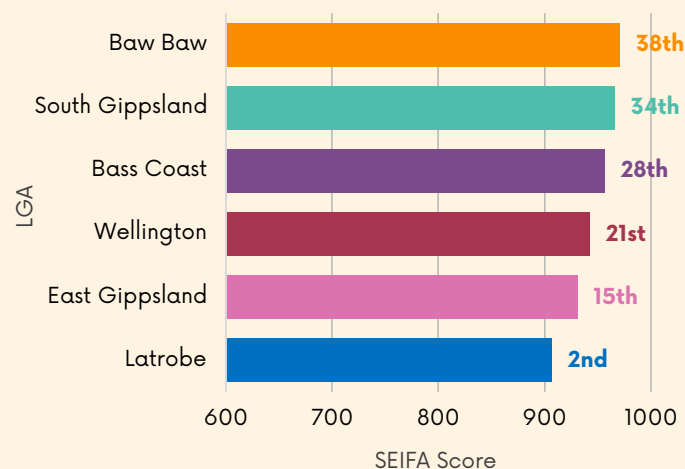
2.4 Socio-economic Overview

Significant socioeconomic variation exists within Gippsland as illustrated by each LGA's Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) Socio-Economic Indexes for Areas Australia (SEIFA) ranking, as well as homelessness and educational attainment data. (Also relevant are income and employment data, included in Chapter 5).

SEIFA Data

Overall Gippsland LGAs are clustered within the lower half of Victoria's 79 LGAs as illustrated by Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) Socio-Economic Indexes for Areas Australia (SEIFA) rankings (Fig. 5). The rankings reflect a pattern that recurs through much of the data in this chapter – Bass Coast, Baw Baw and South Gippsland have a higher socioeconomic status than East Gippsland, Latrobe and Wellington.

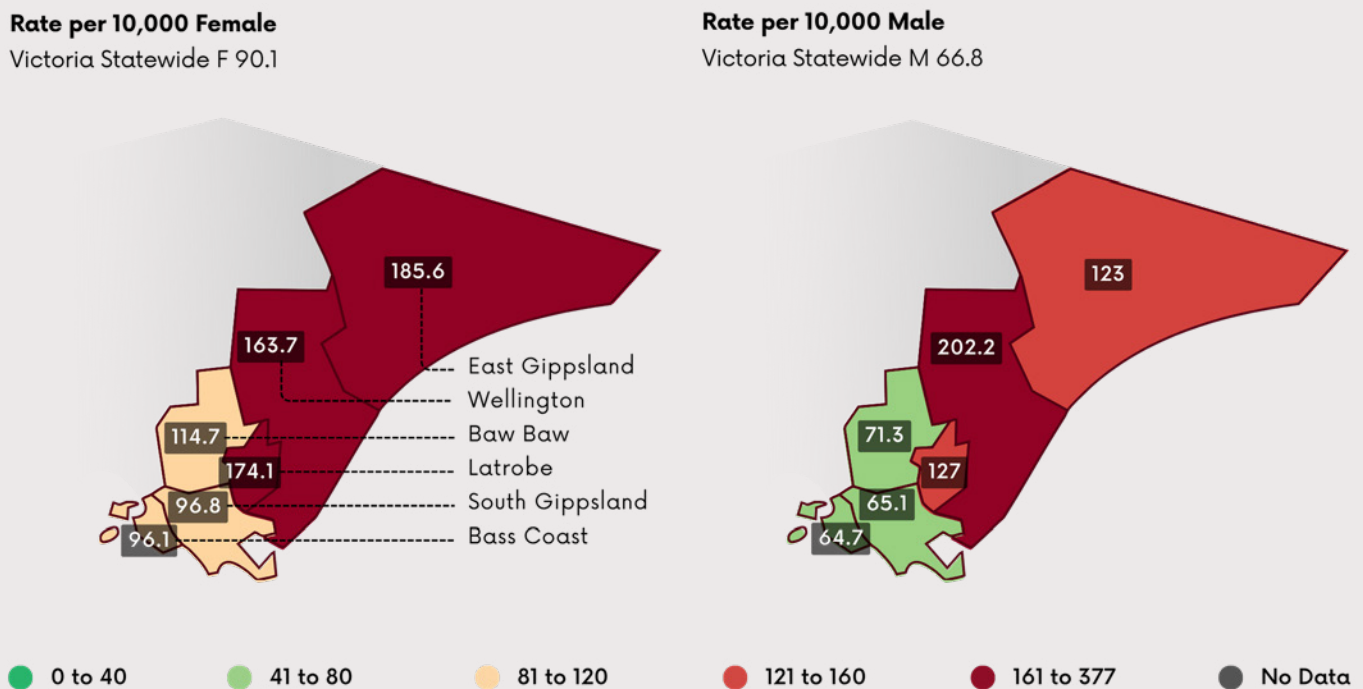
Fig. 5: Gippsland LGAs: SEIFA scores and IRSAD ranking in Victoria (2021)



Source: ABS – Index of Relative Socio-Economic Advantage and Disadvantage (2021): Socio-Economic Indexes for Areas (SEIFA)



Fig. 6: Map showing homelessness rate per 10,000 (females and males): Gippsland LGAs (2024)



Source: Victorian Women's Health Atlas / AIHW Specialist Homelessness Services Collection 2024 / ABS Census (2021)

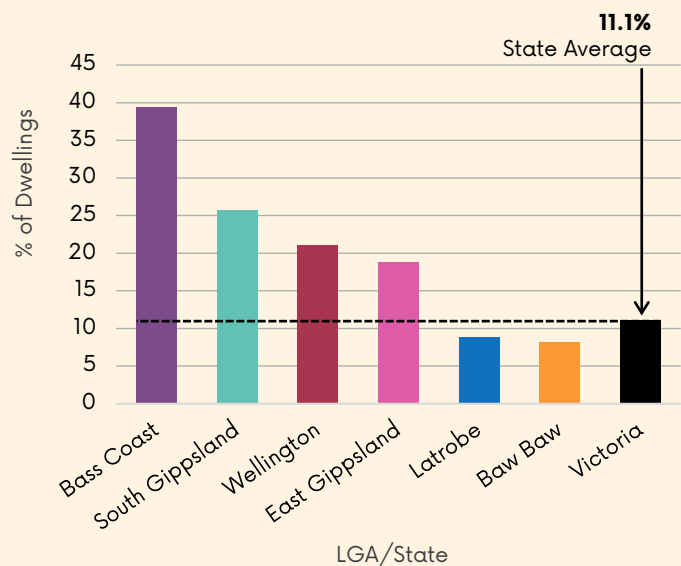
Homelessness

Variation in homelessness rates across the region is another indicator of patterns of relative advantage and disadvantage. Rates of homelessness are significantly higher than the Victorian average in East Gippsland, Latrobe and Wellington, which rank 4th, 7th and 9th in the state respectively for female homelessness out of a total of 79 LGAs. In comparison, rates in Baw Baw, South Gippsland and Bass Coast are closer to the statewide average.

As measured by the AIHW Specialist Homelessness Services Collection, the rate of women experiencing homelessness in Australia is higher than that of men, a picture that was replicated across 5 out of 6 Gippsland LGAs in 2024 (Fig. 6).

The housing shortage in Gippsland has in recent decades been exacerbated by the low proportion (3.5%) of social housing households across Victoria (AIHW 2025a) and the high proportion of unoccupied homes in the region (Fig. 7). Many of these are likely to be holiday homes, given they are concentrated in the 4 coastal LGAs, all of which are popular tourist destinations (Baker, Beer and Blake 2022)³

Fig. 7: Proportion of dwellings unoccupied on Census night: Gippsland LGAs vs Victoria (2021)



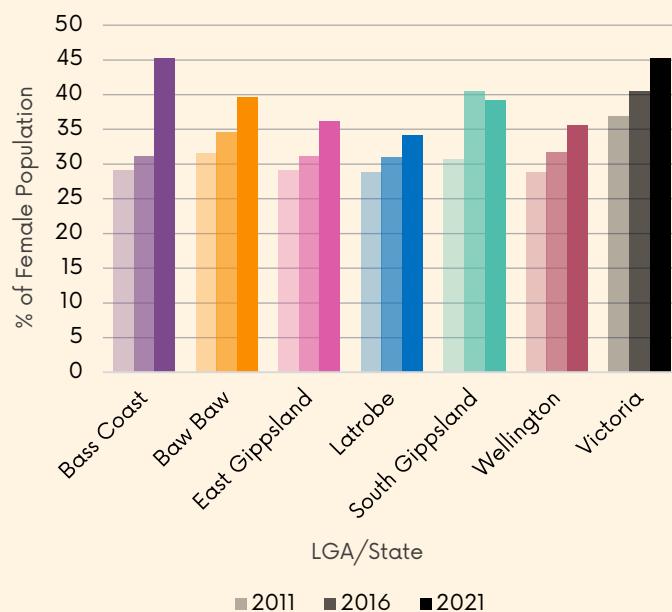
Source: Gippsland Homelessness Network (2022) / ABS Census (2021)

Educational Attainment

As Fig. 8 illustrates, while educational attainment among women in Gippsland improved between 2011 and 2021 across the region, all LGAs other than Bass Coast continue to lag the 2021 Victorian average of 45.3%.

Across Gippsland, women have higher rates of attaining Year 12 or equivalent than men (Fig. 9). Rates of educational attainment are also higher in Inner Gippsland than Outer Gippsland.

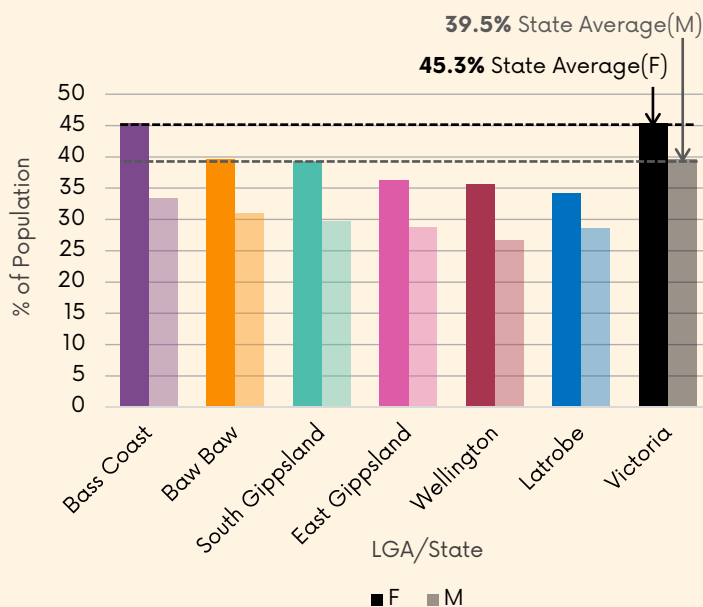
Fig. 8: Proportion of population who have attained Year 12 or equivalent (females): Gippsland LGAs vs Victoria (2011 – 2021)



Source: Victorian Women's Health Atlas / ABS Census (2011 - 2021)



Fig. 9: Proportion of population who have attained Year 12 or equivalent (females and males): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas / ABS Census (2021)

2.5 Underserved Communities in Gippsland

Underserved communities, also referred to as priority populations, are groups within the community that face higher barriers to social and economic inclusion, and higher barriers to accessing health and social services because of structural inequality, leading to poorer health and wellbeing outcomes.

Box 1: What is structural inequality?

Structural inequality occurs 'when differences in access, distribution of wealth, availability of resources, or power are reinforced through structural mechanisms such as housing, education, employment, income, social assistance, health care, and criminal justice (Egede, Walker and Williams, 2023).

These mechanisms often overlap and reinforce one another, for example when an unhoused person finds it difficult to complete education or get a job because they do not have stable accommodation. Their resultant lower level of education or income then makes it difficult for them to take care of their health and access care when needed, leading to poorer long-term health outcomes. (See also [Box 6](#) on the social determinants of health.)

Women and gender diverse people are one such group, due to persistent gender inequality in Australian society. However, other forms of inequality intersect with gender inequality, creating even higher barriers to good health and timely access to quality healthcare. These inequalities operate at the structural and/or interpersonal level and include:

- discrimination towards and lack of services for women living in regional and remote communities.
- the legacy and ongoing impacts of colonisation, dispossession and racism on First Nations women,
- homophobia and transphobia towards LGBTQIA+ community members,
- racism towards women and gender diverse people from ethnocultural minority backgrounds,
- ableism towards women with disabilities, and
- ageism towards older women.

To redress these inequities and improve health and safety outcomes for underserved communities, sustained and coordinated efforts are needed across the health system as well as outside it – in education, employment, the criminal justice system, and more.

The data below provides a snapshot of Gippsland's underserved communities of women and gender diverse people and their health and wellbeing, noting data limitations in relation to some groups.

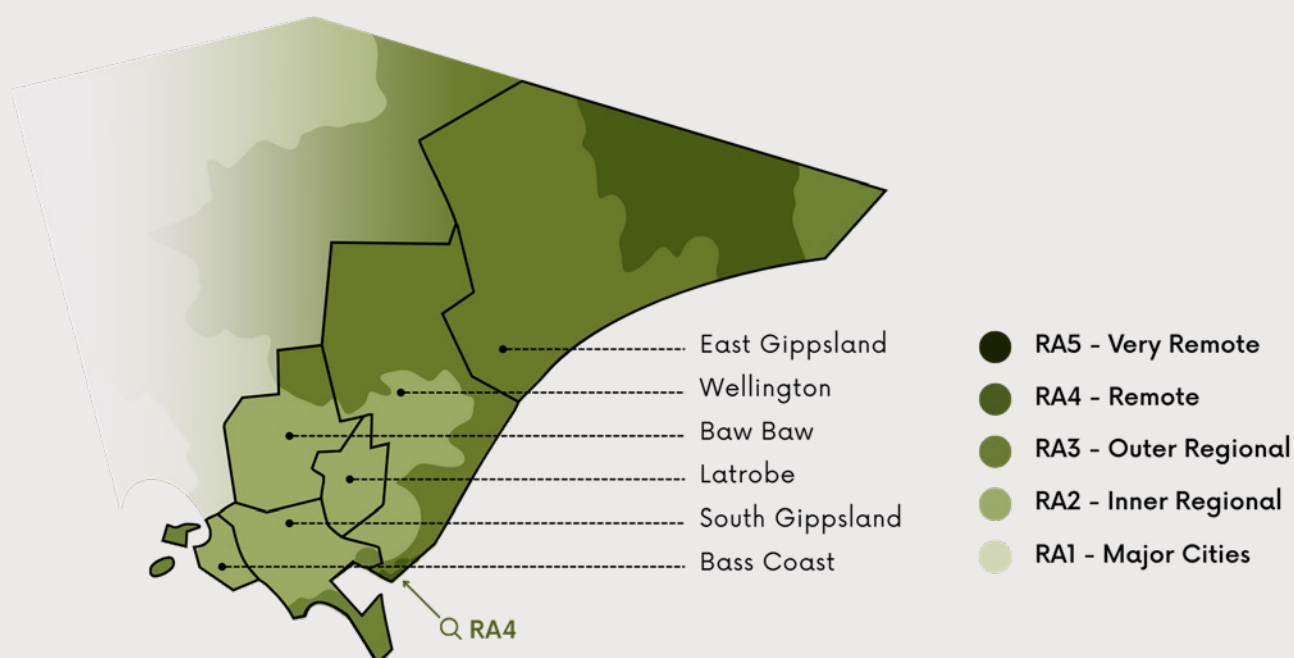
Women Living in Regional and Remote Areas

Women and gender diverse people living in remote parts of Gippsland are disadvantaged by their distance from health care and family and sexual violence services (see Figs. 33 and 34, Chapter 3). The map below shows the relative remoteness of different areas of Gippsland (Fig. 10). Using the

Australian Statistical Geography Standard (ASGS) classifications, different parts of the region range from RA2 (Inner Regional) to RA4 (remote) (ABS 2025b).

While the majority of Gippsland's population lives in LGAs or town centres that are classified as Inner Regional, there are nonetheless many communities in the Outer Regional and Remote parts of the region with particularly limited access to health and support services.

Fig. 10: Map of Gippsland showing LGAs and Remoteness Areas



Source: ABS (2025) *ABS Maps – 2021 LGAs and Australian Statistical Geography Standard (ASGS) RAs*



First Nations Women

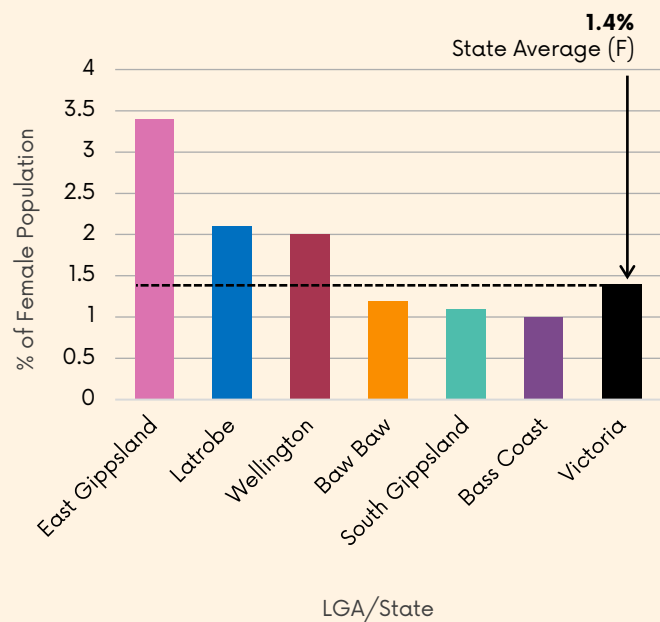
Within the Gippsland region, there were an estimated 2,526 First Nations females (including female children) at the last Census in 2021. East Gippsland, Latrobe and Wellington have higher proportions of First Nations women in the population than the Victorian average (Fig. 11).

Poorer health outcomes and higher rates of family and sexual violence for First Nations people in Australia reflect the legacy of colonisation, dispossession, the Stolen Generations, unpaid wages, and ongoing structural racism including disproportionate rates of child removal and incarceration. National AIHW data from 2018 indicates that the top 5 disease groups contributing to the burden of disease (conditions that cause illness and disability rather than death) for First Nations people include mental health, injuries (including

suicide), substance use, cardiovascular disease, cancers, and musculoskeletal conditions (AIHW 2024a). Diabetes, coronary heart disease, Chronic Obstructive Pulmonary Disease (COPD), lung cancer and dementia are the top five causes of mortality among First Nations women (AIHW 2025).

Although significant work is needed to close the health and wellbeing gaps between Aboriginal and Torres Strait Islander and non-Indigenous Australians, improvements are also occurring. Smoking rates are declining (including among pregnant women), the percentage of women receiving antenatal care is increasing and the rate of Aboriginal and Torres Strait Islander people receiving Indigenous-specific health checks is increasing (Commonwealth of Australia 2025). Culturally safe, First Nations-led healthcare initiatives such as Birthing on Country have had positive impacts such as reducing the percentage of preterm births (Australian Human Rights Commission 2024).

Fig. 11: Proportion of population identifying as Aboriginal or Torres Strait Islander (females): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas / ABS Census (2021)



LGBTQIA+ Community Members

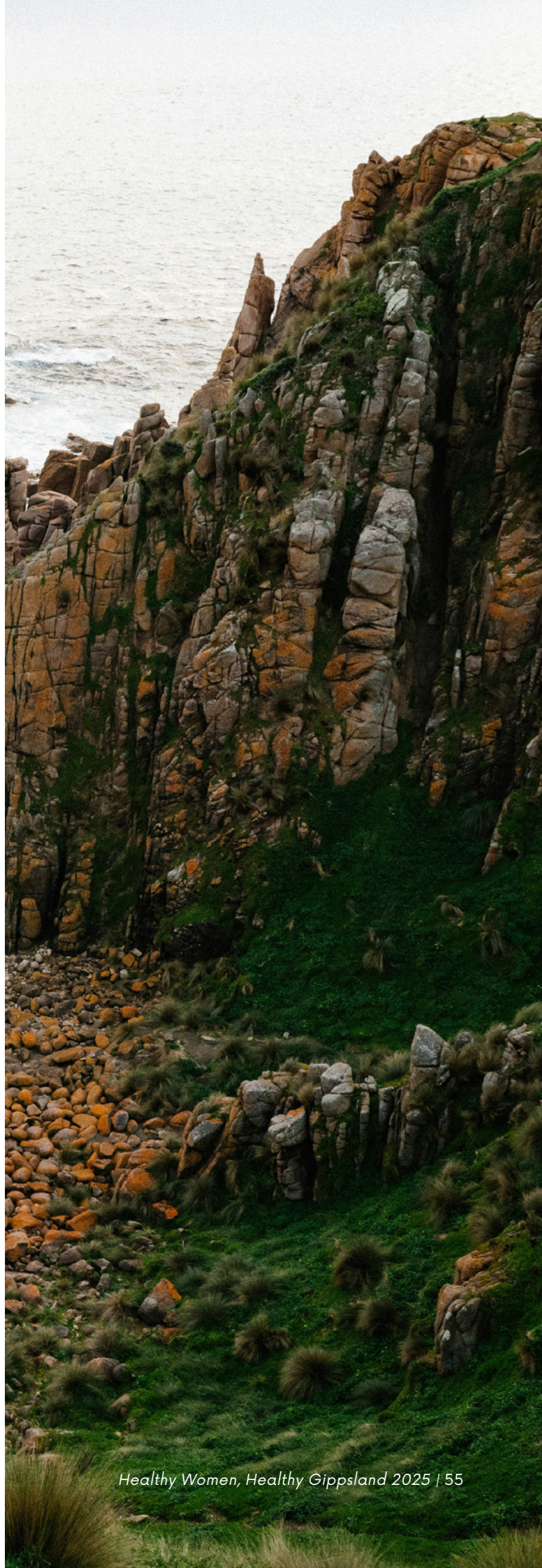
Currently data is not collected at the population level about LGBTQIA+-identifying Australians, although this is changing in the 2026 Census. According to the ABS, around 4.5% of the population aged over 16 identifies as LGBTQIA+. Based on the total Gippsland population in 2021⁴, this would translate to around 11,500 people – a group of significant size, about whom we know little due to lack of data reportable to the LGA level. Fortunately, some insights into this community are available via the *2023 Rainbow Brick Road Report* (Gippsland Pride Initiative and CERG 2023) and at a national level from the Private Lives 3 report (Hill et al 2020), both of which we draw on throughout this report.

As noted in the Victorian Government's *Pride in our future: Victoria's LGBTQIA+ strategy 2022–32* (State Government of Victoria 2023a), higher levels of discrimination, stigma, exclusion and violence faced by LGBTQIA+ Victorians lead to poorer health, economic, social and mental health outcomes than for other Victorians.

Almost 6 in 10 respondents to the national Private Lives 3 (PL3) survey in 2019 reported facing unfair treatment based on sexual orientation, while more than 3 in 4 trans and gender diverse respondents had faced unfair treatment based on their gender identity (Hil et al 2020).

The impact on LGBTQIA+ Australians' health is clear – over half of PL3 respondents reported high or very high levels of psychological distress in the past four weeks compared with 13 % of the general Australian population. Thirty-eight per cent of respondents reported having a disability or long-term health condition, including mental health, compared with 17.7% of the general Australian population (Hill et al 2020).

LGBTQIA+ people living regionally face even higher levels of discrimination and fewer inclusive supports. More LGBTQIA+ people in rural and regional areas rate their health as 'poor' compared with outer and inner suburban communities, and a higher percentage of regional or rural / remote respondents reported ever attempting suicide (Hill et al 2020). These findings are corroborated in the Gippsland region by the *Rainbow Brick Road Report* (Gippsland Pride Initiative and CERG 2023).



Migrant, Refugee and Minority Ethnocultural Background Women

All non-First Nations Australians are migrants. However, asylum-seekers and refugees, recent migrants, temporary workers, and/or people from minority ethnocultural backgrounds in general face more structural racism and barriers to social and economic inclusion than those with a longer history of living Australia or who are from an English-speaking and/or European background.

Compared with other parts of regional Victoria and the state overall, Gippsland has relatively few first-generation migrant, refugee and seasonal worker women and is less culturally diverse, though this is gradually changing.

Refugees

According to the Refugee Council of Australia (2023), just 77 humanitarian visa holders settled in Gippsland in the decade from 2013 to 2023, a relatively small number – though refugees who have been sponsored via the Community Refugee Sponsorship program then relocated to Melbourne may not be captured in these numbers (Lees 2003).

Temporary Migrant Workers

Temporary migrant workers include seasonal workers on the Pacific Australia Labour Mobility (PALM) scheme (including both short and long-term workers) and working holiday makers (WHM), more commonly known as backpackers. Gippsland-level data on the number of seasonal workers and backpackers was not available at the time of publication, much less sex-disaggregated data. At a state level, there were 5,140 PALM workers across Victoria in July 2025, most of whom were in the long-term stream (PALM Scheme 2025). Short-term workers are concentrated in agriculture and horticulture while long-term workers mostly work in meat processing and other industries such as health or social assistance (PALM Scheme 2025).

Permanent Migrants and Women from Minority Ethnocultural Backgrounds

Determining precise estimates of permanent migrant women or those from minority ethnocultural backgrounds in Gippsland, the countries they are from, and their ethnicity is challenging due to government data collection methods (Renzaho 2023). To approximate this information, we report the percentage of Gippsland women born in Australia (recognising that a proportion of these will be second or later generation migrants) (Fig. 12) and most common countries of birth outside Australia (Table 2).

Women in Gippsland are more likely to be born in Australia than the Victorian state average, with the proportion of Australian born women ranging from 77.3% in Bass Coast to 81.9% in Baw Baw.

2021 Census data indicates that the majority of Gippslanders born outside Australia were born in England (3.6%), New Zealand (1.2%) or the Netherlands (0.7%). By contrast, the top three overseas countries of birth of Victorians were India (4%), England (2.7%) and mainland China (2.6%) - see Table 2.

This is likely to change in future, as the top five countries of birth for non-Australian born Gippsland residents from 2017 – 2021 were India, Philippines, England, New Zealand and Taiwan, and skilled migrants are the fastest growing stream of migrants to the region (GPHN 2025).

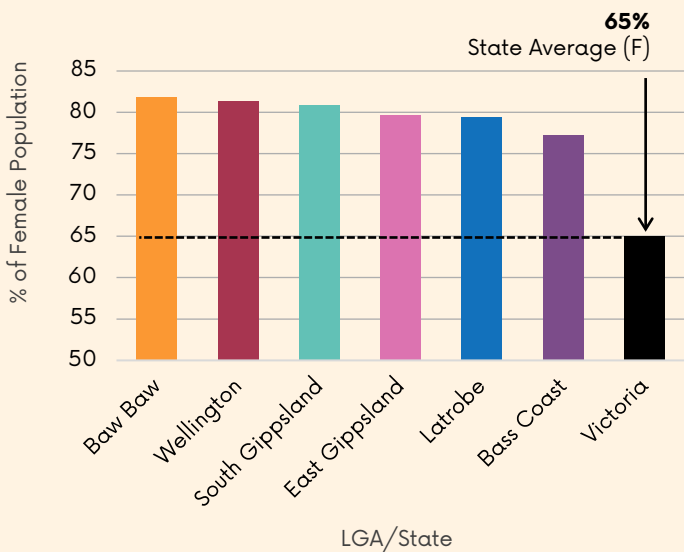
Health and safety needs vary significantly according to people's individual circumstances but sexual and reproductive health, mental health, family violence and occupational health and safety are key priorities for migrant and refugee women and gender diverse people (MCWH 2021; Tran et al. 2023; Coates, Wiltshire and Reysenbach 2023). However, access to healthcare and other support including for family and sexual violence depends on visa class as well as availability of in-language or adequate interpreting services, as well as services that are culturally responsive and low cost. In regional areas such as Gippsland, such services exist but are often in short supply and geographically dispersed.

Table 2: Top five countries of birth (excluding Australia): Gippsland LGAs vs Victoria (2021)

LGA	Top 5 countries of birth (in descending order of size of population)
Bass Coast	England, New Zealand, Netherlands, Italy, Scotland
Baw Baw	England, New Zealand, Netherlands, India, Scotland
East Gippsland	England, New Zealand, Philippines, Netherlands, Germany
Latrobe	England, New Zealand, Netherlands, Philippines, India
South Gippsland	England, New Zealand, Netherlands, Italy, Germany
Wellington	England, New Zealand, Philippines, Netherlands, India
Victoria	India, England, China, New Zealand, Vietnam

Source: ABS Census (2021) – All Persons Quick Stats

Fig. 12: Proportion of population born in Australia (females): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas / ABS Census (2021)



Women with Disabilities

In the Australian Census, the percentage of the population with a profound or severe disability is captured by a question asking if a person needs assistance with one or more core activities (self-care, mobility and communication), whether due to disability, a long-term illness or older age.

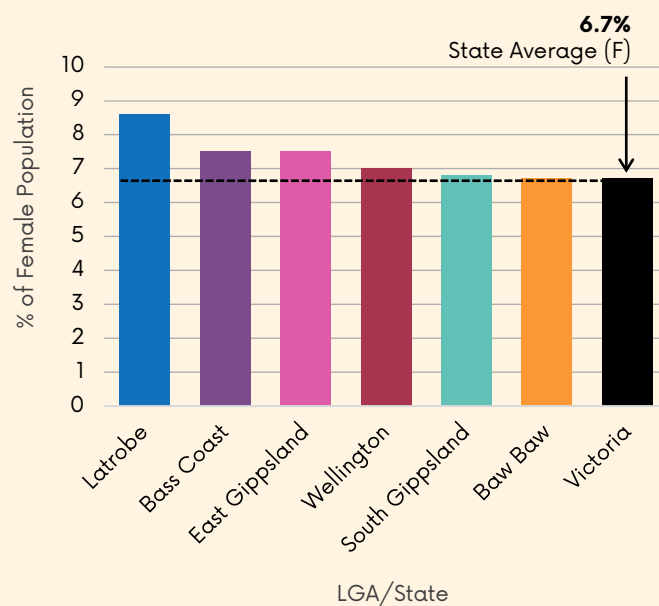
In 4 of 6 Gippsland LGAs in 2021 (Fig. 13), the proportion of women needing assistance with core activities was higher than the state average – Latrobe has the highest proportion of women with disabilities in the region.

People with a disability face significant disadvantage and economic and social barriers that contribute to poorer health outcomes and life expectancy. Barriers to health service access are often compounded in rural and remote areas and include distance and inadequate transport, discrimination, communication challenges and physical barriers.

People with disabilities are much less likely to report excellent or very good health compared with those without disabilities (35% vs 69%) (AIHW 2024b). For those with profound or severe disabilities, this falls to just 12%. Around 3 in 4 people with disabilities report musculoskeletal disorders as their main health problem; for around 1 in 4 it is mental health problems. Around 1 in 3 experience high or very high psychological distress as compared with non-disabled people, rising to over half of people with profound or severe disabilities (AIHW 2024b).

Chronic illness is also more common among people with disabilities, and this is magnified in rural Victoria where people with an intellectual disability have higher rates of diabetes, heart disease and hypertension. Obesity, smoking and a lack of exercise are all higher for people with a disability than for the general population, and they also have lower cancer screening participation rates (Cancer Council Victoria 2025).

Fig. 13: Proportion of population needing assistance with core activity (females): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas / ABS Census (2021)



Older Women

As shown in Fig. 14, East Gippsland has the highest proportion of older women (60+ years) and one of the lowest proportions of women under 18, followed by Bass Coast. At the other end of the spectrum, Latrobe has the 'youngest' age profile of women, likely a reflection of having a higher share of migrants (who tend to be younger) relative to other LGAs in Gippsland.

The same pattern is evident in Fig. 15 below, which shows the percentage of females aged 75 and over living alone by Gippsland LGA in 2021 compared with males, in order of highest to lowest for females. Not only is the percentage higher than the Victorian average for 4 of the 6 LGAs in Gippsland, but the sex disparity is striking – in all LGAs (and across Victoria) the female to male ratio is 2:1.

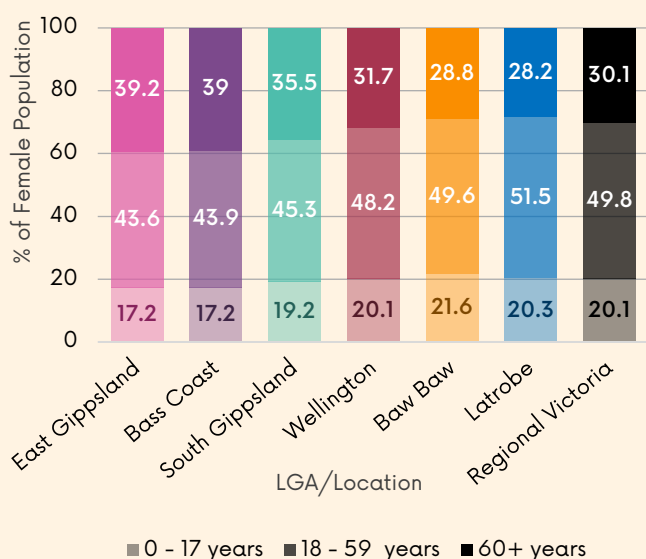
Older women in Victoria face a range of health challenges that are shaped not only by biological ageing but also gender inequality, ageism, and systemic barriers to care (Women's Health Victoria 2023). The leading cause of death of Australian women is dementia (around 12%) followed by coronary heart disease (7.6%), cerebrovascular disease, lung cancer and chronic obstructive pulmonary disease (COPD) (AIHW 2025). Arthritis and musculoskeletal disorders are the leading causes

of pain and mobility issues for older women, and dementia, coronary heart disease and COPD become increasingly common with age (AIHW 2024c).

Older women can also experience mental health challenges including depression and anxiety, often exacerbated by isolation or caregiving stress. As women age, their body image, confidence and self-esteem can be eroded and contribute to poor mental health outcomes because of ageism and invisibility across all forms of media. Loneliness and social isolation especially for women living alone or in residential aged care also contribute to poor health outcomes for older women.

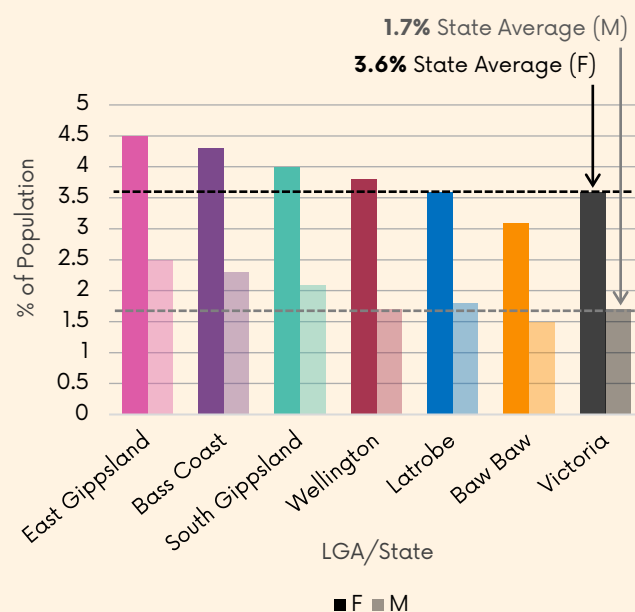
As a result of the current gendered medical model women's experiences of perimenopause, menopause and hormonal changes are often dismissed in mainstream health care. Many older women face significant economic hardship due to the gender pay gap, caregiving responsibilities and interrupted careers impacting their earning capacity and access to sufficient superannuation at retirement. For older rural and remote women their access to timely and appropriate health care is impeded by affordability, a lack of transport, poor digital literacy and medical misogyny and ageism. Timely access to residential aged care services is also challenging for older women in rural and regional areas (AIHW 2024d).

Fig. 14: Female population by age bracket: Gippsland LGAs vs regional Victoria (2021)



Source: idcommunity demographic resources, Remplan, ABS Census (2021)

Fig. 15: Proportion of population aged 75 years and over and living alone (females and males): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas / ABS Census (2021)



3. WOMEN'S HEALTH AND ACCESS TO HEALTH CARE IN GIPPSLAND

In seeking to understand health and safety outcomes and service use for women and gender diverse people across Gippsland, publicly available statistical data captured at the population level or via large-scale surveys is a rich source of information about patterns and changes over time and place. However, to understand what matters to Gippsland women and gender diverse people themselves about these issues, we invited them to share their experiences and stories.

To this end, the *Healthy Women Healthy Gippsland 2025* Report Card involved:

- an online survey for community members with a mix of closed and open-ended questions,
- a series of focus groups, and
- interviews with several regional sector experts ('key informants')

in addition to collating quantitative data on health and safety outcomes and economic participation and leadership.

In this and the following chapters we share the key findings from our analysis of all data collected – further details on our research approach can be found in Appendix 1. We have organised the analysis around the key findings – this chapter focuses on health and health care access, Chapter 4 on preventing and responding to gendered and family violence, Chapter 5 on women's economic participation and leadership, and the final chapter on gender and climate and related disasters.

This chapter presents the key findings from our analysis of survey responses and focus group discussions in relation to health and wellbeing, which are grouped under two overarching themes – accessing health care, and health promotion and prevention. It also includes a third section on the health status of Gippsland women and gender diverse people and key inequities featuring statistical data on health outcomes and behaviours with a focus on three GWH priority areas – mental health and wellbeing, sexual and reproductive health, and chronic disease (including cancer).

Box 2: Presenting participants' quotes

While quotes from key informants are identified by their name and affiliation, to protect people's identities, community member participant quotes are attributed using their gender, age, and LGA only, and whether they were a survey or focus group participant. Focus groups are identified by number or name (Multicultural and Refugee Women Focus Group, First Nations Women Focus Group, and Women with Disabilities Focus Group).

Community member participant quotes are also colour-coded as follows:

- **Positive experiences**
- **Suggestions and recommendations**
- **Negative experiences.**

To learn more about the *Healthy Women Healthy Gippsland 2025* Report Card participants, see [Appendix 2](#).

3.1 Accessing Health Care – Enablers and Barriers, Quality and Availability

Key Finding 1: There are persistent challenges with accessing health care for women and gender diverse people in our region

Access enablers and barriers refer to the factors that either facilitate or hinder people's ability to obtain the healthcare services they need. Underserved or structurally marginalised groups within the community may experience additional barriers or enablers unique to their needs or strengths.

What We Heard

For *Healthy Women Healthy Gippsland 2025* participants, access (or lack of) to healthcare was a prominent theme across all focus groups and throughout survey responses. Access enablers and barriers they mentioned included:

- [distance and travel requirements](#),
- [telehealth](#),
- [wait times and waitlists](#),
- [cost, choice and service navigation](#),
- [stigma, discrimination and privacy concerns](#), and
- [intersecting access enablers and barriers](#).



"I think women and gender diverse people's needs are the same everywhere. They don't have new needs or different needs in Gippsland. The issue is access to services. And access being cost, geographic access, culturally safe access, timely and appropriate. I don't just mean physical buildings, but the whole gamut of what access is."

Catherine Bateman, SRH Nurse, Latrobe Community Health Service

Distance and Travel Requirements

Perhaps unsurprisingly given the large size of the Gippsland region, uneven distribution of its population, and limited public transport, survey and focus group respondents consistently raised the proximity of healthcare services to home as a key factor that either facilitated or, more commonly, created a barrier to healthcare access.

Women and gender diverse people reported highly valuing the ability to access services close to home, either in their local community or in a nearby Gippsland regional town. Close access to a hospital was frequently cited as a positive. Aboriginal and Torres Strait Islander health services, community health centres and neighbourhood houses were also noted as being relatively easy to access.

"I have found an amazing gynaecologist who is based out of Warragul Hospital... She's amazing. And also all the staff are amazing there actually. ... I also see a GP there who specialises in women's health. So I see her in rotation with the gynaecologist. Both really amazing. So I feel kind of blessed that I've found them and I've been able to get in to see them as well."

Woman, 55, Baw Baw (Focus Group 7)

However, many reported they needed to travel to regional centres such as Traralgon or Bairnsdale, or as far as Melbourne for specialist care (see also Key Finding 2).

"... often when we get a specialist service in Gippsland, it's very Latrobe Valley-centric as well. So, people that live in Bass Coast, we would often prefer to go to Melbourne travel-wise than the Valley because it's basically the same length of time. But you've got more options there. So, access to specialist care is really difficult ... I think they're looking at Latrobe Valley for the pelvic pain clinic and so again, if we're having the service, it's in that one location which can also be quite a barrier as well."

Woman, 41, Bass Coast (Focus Group 2)

Other travel barriers mentioned included a lack of public transport options, and the impact of travel on work, family and social commitments, such as the need to take a full day off work to attend a single appointment. Geography, therefore, emerged as the dominant factor for healthcare access, demonstrating a health equity issue for those living in more remote parts of Gippsland or without access to transport – some living in the Latrobe Valley or parts of West Gippsland acknowledged their greater access, particularly the closer they were to Traralgon or Melbourne. Survey and focus group responses indicate that these challenges particularly impact access to women's health services, mental health care and specialist medical services. A driver's license was seen as a necessity by migrant and refugee women with children.

"There is some pretty good health service options the closer to Melbourne you get (while still in Gippsland) as some specialists will travel out to Baw Baw or Latrobe once a week."

Woman, 26 - 35 years, Baw Baw (Survey)

"Critically important to maintain health services locally in regional areas and not centralise to larger towns like Traralgon."

Woman, 51 - 65 years, South Gippsland (Survey)

"And driving. If not] you have to catch the public transport. If you have kids - I had to learn driving for my kids to do everything for them because if I don't, if I want go to buy some food, I have to wait for the bus, if it's hot, if it's raining, you know – yeah, a struggle."

Woman, 47, Bass Coast (Migrant and Refugee Women Focus Group)

"There are many small pockets in Gippsland that often get forgotten. These are the ones where the access to services is much more limited, the towns and communities that are furthest from the LGA centres. Please spend time focusing on these communities. They need your help."

Woman, 26-35 years, South Gippsland (Survey)

Transport support and outreach services that enable access for women and gender diverse people without a vehicle, license or public transport were rated positively. Participants mentioned transport services connected with hospitals or Aboriginal Community Controlled Health Organisations (ACCHOs), the Royal Flying Doctors Service, as well as the [Victorian Patient Transport Assistance Scheme](#), which provides financial assistance to eligible Victorians needing to travel long distances to see a medical specialist. Outreach services included mobile breast screening services and an example outside of Gippsland mentioned was the Rumbalara Aboriginal Cooperative's GP van.

"Ramahyuck Medical in Sale as well as Morwell have drivers which greatly help the community members, especially particularly our middle-aged elderly Indigenous community members, because a lot of them come from a low socioeconomic background. They don't have a car, they don't have a license... expecting a 60 plus-year-old to just hop on the train, get off at Flinders St and then happily navigate by themselves to figure out how to get Peter Mac – it's just not feasible and not doable. So at least one thing they're doing right is they have drivers... which is fabulous because at least then you know they're attending these appointments and staying on top of their health."

Woman, 30, Wellington (Focus Group 2)

"The boob bus that comes to the hospital is a great service."

Woman, 51-65 years, South Gippsland (Survey)

Telehealth

Telehealth – whether over video or phone calls – was frequently raised as a potential access enabler in discussions about distance and travel challenges, with participants expressing mixed views. Being required to attend in-person appointments for certain issues was frustrating for people in remote locations, some of whom found telehealth a convenient solution.

"It was disappointing. One of those things that could have very much been a phone consult instead of having to drive hours away. So I was there to pursue sterilisation. They weren't going to hound me over it, particularly because by that stage I was already a couple of years into my transition, but they're like, 'But we have to get you back to see a separate gynaecologist to sign off before we can actually do this, and for that you would have to book again to see someone else, a second opinion.'"

Non-binary / genderqueer person, 26 – 35 years, East Gippsland (Focus Group 7)

"Telehealth is improving access to many more health services, usually, you can see the health professional you require but the wait times can be extensive."

Woman, 36 – 50 years, Wellington (Survey)

For others, however, telehealth was an unsatisfactory alternative, particularly for mental health care – some participants felt rapport was important and more easily established in person, while others noted that appointments over Zoom at home could feel less private if other family members were around. Women and gender diverse people whose first language wasn't English also found telehealth challenging.

"When I make an appointment, I want to talk face-to-face."

Woman, 75, Bass Coast (Migrant and Refugee Women Focus Group)

"Mental health is light on the ground. Counselling waiting list are huge as there is a strong demographic that do not want to attend online telehealth services and would prefer face-to-face services."

Woman, 51 – 65 years, East Gippsland (Survey)

However, some participants had positive experiences of accessing mental health care online valuable – one focus group participant said bulk-billed counselling via Rural Health Connect was a 'really good' support after her mother died.





Wait Times and Waitlists

Extensive wait times were reported across all service types, from basic GP appointments to specialist care, often driven by chronic workforce shortages across the healthcare system. Several respondents said that local GP practices were not accepting new patients due to insufficient capacity, forcing people to travel significant distances or join lengthy waiting lists just to access primary care.

"Waiting times are pretty outrageously long, especially for GPs."

Woman, 36 - 50 years, South Gippsland (Survey)

"Local GP has not been accepting new patients for over ten years now (Lakes Entrance)."

Woman, 36 - 50 years, East Gippsland (Survey)

"Reducing waitlists for important services by improving available resources & having people who will listen to urgent concerns, not lodging a request for a call back via a text link to the clinic."

Woman, 36 - 50 years, East Gippsland (Survey)

Survey and focus group responses indicate that workforce shortages particularly affect access to specialists, mental health professionals, oral health care and allied health workers, creating bottlenecks that can force people to wait months or even longer for care. One focus group participant in East Gippsland said there was a 12-month waiting list for a gynaecologist in Bega, NSW (closer than the next largest town in Gippsland). These delays often result in women avoiding or postponing care, which can worsen health outcomes – and additional costs for the healthcare system as well.

"I've also spent years on the dentist list. ... Ended up I had to get a root canal. So I got a partial root canal... And then the rest I had to wait three years. And by the time I waited three years they're like, 'You needed the next part done within 3 months of the first part.' So they had to do it from scratch."

Woman, 51, Latrobe (Interview)

Allied health access was similarly affected. A manager at a disability support service in Bairnsdale described how a shortage of local occupational therapists (OTs) and behaviour support practitioners (BSPs) was leading to increased reviews and functional assessments being conducted via Zoom, which she described as 'not appropriate, not accurate, nor successful as far as populating the information needed and required by the NDIS'. Other local NDIS clients were seeing fly-in, fly-out OTs and BSPs from interstate for in-person assessments.

"We have a client here who has an OT who's part of a mob who are based in Perth and they fly across to this side of the country and do a bulk round over a week on a monthly basis to see their clients based in East Gippsland. So that's kind of where it's at."

*Co-facilitator, Women with Disabilities
Focus Group, East Gippsland*

One positive development helping to address wait times were the Urgent Care Clinics in Warragul and Moe. As a 44-year-old Baw Baw woman commented in a focus group, 'they are really good and when I've gone in, I've gotten in really, really quickly.'

Cost, Choice and Service Navigation

Cost of healthcare was repeatedly raised as a healthcare access enabler or barrier. Positively, bulk billing service access was cited by many participants as essential and valued (where available), as were initiatives such as the PIP-IHI (Practice Incentives Program – Indigenous Health Initiative) enabling eligible Aboriginal and Torres Strait Islander people to access subsidised medication for chronic conditions.

"The paediatric clinic near the West Gippsland Hospital is now bulk billing (i.e., part of the hospital) - means we don't have to pay hundreds of dollars for our child to see a paediatrician."

Woman, 36 - 50 years, Baw Baw (Survey)

"We do have access to the PIP program, where [as an Aboriginal person] you pay the concessional rate of your medication on your script, but I think even what's eligible to go on that needs to be re-looked at, especially around chronic conditions and things like that, and I think they really do need to be reduced in price. So that people are getting the medication they need."

Woman, 51, Wellington (Focus Group 3)

Some respondents reported that being able to afford private healthcare resulted in reduced wait times or greater choice or access to private options. However, access was limited by a lack of private service availability and was acknowledged as inequitable. Others described having to travel to access bulk billed or subsidised care. A few people reported delaying or avoiding help-seeking, or self-medicating due to costs.

"...for some [healthcare] can be cost prohibitive, leading to people living with the ailment or issues they're having or trying to find a self-medicated option (for example, drugs and alcohol over genuine psychological help)."

Woman, 26 - 35 years, Wellington (Survey)

"Working women have to pay for most services. Just because you work, it does not mean you can afford to utilise the services that you need, so you just go without."

Woman, 51 - 65 years, Wellington (Survey)

"Wait lists are suddenly not a problem with private health. Privileged people have access to timely services/tests locally."

Woman, 36 - 50 years, Latrobe (Survey)

"[While going through IVF] I had to have monthly ultrasounds, and some ultrasounds weren't covered, some were covered. I was travelling to Drouin from Sale to get an ultrasound to get a rebate. If I drove to Drouin I'd get a rebate, but if I drove to Traralgon then I wouldn't get anything, and it was the same form, the same public health system. And that's just bizarre. So I just choose to drive down there and visit my mum. But when it's a day off work to do that every month, it's just another thing."

Woman, 28, Wellington (Focus Group 2)

Limited choice characterises many areas of Gippsland, with some services or locations having only one provider option. The women and gender diverse people we heard from desired choice – whether in gender of healthcare providers, service types, ability to speak another language, treatment approaches, cost, or opening hours – but rural areas often lack these options.

Choice of service provider was particularly fraught for First Nations women we heard from in East Gippsland. While they valued being able to choose between seeking care from either mainstream services or ACCHOs, sometimes this was not available to them and they were redirected from mainstream services back to ACCHOs. Further frustration was reported related to extended wait times due to non-Indigenous people accessing care at some ACCHOs that did not have a policy requiring proof of Aboriginality.

For the migrant and refugee women we spoke with, access to healthcare professionals able to speak their first language was highly valued, but not always available. In such cases, their preference was to bring their children to appointments to help interpret. Failing that, they used translation and interpreting services. Feelings about these services were mixed, with several women expressing concerns about the quality of the interpreting.

"I think with the Burmese [community] too, when you get a translator, like they don't really say exactly what the doctor's saying. Because I've noticed, mum said when I was with her last time, she understand what the doctors say, just hard for her to speak and then she thinks that the translator is not saying properly to her what the doctor's saying. So that's why it's an issue sometimes with the translators."

Woman, 35, Bass Coast (Migrant and Refugee Women Focus Group)

The complexity, time and effort of navigating available services also creates barriers, with women struggling to find information about accessible services, coordinate care across multiple providers, or access affordable providers.

"Services opening outside of business hours, both before and after hours, would make accessing them easier for women with full time work and caring responsibilities."

Woman, 26 - 35 years, Latrobe (Survey)

"... I think there is such a lack of understanding of how to navigate the system for people or [knowing] where to go and who you can access without a GP mental health plan. Or even getting into a GP to have a GP mental health plan because they do make you book a double appointment. And then the cost of that, you know, accessing bulk billing psychologists is so incredibly difficult across the region. Not to even get started on psychiatry. Like it's just not working how it should. And the step care continuum just isn't working how it should. I know that often the Headspace centres are holding greater risk than they should be holding because CAMS or the area mental health service aren't picking up people because even they're having a massive turnover of staff. So their staff aren't as qualified, or a new graduate, so they are not feeling comfortable, so the whole system is kind of failing."

Woman, 41, Bass Coast (Focus Group 2)

"When you're already down and out, the process of getting a referral, finding a suitable provider, booking an appointment and waiting two months for it is worse than just living with depression."

Woman, 26-35 years, Wellington (Survey)

In the case of time-sensitive care such as abortion, many GPs still require urine tests and ultrasounds to confirm pregnancies and gestation (despite this no longer being routinely required, according to the 2025 RANZCOG Abortion Care Clinical Guidelines). Such tests not only mean additional time, travel and expense for abortion-seekers, they risk unwanted pregnancies going to term. Many GPs also do not provide medication abortion and many pharmacies do not dispense MS 2-step, leading to 'supply' not meeting 'demand' in Bass Coast, South Gippsland and Wellington (see Figs. 36 and 37 below).

One focus group member explained why the SRH Hub at Latrobe Community Health Service (LCHS) in Traralgon is a 'fantastic' exception:

"Some of the GPs at LCHS, they have their own little ultrasound, one on wheels that they have on standby, which is fabulous because rather than having to get the ultrasound and all that done externally, they can be like, 'Yep, OK, you're pregnant. We'll just do a quick little ultrasound.' Then they can at least tick their box and ... then move on to just prescribing the medication. So really trying to be more time-effective [and] eliminating a lot of barriers and costs, which is a really good move forwards because having to do all those extra steps, especially if it's within that time-sensitive period is just very daunting."

Woman, 30, Wellington (Focus Group 2)

Notably in September 2005 the Victorian Government committed to funding on-site ultrasound in all SRH Hubs – the challenge will be for medical practitioners to accept these imaging results when providing medical abortion.



Stigma, Discrimination and Privacy Concerns

Stigma, discrimination and privacy concerns were a final access barrier that emerged in survey and focus group participant responses as well as key informant interviews. Some women described not wanting to be seen accessing stigmatised services such as mental health or sexual and reproductive healthcare in small towns where everyone knows one another – made worse when the service was in a central location.

"[Headspace] has got such a stigma for kids that aren't complex. Because I tried that with a young girl I know: 'Let's go to Headspace.' She was, like, 'Shame job. Not going there. That means I'm mental.' And it's right in the main street. [...]"

Co-facilitator, First Nations Women's Focus Group, East Gippsland

Others observed that sometimes the only provider in town was someone they personally knew, so were forced to travel further afield to see a different provider. Other forms of discrimination women encountered from health care providers or services that could serve as an access barrier included weight stigma, stigma towards chronic conditions such as lupus, and discrimination based on gender or sexuality (see also Key Finding 3).

"I'm on the pill for pain and regularity reasons, and one of the things that I found shocking when we moved down here and then going to the doctor to grab a script for it and you know, they're trying to ask me about, like what's my sexual status type thing. And as soon as they found out that I was in a same sex relationship, they're like, 'Well, what do you need it for?' [I had to explain] it's not just for contraception; it's for other things too."

Woman, 32, Latrobe (Focus Group 3)

"Around here, most of the physiotherapists are male. And I think sometimes they just don't understand the issues. The experience I had most recently is I've got really bad arthritis in both my knees. I used to play a lot of sport and I went for ongoing major pain. And during the session he didn't even touch my leg for starters, and he was just saying, 'Well, you know, you are overweight,' like, 'Yes, I know.' And so I'm trying to explain to him my history with that, and finally, after explaining what's kind of happened and how I've come to all of this, he's like, 'Oh, I've got a really good idea.' I'm like, 'Great, an idea.' And he's like, 'We might change one of your visits to a visit with the dietician.' And I'm like, 'No'. So I felt like I was being treated as an overweight person, not a person with an injury."

Woman, 51, Latrobe (Interview)

Stigma towards certain forms of healthcare can also come from health professionals, particularly sexual and reproductive healthcare.

"... I think there's a lot of aggressive conscientious objection, and even if it's not genuine conscientious objection, it's kind of aggressive de-prioritisation of those services. That they are not important, and they shouldn't be prioritised, that there are more important things to be focusing on. And we see that in the lack of procedural services that are available and not just in terms of abortion, but like how long it takes for patients to get services like tubal ligation that are really important. And they can't afford private, you know, these aren't high income areas, and a lot of cases, and there's just no prioritisation and no interest in collaboration across services."

Catherine Bateman, Sexual and Reproductive Health Nurse, Latrobe Community Health Service

"What's missing in my town? Easy access to abortion care without judgement."

Woman, 51 – 65 years, Latrobe (Survey)

In terms of initiatives to counteract stigma and privacy concerns, school-based programs addressing sexual and reproductive health were mentioned as helpful, providing a safe space to discuss sensitive topics – for example, the Deadly Sexy Health Kit developed by VACCHO (Victorian Aboriginal Community Controlled Health Organisation) for First Nations young people. Similarly, health services designed with a discrete back or side entrance were appreciated (if this was safe).

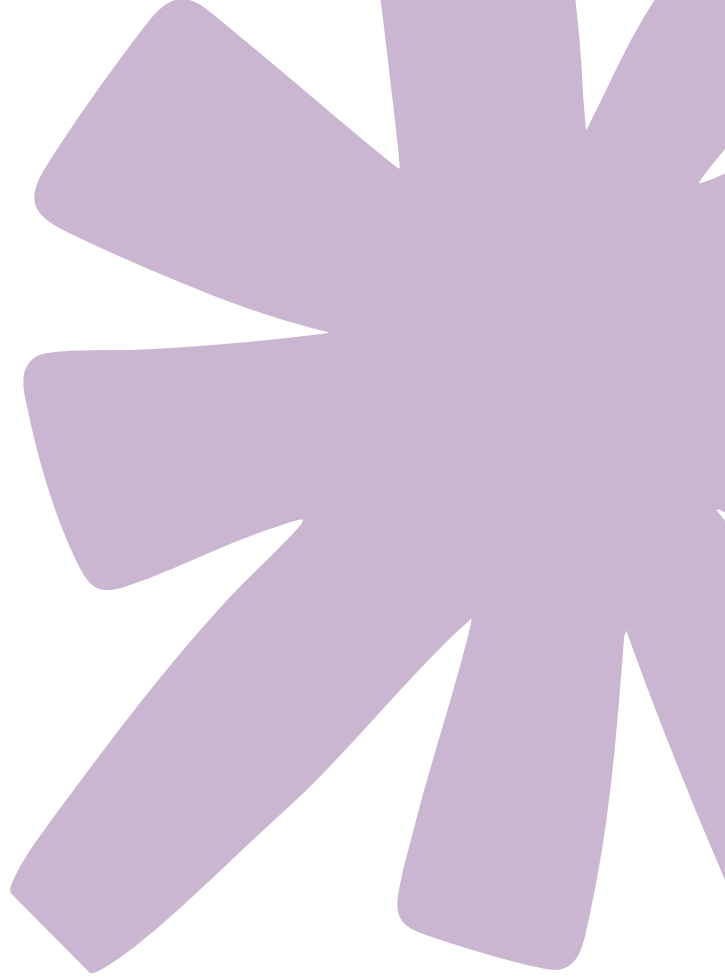
Intersecting Access Enablers and Barriers

"...just like all the different services and the wait times being out in the country and the cost associated with it all. It's, until you start delving deeper into it, it's a lot."

Woman, 28, Wellington (Focus Group 2)

Reflecting the complexity of Gippsland women and gender diverse people's lives and the constraints of the places they lived in, most faced multiple, intersecting access barriers and enablers, as illustrated by the circumstances of two participants in their 50s from Latrobe and East Gippsland respectively.

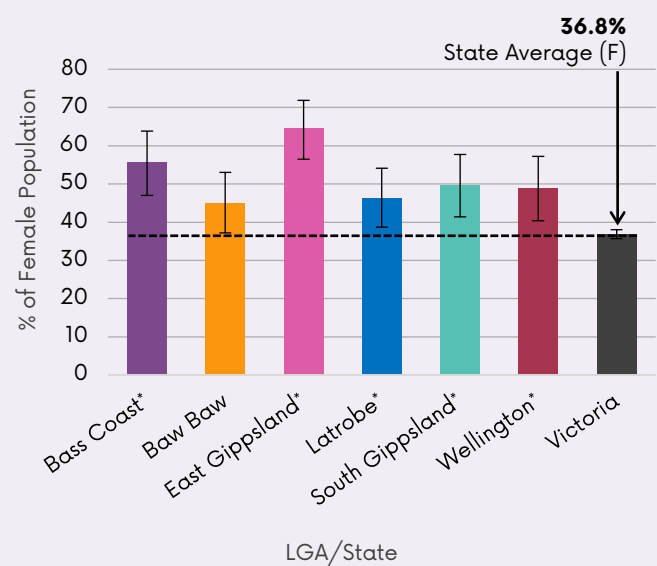
The Latrobe participant had several co-occurring health problems which made maintaining stable employment challenging, and her resultant low income made it difficult to access affordable care – on the other hand being based in a well-serviced regional centre gave her more options. For the East Gippsland participant, managing a chronic disease while living with a disability in a less well-resourced LGA posed challenges in accessing care, but having a job and a partner enabled her to afford the healthcare she needed.



What the Quantitative Data Shows

Data from the 2023 Victorian Population Health Survey (Figs. 16 and 17) provides further evidence of the higher access barriers faced by Gippsland women as compared with Victorian women as a whole.

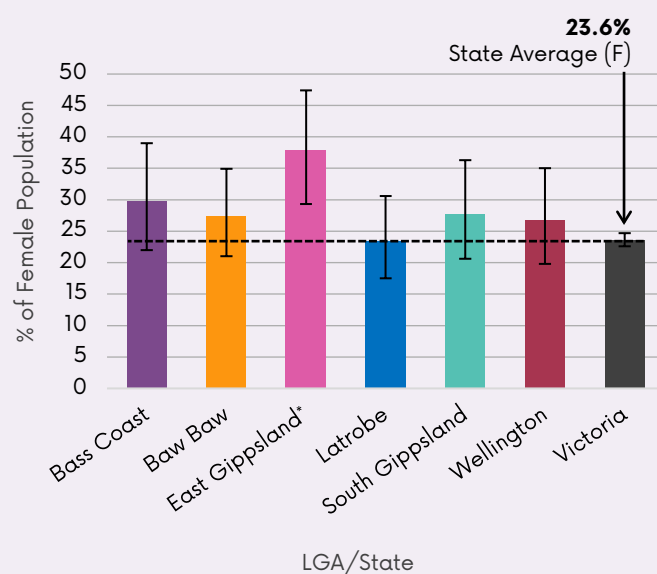
Fig. 16: Waited longer than acceptable to see a GP (%) - females: Gippsland LGAs vs Victoria (2023)



Key: * Estimate is statistically significantly different to the state average (dashed line). Black vertical lines represent 95% confidence intervals.

Source: Victorian Population Health Survey (VPHS) (2023)

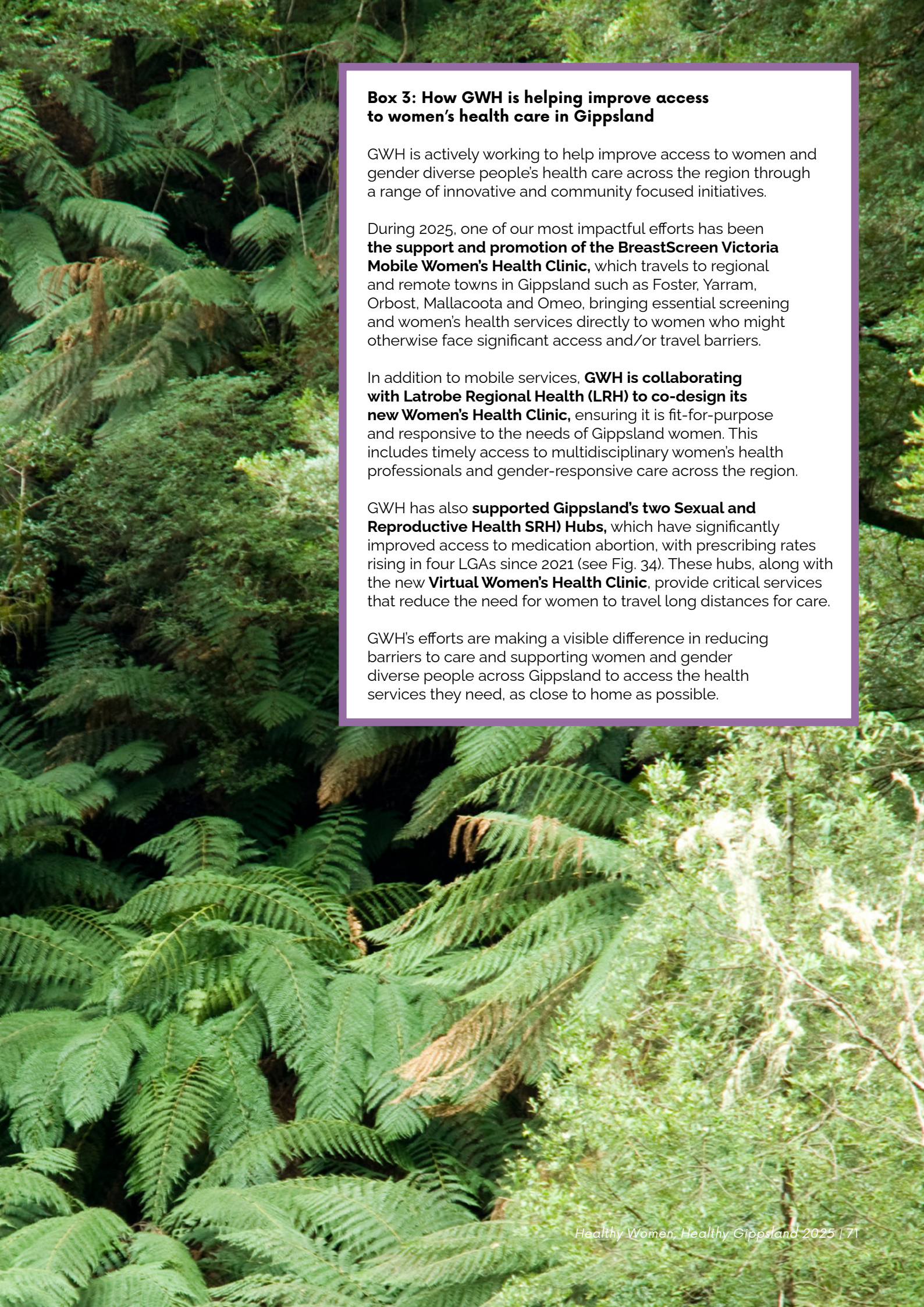
Fig. 17: Did not see a GP when needed (%) - females: Gippsland LGAs vs Victoria (2023)



Key: * Estimate is statistically significantly different to the state average (dashed line). Black vertical lines represent 95% confidence intervals.

Source: Victorian Population Health Survey (VPHS) (2023)





Box 3: How GWH is helping improve access to women's health care in Gippsland

GWH is actively working to help improve access to women and gender diverse people's health care across the region through a range of innovative and community focused initiatives.

During 2025, one of our most impactful efforts has been **the support and promotion of the BreastScreen Victoria Mobile Women's Health Clinic**, which travels to regional and remote towns in Gippsland such as Foster, Yarram, Orbost, Mallacoota and Omeo, bringing essential screening and women's health services directly to women who might otherwise face significant access and/or travel barriers.

In addition to mobile services, **GWH is collaborating with Latrobe Regional Health (LRH) to co-design its new Women's Health Clinic**, ensuring it is fit-for-purpose and responsive to the needs of Gippsland women. This includes timely access to multidisciplinary women's health professionals and gender-responsive care across the region.

GWH has also **supported Gippsland's two Sexual and Reproductive Health SRH) Hubs**, which have significantly improved access to medication abortion, with prescribing rates rising in four LGAs since 2021 (see Fig. 34). These hubs, along with the new **Virtual Women's Health Clinic**, provide critical services that reduce the need for women to travel long distances for care.

GWH's efforts are making a visible difference in reducing barriers to care and supporting women and gender diverse people across Gippsland to access the health services they need, as close to home as possible.

Key Finding 2: Service gaps exist across the health system for most women and gender diverse people living in Gippsland, with particular gaps in availability of primary care, women's health, child health, aged care, mental health, and medical specialists.

Service availability refers to the types and scope of healthcare services accessible to communities, encompassing the presence or absence of services that determine whether people can access appropriate care locally.

What We Heard

Some women and gender diverse people we spoke with reported good availability of GP clinics, and many commented on the availability of valued local hospitals and community health centres. Others described good access to screening, diagnostics,

and allied health services, or the availability of visiting specialist services and telehealth options, as discussed under Key Finding 1 above.

"I live in Foster and we have great services here for aged care and positive ageing as well as allied health through the hospital. The youth clinic is also a fabulous service, and having a community-owned aged care service is very positive for the local district."

Woman, 36 - 50 years, South Gippsland (Survey)

"More specialists are visiting Wonthaggi and Warragul hospitals than in the past. Some are very highly regarded."

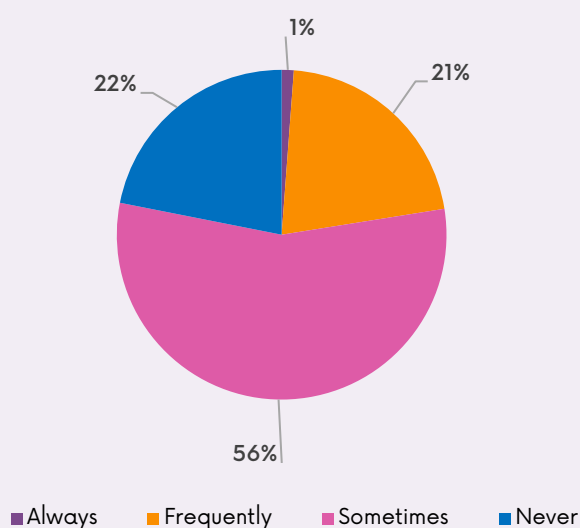
Woman, 36 - 50 years, Bass Coast (Survey)

"Clinic 281 by Gippsland Lakes Complete Health is a great service for those on a low income or Health Care Card."

Woman, 26 - 35 years, East Gippsland (Survey)

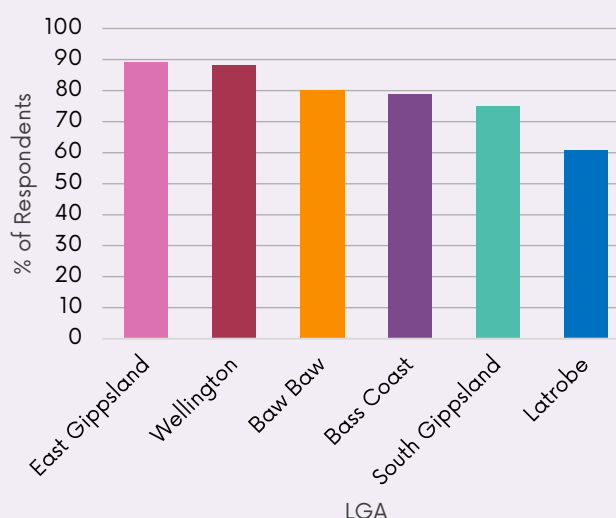
Overall, however, responses suggest service gaps exist across the health system in Gippsland, with particular shortages cited in primary care, women's health, child health, aged care, mental health, and for medical specialists. Current services appear to be sparse and failing to meet population needs, with increasing rurality associated with service gaps.

Fig. 18: How often survey respondents travel outside Gippsland for health care (2025)



Source: GWH HWHG 2025 survey

Fig. 19: Proportion of survey respondents who travel outside Gippsland for health care by LGA of residence (2025)



Source: GWH HWHG 2025 survey

As shown in Fig. 18, almost 4 in 5 Healthy Women Healthy Gippsland 2025 survey respondents (n = 164)⁵ said they had to travel outside of Gippsland for healthcare 'sometimes', 'frequently' or 'always'.

Breaking these numbers down by LGA (see Fig. 19) paints a picture of which LGAs are better serviced than others⁶. Reflecting factors such as the location of Latrobe Regional Health in Traralgon, Latrobe had the lowest percentage of respondents seeking care outside Gippsland (61%). In contrast, East Gippsland and Wellington with their more remote and dispersed populations had the highest percentages (89 and 88% respectively).

As discussed in Section 3.3, this pattern is also reflected in national data from the *Forgotten Health Spend* report (NHRA and Nous 2025) investigating the relationship between health professional availability and remoteness (see Fig. 33).

Healthy Women Healthy Gippsland 2025 Report Card participants who said they travelled outside Gippsland to access services were asked to tell us what services they travelled for (Fig. 20).

As Fig. 20 indicates, women's health was the most common reason – by a large margin – for accessing services outside of Gippsland. Specific services mentioned included abortion, contraception,

fertility treatment and IVF, gynaecology (including surgical procedures), menopause care, pelvic physiotherapy, and antenatal and maternity care. Accessing dentistry (including specialist care and surgery as well as basic dental care) and mental health care services (including psychiatrists, psychologists and inpatient care) were the next most frequently mentioned reasons people travelled outside the region, followed by scans and tests such as CT scans, MRIs, ultrasound, PAP smears, mammograms, X-rays, and colonoscopies.

These findings are supported by comments from respondents about services they felt were missing.

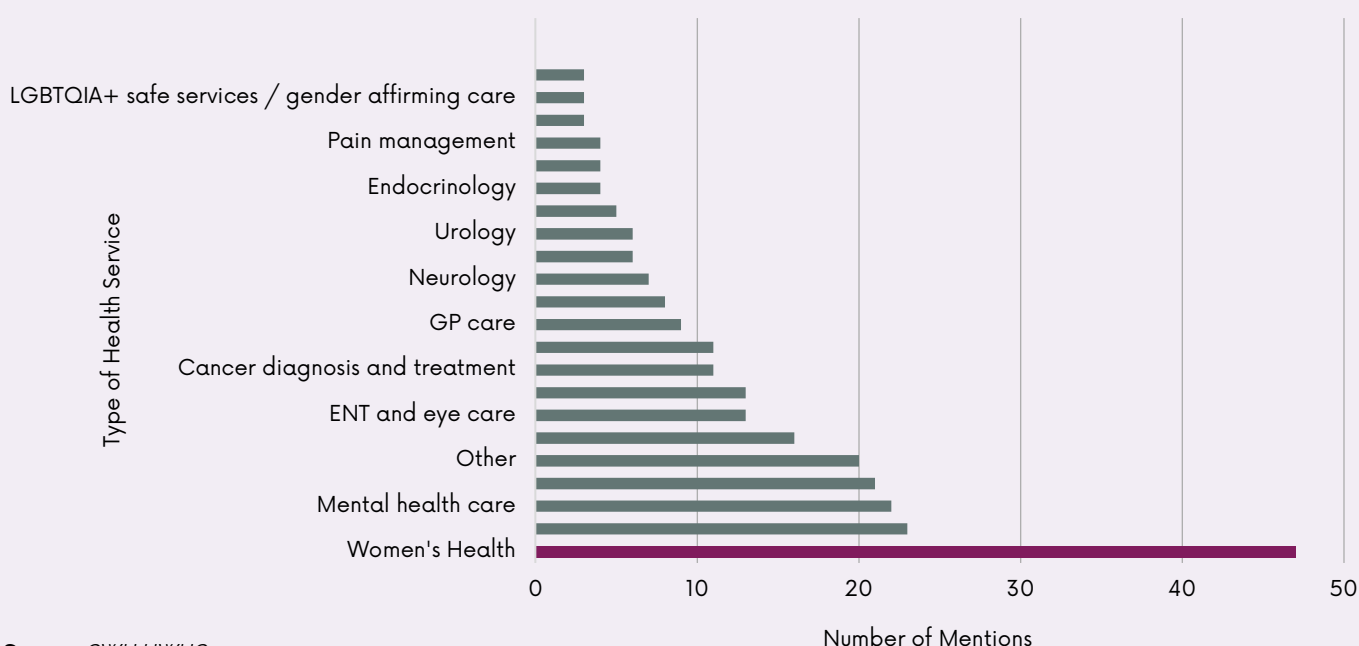
"Specialist women's health clinics like Jean Hailes that can really bring up the quality of women's health care. There are also no specialist STI screening services in Gippsland. Having to see your regular GP for these matters is simply not good enough - we need the specialist expertise. Instead we get sub-care and sub-care outcomes."

Woman, 36 - 50 years, Baw Baw (Survey)

"...whereas we seem to be providing a lot of maternal and child health services here, albeit they are still spread pretty thin, there are no services that I'm aware of that fall into the other end of the scale. So menopausal, healthy ageing women."

Woman, 59, East Gippsland (Focus Group 5)

Fig. 20: Services survey respondents travelled outside Gippsland to access (2025)



Source: GWH HWHG 2025 survey

"Maternity care at Warragul Hospital needs to be extended, more staff needed, more resources required."

Woman, 36 – 50 years, Baw Baw (Survey)

"Lacking in care for endo and menopause health knowledge and clinics – we have a significant ageing population of women in the area who are need of support and treatment."

Woman, 36 – 50 years, Bass Coast (Survey)

Women and gender diverse people's responses demonstrate strong community demand for dedicated women's health clinics, menopause support and comprehensive sexual reproductive health services that support contraception and abortion access, fertility treatment and perinatal health.

Participants also commented on limited availability of mental health support, with minimal options for children, youth and acute (inpatient) care. Specialist services frequently cited as unavailable or limited include psychiatry, gynaecology, paediatrics, neurology, pain specialists, ENT and urology. Allied health shortages were also mentioned, including women with disabilities, with a desire for increased access to physiotherapy, occupational therapy, exercise physiology, nutrition, and podiatry. (See [Box 3](#) for how GWH is helping to support better local access to these services.)

"There's a lack of psychiatrists, specialist psychologists, and eating disorder specialists in Gippsland. Without telehealth I'd need to travel to Melbourne to see these specialists."

Woman, 36-50 years, Baw Baw (Survey)

"I am not super educated but I don't think I've heard of a psych ward being in our hospital or anything. Or gender-affirming care."

Woman, under 18 years, Baw Baw (Survey)

"Access to pediatricians & psychologists, wait lists are ridiculous – no wonder so many kids have problems."

Woman, 36-50 years, East Gippsland (Survey)

Mental health promotion officer Susanne Lampitt shared her perspective on the reasons mental health services were stretched in Gippsland:

"I always do a bit of a diagram like an upside-down triangle and I say, well mental health services are for that top 5 or 10% of people with really complex needs. Down the bottom we've got the people that might see a psychologist or Headspace or some of those things which often you have to pay for. And of course at the top our service is free and then as the Royal Commission highlighted we've got that missing middle. They're the people who are too unwell to be looked after in the bottom part, but not unwell enough to come under the mental health service, not complex. So they're on that path to putting in wellbeing hubs – Mental Health Locals, Head to Health and all that sort of stuff – at a local level to try and fill that gap. But of course, while that gap is not properly filled, the people that either can't access the lower services or can't afford it, they come up to the top because we're free. So it pushes people up to that pointy end and of course the public system is just totally overwhelmed. And [the services for those in the middle] – it's not going to happen overnight, it's going to be a decade-long thing."

Susanne Lampitt, Mental Health Promotion Officer, Latrobe Regional Health

What the Quantitative Data Shows

Abortion continues to be a key service gap in many parts of Gippsland, though prescribing (MBS) and dispensing (PBS) data suggest recent efforts to increase provision of medication abortion (a safe, non-surgical method available up to 9 weeks gestation) are starting to make a positive difference.

Case study - availability of abortion services in Gippsland

Abortion access has been a long-standing challenge for rural and regional women and gender diverse people across Victoria. Analysis of calls to Women's Health Victoria's abortion information service 1800 My Options (Sarder, Mogharbel and Kalman 2024) found that rural and regional callers (across Victoria) were more likely than metropolitan callers to mention geographic access (20.7% compared with 0.3%).

At the time of publication there were just 3 Gippsland-based surgical abortion providers listed on the 1800 My Options with gestation limits of 12-13 weeks, though we are aware that services are available in all LGAs except East Gippsland. Provision of medical abortion has gradually improved in recent years in the region, with prescribing noticeably improving following the establishment of two SRH Hubs with locations in Latrobe, Baw Baw and East Gippsland (see Fig. 21). The increase in dispensing, however, has been more gradual (Fig. 22).

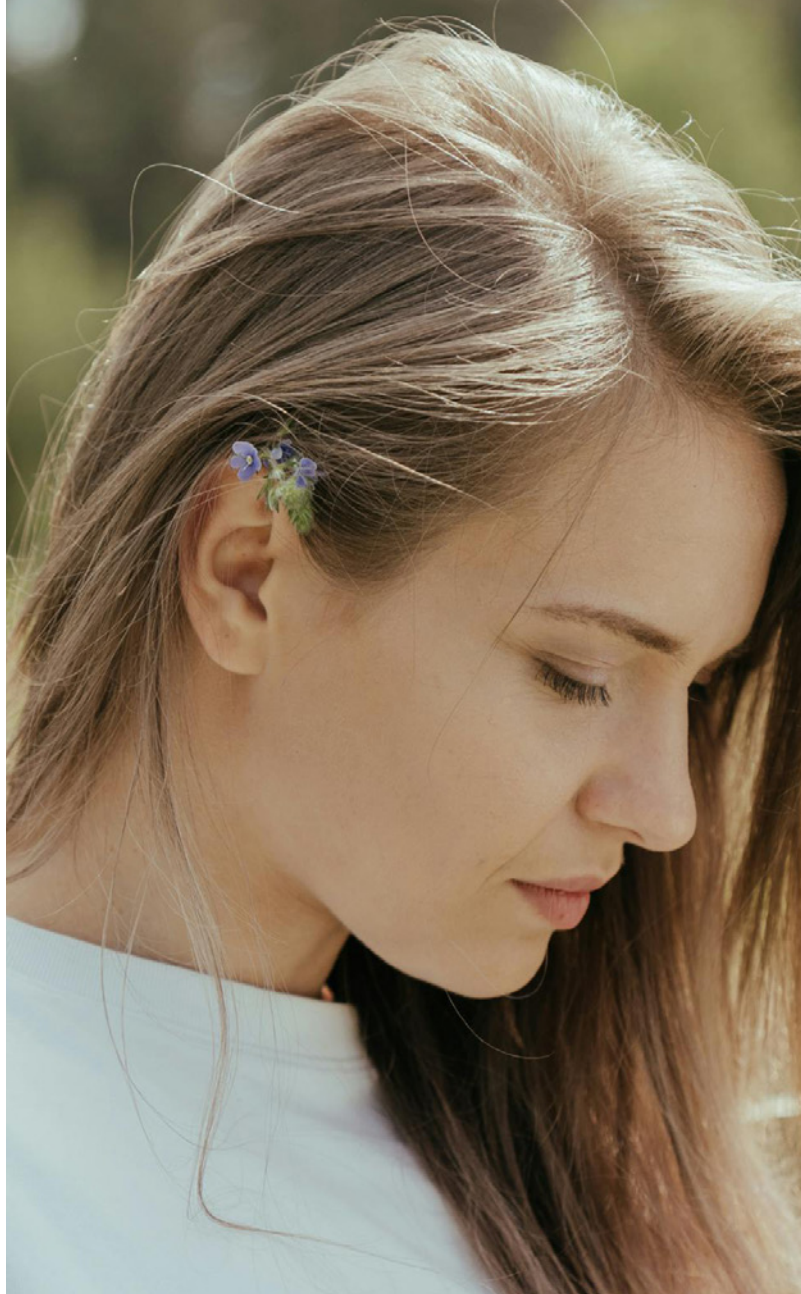
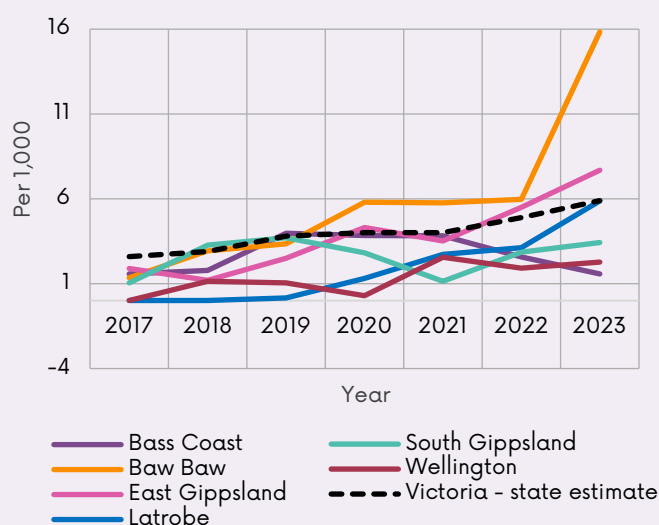
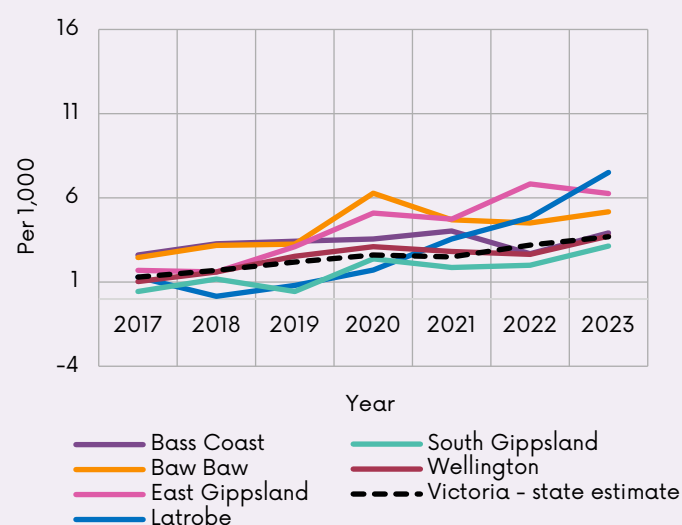


Fig. 21: Medication Abortion - Rate per 1,000 by prescriber location (females): Gippsland LGAs vs Victoria (2017 - 2023)



Source: Victorian Women's Health Atlas

Fig. 22: Medication Abortion - Rate per 1,000 by pharmacy location (females): Gippsland LGAs vs Victoria (2017 - 2023)



Source: Victorian Women's Health Atlas

Bass Coast, Wellington and South Gippsland continue to lag not only the LGAs with SRH Hubs but also the statewide averages in rates of medication abortion prescribing (doctors) and dispensing (pharmacists) as the maps below illustrate for 2023, the latest year of available data (Figs. 23 and 24).

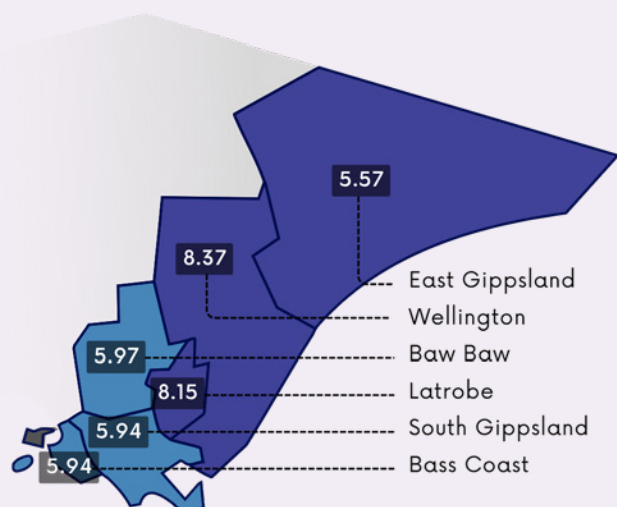
Where the colour of the LGA in each map is the same, supply and demand are approximately matched, whereas a lighter colour on the second map indicates demand exceeds supply, an indication that many abortion-seekers are needing to travel outside their LGA to access services or rely on telehealth. Other service availability issues raised by SRH Nurse Catherine Bateman include:

- limited surgical abortion options, meaning many abortion-seekers don't have a realistic choice between medication and surgical options,
- limited number of abortion providers with on-site or nearby ultrasound, introducing delays and cost into the abortion process⁷,
- low uptake of SRH training opportunities by GPs even when these are offered,
- poor coordination between service providers (e.g. hospitals, GPs, community health), and
- a consequent over-reliance on individual clinicians to deliver the majority of abortions.

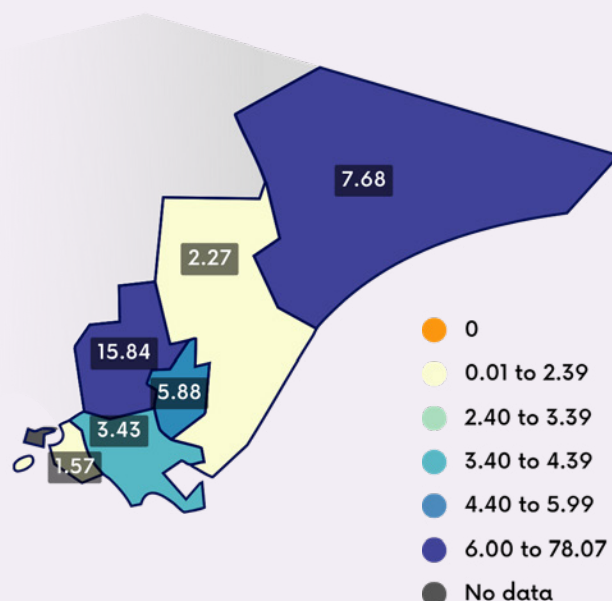


Fig. 23: Medication abortion provision in Gippsland:
Rate per 1,000 patient location vs prescribing (2023)

Rate per 1,000 by Patient Location
Victoria Statewide F 5.9



Rate per 1,000 by Prescriber Location
Victoria Statewide F 5.9

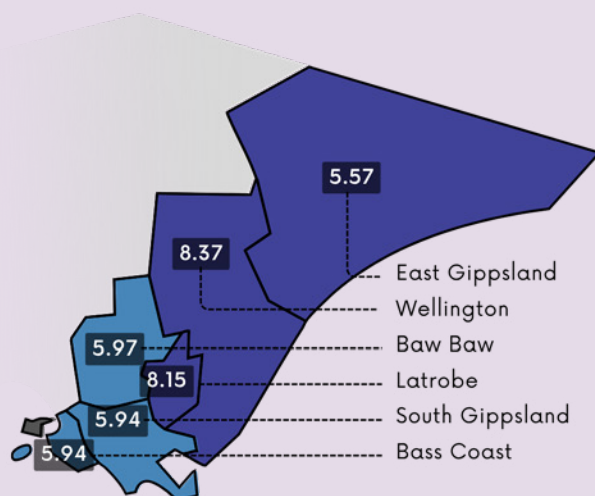


Source: Victorian Women's Health Atlas

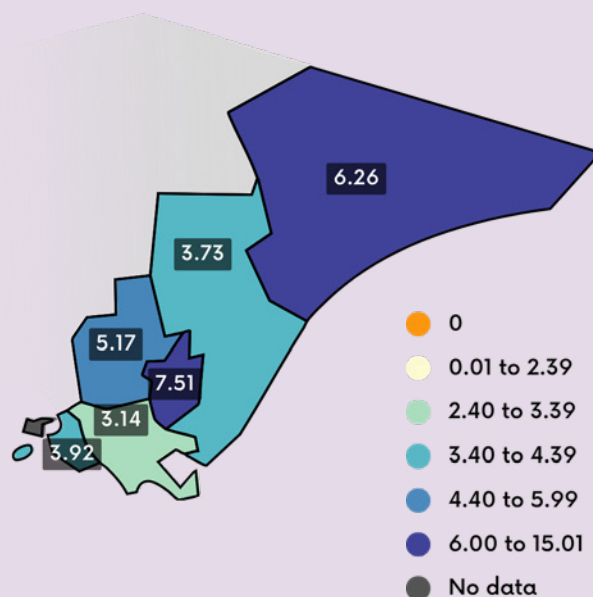


Fig. 24: Medication abortion in Gippsland: Rate per 1,000 patient location vs dispensing (2023)

Rate per 1,000 by Patient Location
Victoria Statewide F 5.9



Rate per 1,000 by Pharmacy Location
Victoria Statewide F 3.7



Source: Victorian Women's Health Atlas

Key Finding 3: Women in Gippsland experience significant variability in health care quality. Whilst some positive experiences are reported, there are consistent challenges with continuity of care, health professional knowledge gaps, and a lack of inclusive and respectful care

Quality of care refers to the standard of healthcare delivery experienced by consumers, encompassing service effectiveness, therapeutic relationships, safety perceptions, care coordination, and professional competency that determine whether they feel appropriately supported.

What We heard

When asked about their experiences of care in Gippsland, *Healthy Women Healthy Gippsland 2025* survey and focus group participants commented on the following elements of healthcare:

- [organised, effective services](#),
- [continuity of care](#),
- [health professional education and attitudes](#), and
- [inclusive, respectful, trauma-informed and culturally safe care](#).

Women and gender diverse people in Gippsland are experiencing significant variability in healthcare quality. Many respondents reported positive healthcare experiences, particularly valuing professionals who show genuine care and take time to build meaningful relationships. Many appreciated services that feel well-organised and welcoming. Community members particularly valued professionals with local knowledge and understanding of their communities. Some reported excellent experiences with specialist services, including positive maternity care and pregnancy services.

"There are really wonderful staff across many different services who go above and beyond to advocate for patients and service users and make them feel cared for."

Woman, 26 - 35 years, Latrobe (Survey)

"One standout experience I had was with a GP in Traralgon. I was referred to her when seeking access to medical abortion services, and her welcoming, friendly, and non-judgmental approach made a potentially daunting experience feel safe and manageable. The doctor took the time to thoroughly explain the process and what to expect, which helped me feel informed and supported throughout. Her compassion and professionalism left a lasting impression on me, and I consider her an exceptional GP."

Woman, 26 - 35 years, Wellington (Survey)

"I have found the A&E at Bairnsdale Regional Health Service (BRHS) very good and helpful, particularly the nurse consultant."

Woman, 51 - 65 years, East Gippsland (Survey)

Organised, Effective Healthcare Services

Services that feel organised and effective make patients feel their needs are being met appropriately, and many people reported positive experiences.

"But because of that screening process, they got [mum's breast cancer] early. And ... the way that the coordinated care has happened across Gippsland, I think they work particularly well in that area. It has been - as someone like myself, who has accessed a lot of health services for chronic illness, and you're always having to do these things yourself. [But] the way the system came together with her diagnosis was actually incredible to see - the specialist at the clinic at Traralgon, they called her GP. She had an appointment the next day. They picked the surgeon. She was still with the surgeon the next day, like the communication of care, and then the breast care nurse referral was all done. ... So I think that that's one area that we're really doing well in."

Woman, 41, Bass Coast (Focus Group 2)

However, for other health conditions this kind of experience was rare. Instead, women and gender diverse people expressed frustration at having to push for seemingly simple requests such as referrals or even just accurate information on referrals. Others described having to try to forge their own complex pathways to care based on cost and travel considerations.

While such experiences undoubtedly reflect an over-stretched healthcare system, they can leave women feeling lost and unsupported. More seriously, some experience adverse health outcomes. One focus group participant described losing a fallopian tube after an ectopic pregnancy wasn't picked up until it had ruptured and she was bleeding

internally, despite having had 3 ultrasounds at the same hospital over the previous week. Other women reported care simply not being available.

"But just in terms of mental health services in the area, it was slim to none. And I've essentially been told if you want to see a psychologist in person, you're going to have to go to Melbourne. And I've actually tried to get referrals again just to get my medication changed and I've gone back to my GP ... And [my GP] organised a referral for me for the Royal Flying Doctors. Apparently, they'll do psychiatry via telehealth free-of-charge for rural or regional people. But he put through 3 referrals, and I never heard back. So I'm just living my best life with my mental health issues and supporting myself...! [laughter]"

Woman, 42, Bass Coast (Focus Group 2)

Members of the migrant and refugee women's focus group noted differences in the level of care for certain health conditions as opposed to others. Diabetes care was described as more structured and holistic with allied health professionals involved, as compared with conditions such as hypertension (high blood pressure) or hyperlipidemia (high cholesterol) which were symptom-focused and managed by a GP.

"My mum's a diabetic. She's seeing a diabetic specialist and a diabetic educator as well. When she was first diagnosed, a special nurse came into the house, show her how to do the insulin and then sugar and then they look after her. And then she saw a diabetic educator regularly and then got to the point where her sugar was too high. So then the diabetic educator refer her to the specialist and so she's been seeing specialist every 6 months.... She's being referred to a dietitian as well to see with her diet and that. But otherwise, yeah, with [fellow focus group member who has high cholesterol], the doctor's just do blood tests and give her meds. Just [treat] the symptoms, nothing else, and [recommend] walking."

Woman, 35, Bass Coast (Migrant and Refugee Women Focus Group)

Continuity of Care

Exasperation about care continuity and coordination amplify concerns about quality of care, with participants reporting seeing different GPs at each appointment, experiencing poor follow-up, and limited communication between services. Many women mentioned that having to retell their stories repeatedly was exhausting, and particularly onerous in the context of a chronic condition.

"I feel very isolated in South Gippsland in terms of accessing mid-life health care and support. As I have had no continuity with a doctor since my regular doctor left two years ago it's been stressful trying to get appointments and support with continuity."

Woman, 36 - 50 years, South Gippsland (Survey)

"It's very hard to get appointment [with the GP]. Takes weeks and weeks. And they always move. They come and go. So you don't have the consistent GP or anything. And especially when you have a long-term health condition, you really need that to be able to see the same person who - you don't have to tell your story again and again. So sometimes they're lost in translation [when you] describe your health issue to one GP then [have to] move to another GP."

Woman, 55, Bass Coast (Migrant and Refugee Women Focus Group)

"Well, to compare to Melbourne, where I had the same doctor for 45 years of my life and ready access to specialist services on the doorstep, literally. Now I think in the space of those seven years [I've been living in Gippsland], I think I've already had probably 4 doctors. Doctors that have come and gone, done their time in the country and moved back to the city."

Woman, 59, East Gippsland (Focus Group 5)

Reflecting on the difficulty of keeping health professionals in Gippsland, one focus group participant called for this to be investigated so that attempts could be made to address the drivers of health professionals leaving, while Andi Connell from the Gippsland Region Public Health Unit (next page) shared her personal views on the some of the systemic factors at play.

"How do we get quality doctors to stay regionally? Like what is that problem? Do we even know - and we've not dealt with it, or we don't know? I mean, we're two hours from the city by a two-lane highway. It's not like we're in the middle of the outback and you have to drive a whole day, yet still we don't get quality healthcare. So have we done the research of why that's happening, why can't we keep them down here? Is it schools, because we don't have quality schools? In their opinion, like what is it? Because we're a really beautiful place to live."

Woman, 50, Latrobe (Focus Group 3)

"... this is completely anecdotal from my own experience in healthcare and in public health. But the way the medical [training] model is set up is that regional areas are often seen as a placement. So it seems like GPs are often coming to regional areas to gain experience with working with regional or remote communities. They tick that box, then move back to their metro areas because that's the way the model has been set up – that you need to get that experience, you need to work with priority populations. So I often do think about that as perhaps not a great way of establishing sustainability. Because I think there are incentives applied as well for GPs to relocate to regional areas but once they run out, that tenure's finished. There are also other factors like schools. But housing is one of the major issues. So if you want to relocate to Gippsland, it's pretty difficult to get a rental property, especially in seasonal tourism towns where the occupancy is low, but the properties are not available. So that's a big barrier."

Andi Connell, Acting Manager, Gippsland Regional Public Health Unit

Certain programs and initiatives were commended for supporting continuity of care, such as the Integrated Team Care program run by the Gippsland Primary Health Network, designed to support First Nations Gippslanders with two or more chronic conditions, as well as chronic disease educators and Social and Emotional Wellbeing (SEWB) workers.

"...It's unfortunate for us fellas down here but when we go in – we've seen about 5 different GPs this year for example. So when we go in, we're repeating ourselves. And it's building the trust with a GP and then having to start all over again. And so a lot of mob just don't want to go. And it's fortunate for the near 30 people on the ITC program who have those kind of stats that are tracked, you know, through a phone call, 15 minutes. I reckon it's useful because at least you can count and track where you're heading. ... [but] having like a set 30 people. It's just not enough."

Woman, 39, East Gippsland (First Nations Women Focus Group)

Health Professional Knowledge and Attitudes

The women and gender diverse people we spoke with reported a perception of knowledge gaps among health professionals, particularly GPs, in key areas such as women's health, gender-

responsive care, and cultural safety. Respondents shared negative experiences of seeking support for menopause, contraception, abortion, pregnancy, ADHD, autism, mental health and chronic conditions. Many respondents felt that their healthcare providers lacked expertise in these critical areas, which affected the quality and appropriateness of the care they received. Others described experiences of gender bias such as feeling dismissed and receiving inappropriate treatment based on their gender.

"GPs need to be better educated about perimenopause and menopause. There are still a lot of GPs, particularly men prescribing antidepressants to women who are experiencing hormonal fluctuations. When I visited a male GP at age 48, he told me I was too young for menopause and dismissed it as an issue."

Woman, 36 - 50 years, South Gippsland (Survey)

"GPs need to be trained up to provide better care for young women, they should be taught to believe women's concerns about their health and not dismiss them."

Woman, 18-25 years, Baw Baw (Survey)

"My local GP told someone, 'Stop worrying about it, it's nothing,' and when I pushed that person to get a second opinion (out of Gippsland) we discovered it was cancer... I find local GPs are also very misogynistic. Women constantly get turned away with serious issues under the 'anxiety' banner when the issues are very real. This has personally impacted every woman I speak to in this town and the one over."

Woman, 26 - 35 years, South Gippsland (Survey)

"The patriarchy and misogyny is very prevalent, particularly with male GPs."

Non-binary / genderqueer person, 51 - 65 years, Baw Baw (Survey)

Knowledge gaps among health professionals can also result from discriminatory attitudes towards particular areas of healthcare. For example, SRH Nurse Catherine Bateman acknowledged that the establishment of two SRH Hubs in Gippsland (LCHS at Warragul, Morwell and Traralgon and Gippsland Lakes Complete Health at Bairnsdale) has helped increase access to abortion in Gippsland. However, she observed that the increase in service provision has been more modest than hoped, prompting her concern that the hubs were providing a 'get out of jail free' card to GPs in the region, some of whom simply refer patients to the hubs rather than provide abortions themselves.

In addition to knowledge gaps about health conditions or treatments, participants also commented on health professionals' lack of knowledge of available services.

"I had a negative experience recently where I was charged for my cervical screening because I got it done at 57 months rather than 60 months – my GP didn't know I would be charged for getting it done a bit early. More education needed and less barriers for women to do the test. It was great I could now do it myself but this isn't commonly known. Also shouldn't have to pay if done within a certain window of it being due."

Woman, 36 - 50 years, Latrobe (Survey)

"A lot of the GPs as well don't even know what a CTG [Closing the Gap PBS Co-Payment Program] is, or don't have the training. Because a lot of our mobs are going in after the 715 [health check] and the doctors, we have to explain to them what a CTG is or if they come to LEAHA (Lakes Entrance Aboriginal Health Association) we have to make sure they have that training as well."

Woman, 39, East Gippsland (First Nations Women Focus Group)

Box 4: How GWH is helping build Gippsland health professionals' capacity in gender-responsive healthcare

GWH is actively building the capacity of health professionals across the region to deliver gender-responsive healthcare through a range of targeted initiatives.

Central to these efforts is the annual **Sexual & Reproductive Health Forum**, which in 2026 celebrates its highly anticipated 15th year. The forum provides a vital platform for regional health professionals to connect, share knowledge and engage with emerging best practices in SRH. Attendees consistently report increased understanding of complex issues such as pelvic pain, abortion access and menstrual health, and report feeling equipped to take actionable steps to improve care in their own practices.

GWH also delivers **Equitable Leadership training** to health service executives and community leaders, with over 50 participants engaged in the first half of 2025. This training enhances awareness of intersectionality and the systemic benefits of gender equity in a range of workplace settings including healthcare.

GWH partners with **Sexual Health Victoria** to provide additional capacity and build the knowledge of the medical, education, youth and disability workforces across Gippsland. These opportunities are a priority to ensure access to evidence-informed best practice within the regional and rural workforce. For example, GWH has actively supported SHV's menopause checklist training for general practitioners to build their understanding in providing menopausal care.

GWH supports knowledge-sharing across Gippsland by facilitating expert presentations, such as inviting the **Australian Centre for the Prevention of Cervical Cancer** to present to the Gippsland SRH Governance Group and regional health professionals. In 2025 we became a member of the Latrobe Regional Health Research Partnerships Committee, with the aim of contributing a gender lens to local research initiatives. We also joined the statewide **Gender Equity in Cancer Care Project** with key partners including Women's Health Victoria, the Gippsland Regional Integrated Cancer Service (GRICS) and Transgender Victoria to help build regional health professionals' capacity in gender-responsive cancer care.

Through these initiatives, GWH is helping build Gippsland's health workforce with the knowledge, tools and community connections needed to provide inclusive, respectful and effective care for women and gender diverse people.

A frequently mentioned issue was the lack of time for building rapport with healthcare providers, with many women and gender diverse people struggling to find professionals who take time to listen and try to understand their concerns rather than making appointments feel rushed and defaulting to prescribing medication. One focus group participant commented that it often came down to the individual, observing that some GPs make you feel 'like it's a business' whereas others 'make you feel like they have all the time for you, you feel comfortable. Even if they have to take extra 5 minutes, it doesn't matter.'

Respondents expressed a strong desire for compassionate, genuine care enabling them to feel believed and respected. While many shared positive experiences with their health professionals, as noted in the previous section, experiences of feeling unheard, dismissed, or unsafe when accessing healthcare were common.

"It is good when you are believed. It is frustrating, disheartening, and awful when you are not."

Woman, 36 - 50 years, Baw Baw (Survey)

"It is very difficult to find a GP who has time and genuine care to build a therapeutic relationship."

Woman, 36 - 50 years, Baw Baw (Survey)

"My history with GPs locally really grinds me for a number of reasons. Sometimes I have felt that they don't listen. You're being pushed through these cycles of get in / get out and they're not really taking notice... I've been seeing a local GP in Morwell for years, so when I transitioned into the perimenopause stuff, I then went to a Melbourne doctor who was able to also backtrack on why I was getting severe period pain, which my normal GP never really dealt with. Never really followed through with anything except for either pain relief or staying on contraceptive. And so again, the attention to detail, the lack of what feels like any genuine care or building rapport."

Woman, 50, Latrobe (Focus Group 3)

Inclusive, Respectful, Trauma-Informed and Culturally Safe Care

Survey and focus group responses indicated significant gaps exist in the provision of providing inclusive and respectful care, particularly for LGBTIQ+ people. First Nations women and their families, women and gender diverse people from migrant or refugee backgrounds, those living with disabilities, or young or older people. A few examples of good practice were mentioned, but overall the picture painted by respondents was of services that were not inclusive or culturally safe.

"Aboriginal health services, Aboriginal Advisory Committee at Sale Hospital, Ramahyuck Family Practice, GWH, women's family violence help / support group through Neighbourhood House Moe are a few positive health services in Gippsland."

Woman, 36 - 50 years, Wellington (Survey)

LGBTQIA+ people reported issues including healthcare providers not using preferred names or pronouns, making assumptions about relationships and family structures, gendered bathrooms even in larger health services, and a general lack of visible LGBTQIA+ inclusivity signage.

"I have trouble having services recognising and using my preferred name and pronouns even after reminding them."

Non-binary / genderqueer person, 36 - 50 years, East Gippsland (Survey)

"There are always improvements that could / should be made around service systems, service directory, cultural safety and wellbeing [for Aboriginal and Torres Strait Islander clients], upskilling employees, learning and development."

Woman, 36 - 50 years, Wellington (Survey)

"Patient-centred care is significantly lacking and cultural and contemporary queer sensitive practices are non-existent."

SR165 (woman, 51 - 65 years, Baw Baw)

"I do not find health services in Gippsland inclusive or knowledgeable outside of my community where it's more that they know me as a person rather than being comfortable with a visibly non-binary, gender non-conforming person. Even in Rainbow Tick-accredited services many staff and doctors appear uncomfortable or unsure of how to treat me."

Non-binary / genderqueer person, 26 - 35 years, East Gippsland (Survey)

A number of respondents who did not identify as being part of an underserved community nonetheless expressed concerns about the accessibility of health services for these groups. Some connected the struggle for LGBTQIA+ accessible care with larger tensions over access to reproductive health services such as abortion.

"There are definitely cohorts of people, who are marginalised (living with disabilities, trans/ gender queer, Aboriginal and Torres Strait Islander, migrants etc) who know of services, who don't feel services would be inclusive/ safe for them who as a result do not access services, at all. This is a huge problem."

Woman, 36 - 50 years, Bass Coast (Survey)

"Gender diverse should be the norm, not a problem."

Woman, 51-65 years, Latrobe (Survey)

"I'm concerned that our already limited access to services like abortion and gender-affirming care in Gippsland may be further reduced due to attacks from far-right politicians and commentators... I also think more needs to be done to bring women from marginalised and disadvantaged backgrounds along on the health journey in an empowering way."

Woman, 26-25 years, Latrobe (Survey)

Members of the First Nations women focus group discussed the limitations of a 'white uniforms, white walls' approach to mental health, particularly for their younger community members, describing clinicians who alienated clients by going straight into formalities without trying to build a relationship first. They contrasted this with taking a self-determination approach by building their own communities' mental health support resources through programs such as the Aboriginal and Torres Strait Islander Mental Health First Aid program or a former suicide prevention initiative by Gippsland and East Gippsland Aboriginal Co-operative Limited (GEGAC) called You Can Talk To Me.

"... my mob, my Country, we're practising a lot of stuff up there – we've got to get more active in creating a mental health first aid crew. A group of people that will go and step in – Aboriginal people. Our kids don't feel comfortable going to non-Aboriginal people in white uniforms, white walls and going to psych units. Because they go deeper and deeper."

Woman, 61, East Gippsland (First Nations Women Focus Group)

For migrant and refugee women who didn't require interpreting assistance for healthcare appointments, a health professional's manner and ability to empathise with them were nonetheless very important.

"I had an experience during COVID, and it was so traumatic because the GP didn't consider my mental state at the time. And she was absolutely rude. I'm very strong emotionally, mentally, because I work on it. But when I went home, the first thing I related to was, 'What if it was another person in this state? ... If I could wave a magic wand over them, I would like [GPs] to have the same sort of compassion and empathy as allied health professionals, because you're not just working on the physical side for that person, you're working on emotional, because sometimes the emotional things cause the physical as well, and they don't seem to look at it that way. ... And then I went off to a GP here in Wonthaggi... and it was totally different. I just

walked in, I didn't know who I was seeing, and she was from a migrant background. I'm not trying to say that they're different, but I think she understood my situation better. I want to walk in and see any doctor, not be, 'OK they've got to be a migrant...'. But I'm looking at other people. I've experienced it. Everyone is an extension of who I am. So I did report that GP."

Woman, 65, Bass Coast (Migrant and Refugee Women Focus Group)

From a health services perspective, LRH Mental Health Promotion Officer Susanne Lampitt noted several initiatives and developments at the hospital aimed at providing more culturally safe and gender equitable care. A dedicated Aboriginal Health Unit was established in 2024, staffed by First Nations workers, and with a direct entrance from the Emergency Department, along with a garden area for Aboriginal in-patients and their visiting families to use as private, non-clinical space.

To facilitate more gender-responsive healthcare, LRH has also provided MARAM training⁸ to staff to enable them to screen incoming service users for experiences of family violence and factor this into individuals' healthcare as appropriate. The hospital has also redesigned their mental health inpatient unit so that it is gender segregated, in line with the 2021 Mental Health Royal Commission reforms.



Key finding 4: Health care access and quality issues have gendered impacts – poor access to quality healthcare impacts women's and gender diverse people's health and wellbeing

What we heard

Inconsistent and inequitable access to quality healthcare affects all Gippslanders, but the impacts vary by gender. The common themes among *Healthy Women Healthy Gippsland* 2025 participants' responses were:

- [the toll of struggling to access healthcare](#),
- [isolation and loneliness](#), and
- [caregiver strain](#).

Toll of struggling to access healthcare

Many participants described the mental, emotional, and financial impacts of the struggle to access care that was timely as well as of adequate quality. They talked about the stress and cost (in terms of time as well as financial costs) of travel, particularly for time-sensitive care (e.g., IVF and abortion) or longer-duration care (e.g., cancer treatment). Women and gender diverse people also shared the emotional toll of having to navigate complex service systems or repeatedly follow-up with over-stretched health services, and the negative impacts of feeling unsupported by health professionals or health services.

"A friend of mine raised money for the local charity Footprints Foundation, which supports women in and around Sale who are struggling financially and who have breast cancer. And she said... they've only got to travel to Latrobe, which is about 45 minutes from Sale, for treatment. But some of the women were actually cancelling their radiotherapy appointments in Traralgon because they didn't have enough money to pay for petrol to get from here to drive to the next city to get radiotherapy. That's just absolutely appalling that you can't even afford just to pay for fuel, just to get the treatment to save your life. There needs to be a lot more local supports for people who have cancer."

Woman, 37, Wellington (Focus Group 5)

"A friend was diagnosed through a psychologist with ADHD and possibly autism but needed a psychiatric doctor to formally diagnose her, for which she needed a referral. She had to go to her GP maybe half a dozen times to actually get the referral sent. They said yes, they'll send it. They never sent it. She had to go back, like, to the point that they stopped charging her for the appointments because they were acknowledging that they were not fulfilling her need, but the need to have to go back to make sure that they were sending out the referral, it's just – the mind boggles."

Woman, 50, Latrobe (Focus Group 3)

"...we brought my mum down from Melbourne to be with us and she went into aged care in my town. As she had dementia, I rang Dementia Australia just to get some help and they took my name and number and then by the time they rang me back I was just pulling up to try and empty her room out because she'd died by then. And just got no help with her dementia at all. It was just tragic, and I had no idea about the end for her, and I think I handled it really badly ... everything just got sort of taken over in this whirlwind of what went on at the aged care place, it was just absolutely terrible and... you know, I reached out, but you know, I guess that's the whole thing – there's just waiting lists that probably I was on, but then by the time they got back to me, it was too late."

Woman, 66, East Gippsland (Focus Group 5)

Isolation and loneliness

The significant negative health impacts of social isolation and loneliness are increasingly being recognised and include both mental (e.g., emotional and psychological distress) as well as physical illness (e.g., high blood pressure, a compromised immune system, the development of dementia). The health benefits of social relationships are reflected in the Victorian Government's new Wellbeing Strategy which includes feeling connected to community as a key element of wellbeing (ELT 2020; State Government of Victoria 2025c).

Feelings of disconnection and loneliness were mentioned by many participants as an impact of poor access to health care and social services, compounded by living in a geographically dispersed area such as Gippsland, lack of free or low cost community activities, shortage of mental health services, and the rise of digital platforms as sites for service provision and communication.

"And just even the isolation of living in Gippsland, whether you're new to the area or you've left high school and your friends have moved away. There's a lot of isolation. I think that can contribute to mental health issues, and especially if it's issues that someone might have had that could have been picked up earlier but then aren't because they haven't spoken a professional."

Woman, 42, Bass Coast (Focus Group 5)

Particular groups of women and gender diverse people were seen as being at greater risk of loneliness and lacking a sense of belonging, including:

- newcomers to Gippsland,
- people whose friends or family members have moved away,
- people living with disability,
- migrants and refugees,
- people who are not working or volunteering, and
- people who find using technology challenging.

"I think when you come from overseas you find it hard. You find it very difficult to find a job. Because your language and the culture won't allow you to have a job. So yeah, I think that's gonna be a problem. And you're not citizen. You can get some money from Centrelink, but life very expensive. Yeah, this make you feel, 'It was better in my [home] country. I could have made more money. And now I feel very... 'It's not good feeling. Until you start learning English and get a job, but that's gonna take you years to become like where you were in your [home] country, at the same level. It's a challenge, yes."

Woman, 47, Bass Coast (Migrant and Refugee Women Focus Group)

"Isolation is a big problem. And disconnected. Jobless. But you can overcome those things. I suffered from depression for a while. Not working. Sitting in my room. Not wanting to come out. Not wanting to go the front door anymore. Angry. Hurt. Disconnected from everything. But, I started reaching out. Going home. And also reaching out to the closest [people] in my life helps. But [attending this session today] is the first time I've been out. Like actually out-out. I found that – no doctors. No psychiatrist. Nothing I wanted to go to. But finding a strategy to get out my front door and get back out. It's the first time I've been anywhere. I have my art world. But you can't keep painting, doing craft in your house. You gotta get out. But with the people that you're close to, connected to all the time, before you can make that next step."

Woman, 61, East Gippsland (First Nations Women Focus Group)

Several participants had suggestions about the kinds of services or initiatives they thought would help promote greater social connection and wellbeing or had been successful in the past, though noted time-limited funding or budget constraints as barriers.

"I remember back in the day when Aunty [name] worked on reception in the Co-op, and you'd just walk in, and it didn't matter, you could just walk around the back. You could make a cuppa, use the phone. But notice the difference in the mental health? Like those little things like that. I feel like that helped prevent some of the issues that we've got today because there was always somewhere to go and feel invited and connected."

Co-facilitator, First Nations Women's Focus Group, East Gippsland

"I have one NDIS client who struggles every day with her mental health and even has suicidal ideation. Very lonely, very isolated. And I previously worked for a mental health company in Gippsland, which was absolutely wonderful. Unfortunately, they lost a huge amount of funding back in 2022 and they had to close their doors and this particular [woman] was a client at the time of that business and I'm absolutely certain that if that business was still going and she had that support, she would be in a far better place than what she would be now. So, from that perspective, we need a lot more mental health organisations in the area. And that's not the only one that's unfortunately shut their doors in the last couple of years, so it's been a massive impact around here for sure."

Woman, 37, Wellington (Focus Group 5)

"It's a basic human need for human connection and sense of belonging and I actually don't think the councils in this region invest enough in that side of things. I mean, it sits usually with council, right? But, they don't have the resources either to be able to support – the community centres are there, but they're very small, they're not open for long hours either. Like they tend to sort of shut by 3:00pm, from what I can tell. So even from a participation perspective, to elevate mood and sense of belonging, it's pretty restricted, I think. That's just my own observation."

Woman, 55, Baw Baw (Focus Group 7)

Caregiver strain

Nationally, around 3 million Australians are unpaid carers, including 1.2 million primary carers. For the purposes of policy and services, a carer is defined as someone who provides 'unpaid care to a person requiring additional support which may be a partner, a family member, friend or neighbour'; it excludes parents of children without additional needs. While just over half of carers are women, they make up two thirds of primary carers. Around 13% of Australian girls and women are carers, compared with 11% of men and boys. The average age of a carer is 50, and primary carers are on average 54 years old (ABS 2024; Commonwealth of Australia 2024).

Among the *Healthy Women, Healthy Gippsland 2025* Report Card participants, we also included caring for dependent children when asking about caregiving responsibilities (Fig. 63). However, excluding care for children, the proportion of participants providing other forms of unpaid care was also 13%.

While caregiving can be rewarding or an expected part of relationships, it can also have significant impacts on the caregiver, including their health and wellbeing, financial status, employment and education (Sibly and Anderson 2024). These impacts are greater for caregivers from underserved communities including regional and rural communities, where health and support services may be harder to access. Many of the carers we heard from had minimal or no formal supports.

"I provide care for my neurodivergent primary school aged child, who is currently being homeschooled due to the lack of support in our local schools. Additionally, I care for my high school aged child, who has neurodivergent and mental health diagnoses, and my husband, who works part-time while dealing with his own disability. Recently, I have also received my own neurodivergent and mental health diagnoses. Our family manages to get by on a single income that fluctuates due to burnout, living pay cheque to pay cheque. Unfortunately, many of our support needs go unmet due to lack of availability and the high cost of living, making most days extremely challenging for me to handle."

Non-binary / genderqueer person, 36 – 50 years, Wellington (Survey)

"Just the mental health, the load, like you said. We take on so much – if it's not working, it's kids, it's caring for others. And how do we best support that? As you know, I'm a carer but I don't get any other support. And yeah, you struggle. You feel like there's no light at the end of the tunnel. Especially if you've got family members [with challenges]."

Woman, 30, East Gippsland (First Nations Women Focus Group)

"Carer support specific to neurological / brain issues in the person I care for are held in Latrobe Valley and Baw Baw shire. Travelling to access these is difficult. Carer support events are held during business hours. I can't get time off work to attend. My time off work is to take my husband to specialist medical appointments in Melbourne every 3 months. Anything else would jeopardise my position."

Woman, 51-65 years, Wellington (Survey)

A shortage of health and social care services in regional areas can also push people into caregiving roles in the absence of formal supports, taking on greater responsibility than they might otherwise, and relying more heavily on informal relationships.

"I am fortunate that I have family and friends to support me while my partner, who is in his early 70s is unwell. He requires significant support at the moment and we're unsure how well he will recover and if he will need ongoing assistance. I have previously worked in aged care assessment services and am aware there are long wait lists not only for services but also for eligibility assessments so we haven't even bothered to seek external support. I am also aware that while there are good carer services in the region, they are also stretched beyond capacity and we would be unlikely to get timely support. If I didn't have the informal supports that I do, I would not be able to cope with the carer responsibilities."

Woman, 36 – 50 years, South Gippsland (Survey)

"In terms of unpaid care when it comes to the unrecognised support that friendships play in that mental health space – I find a lot of people will talk about how they're supporting someone going through this and I think the mental health toll of that, it is something that I didn't see existing, I would say until the last three or five years. But just a lot of women supporting women in a very informal capacity. And I mean, it's great that we've got women that are standing by each other, but it's also I think it's something that isn't spoken about in terms of the toll that takes."

Woman, 24, Wellington (Focus Group 5)

"Our Maternal Child Health system needs some work - it's really hard to book appointments with the MCH nurse when needed, and the process of going through pregnancy to toddlerhood is difficult to navigate as a first-time mum. ... If I didn't have friends and other support networks I would have felt completely lost on where to go and what to do."

Woman, 26 - 35 years, Wellington (Survey)

The First Nations women we heard from shared their frustrations with the approach to kinship care taken by the Department of Families, Fairness and Housing (DFFH) and related services including Aboriginal Community Controlled Organisations (ACCOs) and ACCHOs. They described last-minute phone calls notifying them of children coming into or leaving their care, which was emotionally distressing and very damaging to familial relationships. Lack of support for families in the lead-up to children being removed was also a concern, as were the heavy expectations placed on kinship carers, and the unpredictable duration of care arrangements.

Participants described having to undertake a complex array of negotiation with the Department over the number of children they were sometimes expected to accept, with ACCHOs for necessary supports, with services for appointments for the children, and with employers to manage work commitments. One woman described her experience of taking 2 extra grandchildren in addition to 3 other children already in her care:

"I got a phone call at 6:30: 'We've got your grandkids. Do you want them?' I said yes straight away. Don't know how long they were sitting in the office for. Think they grabbed them from school. I was only meant to have the 2 kids for two weeks. That turned into what – how many months? I pushed for respite, but no. Because I was still working [while I had] the 5 kids – thank God I've got an awesome bloody partner because he had my back on a lot of it."

Woman, 57, East Gippsland (First Nations Women Focus Group)

So around supports around mental health regards to that, I think that out-of-home care's a lot to deal with as well as Department. My mental health dealing with them really went down. So – and I feel like a lot of our communities are more exposed to Department. So how do we then support them? You know, there's a higher rate of removal of our kids from our women. So how do we support our women? Like, I'm looking after my family member's children. But I'm scared my kids are going to get taken. So just that I suppose.

Woman, 32, East Gippsland (First Nations Women Focus Group)

To help themselves, women with caregiving responsibilities used a range of strategies including calling on family and friends to help and accessing formal supports where possible (e.g., NDIS, My Aged Care, home-based care via health services, financial support such as the Childcare Subsidy, supported accommodation, residential aged care). Many however said they had no formal supports, and several described experiencing burnout. Few had accessed carer support services, and awareness of supports such

as the Carer Gateway or the Mental Health Connect Centres seemed low or non-existent. Also highly valued was simply the opportunity to spend time and talk with others with similar experiences.

"I just want to say how good it is, just this yarn and listening to the different things we can all offer and that I'm not going crazy 'cause we are going through the same stuff. Yeah, so that was verified today."

Woman, 32, East Gippsland (First Nations Women Focus Group)

Andi Connell from the Gippsland Regional Public Health Unit offered a final observation on the gendered impacts on physical health of not being able to consistently access quality healthcare:

"I think it all speaks to the disadvantage that women experience in terms of healthcare. So to do preventative healthcare you need to have a lot of things line up for you in terms of access, affordability, time, knowledge, health literacy. So if we don't have all of those things in place, we end up with disease or comorbidity. And that's why we see such high rates in Gippsland, because that prevention is just not able to be achieved. I think women and gender diverse people experience that disproportionately to men specifically."

Andi Connell, Acting Manager, Gippsland Regional Public Health Unit

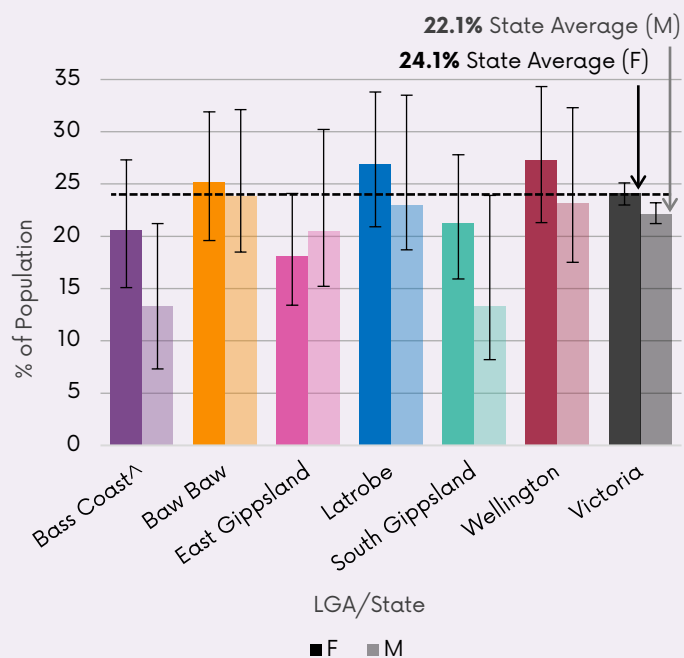


What the Quantitative Data Shows

Data from the 2023 Victorian Population Health Survey indicates that the proportion of people experiencing loneliness varies across Gippsland LGAs, but apart from East Gippsland, women are more likely to feel lonely than men (Fig. 25). Compared with Victorians on average, a higher proportion of both women and men in Baw Baw, Latrobe and Wellington are lonely (and a lower proportion in the other 3 LGAs).

Sex-disaggregated data on caregiving in Gippsland from the 2021 Census can be found in Chapter 5 (Fig. 63), showing that a higher proportion of Gippsland women provide informal caregiving than both Gippsland men and Victorian women on average.

Fig. 25: Proportion of people who feel lonely (females and males): Gippsland LGAs vs Victoria (2023)



Key: ^ Male estimate is statistically significantly different to the male state average. Black vertical lines represent 95% confidence intervals.

Source: Victorian Population Health Survey (VPHS) (2023)

3.2 Health Promotion and Prevention

Health promotion and prevention refer to upstream initiatives aimed at preventing health issues before they occur, promoting healthy behaviours, enabling people to have more control over their health, and addressing structural factors that influence community health and wellbeing and that go beyond the health system.

"You know the Biggest Ever Bloke's BBQ – I think they're a fantastic opportunity to get [health] messages out, but why don't they have like a women's big day out or something like that to talk about all women's issues? You feel supported by the people around you and raising awareness and support through those kinds of events. I think there needs to be more of them. Rather than ad hoc, [have it] once a year or every couple of years. I think there definitely needs to be more awareness-raising and talking about different specific issues and solving our own solutions to our own problems. And providing that information I think is important too."

Woman, 51, Wellington (Focus Group 3)

Key Finding 5: Women in Gippsland want more control over their own health through health promotion, education and preventive health

What We Heard

Responses to the survey and focus groups revealed women and gender diverse people in Gippsland were supportive of and eager to see more prevention-focused approaches addressing the underlying drivers and risk factors for poor health outcomes. Their reflections clustered around three themes:

- [Under-resourcing of preventative care](#)
- [The role of social determinants of health](#)
- [Knowledge gaps about health conditions and available services](#)

Under-Resourcing of Preventative Care

Participants expressed frustration that relatively little health funding seemed to be set aside for prevention compared with treatment and traditional health services and described medical practitioners as having little inclination for preventative approaches.

"In my experience of that community aspect of any kind of wellbeing, whether that's mental health or perimenopause, having like-minded people that you can connect with and share experiences and outcomes is how we learn. And I'm not really familiar with a lot in that preventative space. It's very much: GP, hospital. ... And when you're talking about some of those chronic illnesses – I don't mean to attack GPs – like the process is obviously prescribing medication, but should they be looking more at a preventative healthcare style as well? Diet changes. Exercise changes, lifestyle changes that may be more cost effective, holistic healthcare like chiropractic or physio or whatnot."

Woman, 50, Latrobe (Focus Group 3)

One focus group member shared her perspective based on her experience as an allied health practitioner at a smaller regional hospital. She described the 'never-ending wait list' they had for community education (on topics such as diabetes, bone health and cooking) and wasn't sure why there wasn't more funding given the demand for the sessions and the cost-effectiveness of prevention. A related concern she raised was about underserved groups such as older women who lived alone and were reluctant to ask for more assistance, even though this would potentially help prevent more complex health problems and significantly higher support needs.

"I know this lady who has someone come and take her shopping once a fortnight and she barely manages. Her daughter's organised for her to have meals so that she doesn't have to cook. But she won't ask for any more than that because she just thinks that, I guess it's that woman thing of thinking that you're needy and that other people need it more than you or humility and that. And she just doesn't ask and it's just terrible, she has eyesight problems and mobility problems."

Woman, 24, South Gippsland (Focus Group 5)

A desire for upstream approaches to mental health was also mentioned, including mental health promotion and community resilience building. Responses indicated a need for community-based wellbeing programs for women, support for carers to prevent burnout and family stress, efforts to address the social determinants of mental ill-health, eating disorder prevention programs, and reducing mental health stigma.

"Encouraging women, girls and gender diverse people to engage with community exercise is a great way to improve physical and mental health and is always something that can be targeted."

Woman, 26 – 35 years, South Gippsland (Survey)

"Like the other day with the carers' pamper day – you don't realise how important it is until you actually stop. And we're always like, 'Oh, you know, somebody else [needs it].' And then someone's like, 'No, you need this much more.' [You have] to be able to be like, 'You know what? I actually deserve this as a person.'"

Woman, 32, East Gippsland (First Nations Women Focus Group)

Gippsland Regional Public Health Unit Acting Manager Andi Connell shared her observations on data trends in relation to chronic disease and the three priority areas for the GRPHU – reducing smoking, increasing healthy eating, and increasing active living (GRPHU 2024). While the types of chronic disease affecting Gippslanders hadn't changed much in the last 5 or 10 years, she noted that some lifestyle behaviours were changing for women – both positively and negatively (see Figs. 26 – 29 for selected 2023 data from the Victorian Population Health Survey). Fruit and vegetable consumption was improving for women, but smoking rates were still high, and vaping was particularly prevalent among young people. Andi explained why physical activity for women and girls in Gippsland could be challenging, and why it was a priority for the GRPHU:

"Physical activity for women and girls as a specific cohort isn't getting much better. In fact, that's probably getting worse. Part of the issue is around access and equity – safe access to recreational activities, especially in the natural environment, so low or no cost active recreation such as walking, riding a bike, and safe access within sporting clubs and rec facilities. Fair access policy has been really important to mitigate that, but it's still in a very early stage in Gippsland and I'm not sure many women and girls know about that."

So that's our main concern - how do we activate spaces for women and girls to participate in active recreation, whether that's sport or going for a walk, with safety being the main concern, especially in Latrobe Valley."

The geography of Gippsland is also quite complex. So we obviously have less access to recreation through transport. Or you rely on transport - to be able to walk somewhere, you have to walk quite a long distance and whether that track is safe is hit and miss. Adequate lighting funding to create better active recreation or active transport type facilities isn't often a priority. There's many other factors too – even just the cost of living."

Our families, especially in our lower socioeconomic groups being Latrobe - they're not prioritising active recreation when they've got to work full-time. They leave work when it's dark. It's not safe to go for a walk or they've got children to take to sporting or extracurricular activities or they've just got to go home and make dinner. So there are many barriers that are probably not too unique to Gippsland, but that geographical impact is very powerful as a barrier to getting active."

Andi Connell, Acting Manager, Gippsland Regional Public Health Unit

One aspect of prevention that received mostly positive feedback was screening initiatives and programs, including mobile breast screening, cervical screening and skin cancer checking services. As shown in Figs. 30–32, compared with Victorian women as a whole, a relatively high proportion of Gippsland women participate in breast and bowel screening but cervical screening participation is closer to or slightly under the state average.

Suggestions for improvement included better education about cervical screening options including self-collection, and the availability of free mammograms for women aged 40 and over. Community services organising group appointments or education sessions for underserved communities were seen as effective. For example, the Neighbourhood House that hosted the Migrant and Refugee Women focus group had arranged a group booking for its regular multicultural women's group members, while Gippsland Disability Advocacy Inc (GDAI) delivered cervical and bowel screening information, education and awareness sessions for women attending a disability support service in East Gippsland.

"I just had my first mammogram a few weeks ago at BreastScreen at the Wonthaggi hospital. And I was very surprised at how easy and painless it was. ... I didn't have to wait. I think I knew that it was going to be free, but I was just very surprised by the quality of care."

Woman, 42, Bass Coast (Focus Group 2)



Box 5: How GWH is supporting preventative healthcare for women and gender diverse people in Gippsland

GWH is leading the way in supporting preventative healthcare for women and gender diverse people across the region. By promoting early screening and health education, GWH is helping to reduce the risk of serious health conditions and improve long-term outcomes.

GWH promotes **BreastScreen Victoria's Mobile Women's Health Clinic**, which brings breast and cervical screening services to remote towns across the region, enabling women and gender diverse people to more easily access preventative care without the burden of long-distance travel.

GWH is **collaborating with Cancer Council Victoria to support the 'In Your Hands' campaign**, encouraging cervical screening (including self-collection) and providing culturally appropriate resources in Latrobe and surrounding areas.

Through our **Women's Wellbeing Groups** and **'In The Know' sessions**, GWH is educating community members about the importance of regular health checks, including breast, bowel, and cervical screenings, and cervical screening self-collection demonstrations. Other preventative health information education included promoting good cardiovascular health, and the importance of social connection for mental health and wellbeing. These sessions build the confidence of participants to take proactive steps in managing their health.

These efforts are making a significant impact by increasing screening participation rates and ensuring that preventative healthcare is accessible, inclusive, and tailored to the needs of Gippsland's diverse communities.

Awareness of the Social Determinants of Health

When reflecting on health needs and services in Gippsland, many women and gender diverse people connected health outcomes to social determinants of health (Box 6), **citing issues such as financial stability, education, community connection, and freedom from violence as foundational to good mental health and the ability to prevent or manage chronic disease.** These observations highlight not only community members' broad understanding of the 'whole of life' factors that shape health and wellbeing, but also the important role played by systems, stakeholders and policies outside the health system including education, housing, employment, family violence response and the wider economy.

"I think it's the avoidable deaths from chronic diseases like COPD, diabetes, some cancers. They can be prevented and looking more at that social model of health, we rely on treatments and diagnosis and all of those scans, but if we really take ownership of that education and support... it's cheaper. We live happier, longer productive lives. My kids at school, they all know I say: 'If you don't have an education, what do you do?' They go, 'You die early.' I know that sounds a bit rough and aggressive. But if I'm getting these 15-year-old boys to at least say that, it's like they are valuing education as a precursor to a happy, healthy life."

Woman, 53, Bass Coast (Focus Group 2)

"I guess one thing I would touch on is family violence. ... I think that's really contributing to [poor] mental health, is just women being I guess scared, fearing for your life or those sorts of things."

Woman, 24, Wellington (Focus Group 5)

"...so I've had this kind of rollercoaster really, of being employed and unemployed and it definitely directly affects health and your access to it... When you've got chronic health problems, there's just this clash where you have to work because you just can't [financially] manage the chronic illnesses."

Woman, 50 Latrobe (Interview)

In terms of health services, **greater access to bulk-billed services was seen as a solution to assist the 'middle income' bracket** – those who are ineligible for a Health Care Card but whose real wage has been eroded by inflation. As one focus group participant commented, 'I haven't had a pay rise in four years. But everything has gone up. Crazy up. So that's why I actually work two jobs – to be able to live basically.'

Box 6: What are the social determinants of health?

According to the World Health Organisation, the social determinants of health are 'the conditions in which people are born, grow, live, work and age, and people's access to power, money and resources' The 'non-biological and non-clinical factors' that profoundly influence health inequities between population groups, social determinants of health account for an estimated 30 – 55% of health outcomes (WHO 2025; Orille, Steck and Brannan 2024).

Knowledge Gaps About Health Conditions and Available Services

Women and gender diverse people's responses highlighted **gaps in health literacy and access to information about available services, and a high level of interest in more education on both fronts.**

Sexual and reproductive health education needs mentioned include better information about contraception options and accessibility, menopause and perimenopause support, and young women's health issues, including endometriosis and period pain.

"More information on endometriosis and young women's health so there are more options for bad periods / IUDs."

Woman, under 18 years, East Gippsland (Survey)

"I think for young females it's still having that stigma of talking about periods and what that normal level of pain is that one time a month. I see a lot of information on social media now and it's starting conversations, but you know, just still having not fully open conversations or not knowing when you should go to the doctor and see if something is going on. I know a lot of people that are reaching that late 20s, early 30s and discovering they have endometriosis or things like that or struggling to fall pregnant and then discovering there's these sort of issues going on and I think that's something that wasn't really talked about a lot when I was in high school."

Woman, 24, Wellington (Focus Group 5)

LRH Mental Health Promotion Officer Susanne Lampitt observed that mental health literacy had improved over the course of her career, particularly more recently.

"10 years ago it was really hard for me to get a seat at any table. And also people were more naive around mental health and mental illness and its impact and the fact that the behaviours, for want of a better word, are illness-related, not a willful decision to not get out of bed or whatever. I think that is shifting quite significantly and probably COVID had a lot to do with that around that isolation and loneliness and coming out the other side and people appreciating how important connection was. And I can also see a shift in young people. So if I think back to when I went to school, you didn't hear any of this stuff. It wasn't talked about. And then my kids who are in their early 30s, it was starting to be talked about. But now I watch my grandchild and the amount of health and wellbeing things that are in the curriculum, the everyday, it's just astounding, you know, and they talk a lot more about it than they ever did. So I can really see a shift in people's knowledge and understanding."

Susanne Lampitt, Mental Health Promotion Officer, Latrobe Regional Health



Better information about available services and how to access them was repeatedly highlighted as an area of need. A focus group participant working in health promotion regionally shared how she had only recently learned that LCHS provided abortion care, despite the service having been in operation for three years.

Underserved communities of women and gender diverse people such as migrants and refugees, those living in remote locations, and both older and younger people were noted as particularly lacking access to information and education.

"I know that there's a system for reimbursement if you have to travel somewhere else [for healthcare], but I doubt whether any members of this group have ever made a claim or would know about it. ... You don't know what you don't know. And it's very hard because people have so many other priorities too."

Co-facilitator, Migrant and Refugee Women Focus Group

"I feel a bit lost in that I'm not on social media then to know much of what's going on with groups and so on. I think I miss a bit that way... the communication of things that are available is really important. Because there might be things going on that people just don't know about because they're not necessarily linked in with every form of communication."

Woman, 66, East Gippsland (Focus Group 5)

"... sometimes I feel a lot of people aren't aware that there's different home care packages or different types of subsidised healthcare. I work at a private clinic as well. So people usually get a care plan and they just come to the private clinic, but if they go straight to the hospital to see a physio or diabetes educator, it's a lot cheaper. They might be paying \$110 to see me at the private clinic, whereas they would have to only pay \$10 at the hospital. So it's just I guess providing people with the right services. Because a \$10 consultation, which is exactly the same as the \$110 one, that's a huge difference."

Woman, 24, South Gippsland (Focus Group 5)

"The other [migrant] women were just saying they don't really have problem with mental health in their families or see anyone. But the thing is they just want to ask about the support, the health service they could get, like in case it happens to their family members so they can prepare. They just want to know if there is anything in the area. So they don't have to travel too far."

Woman, 35, Bass Coast (Migrant and Refugee Women Focus Group)

Some respondents commented on the importance of actively and creatively trying to reach these groups via different avenues, including **information sessions at libraries, community centres, and in shopping plazas, or early intervention measures such as whole-of-school approaches** that support the development of healthy attitudes and behaviours.

"We need a positive visual poster created for East Gippsland people with local supportive services. To be placed on all public toilet doors."

Woman, 51-65 years, East Gippsland (Survey)

"More help for young kids. Getting more programs in schools and gender-based ones especially in high schools. There are so many kids vaping, smoking and doing drugs, it's scary - even kids in Year 7 and Year 9 have unprotected sex and that's just the ones we know about. We need more than just the teachers trying to spread the word and support these kids. So many of them don't realise just how toxic their friendships and relationships are. Teachers need medical and health professional back-up - not just nurses in schools but actual programs to teach kids, there are not enough resources in schools."

Woman, 26 - 35 years, Wellington (Survey)

Some participants were more optimistic that an increased focus on health promotion was making a difference over time, and that **the community's lack of awareness of services was a bigger issue** than lack of services.

"I do think that health promotion, health awareness and enabling people to make healthier choices is happening. I think it's a lot. It's bigger conversations, bigger awareness. The stigma is going away. I mean, my parents, it was all just about, 'What's the pill I take?' and, 'The doctor will tell me what to do.' But I think now... we have got more permission now to take control and to make choices and informed choices as well."

Woman, 53, Bass Coast (Focus Group 2)

"I think we have a reasonably accessible health system, but I do think people's education on availability of these services is probably lacking."

Woman, 26-35 years, Wellington (Survey)

See [Box 7](#) to learn about what GWH is doing to build women and gender diverse people's health literacy and knowledge of services in Gippsland.

What the Quantitative Data Shows

Lifestyle Behaviours

The following data from the 2023 Victorian Population Health Survey highlights some of the key lifestyle behaviours that influence health and wellbeing outcomes – alcohol consumption, tobacco smoking and e-cigarettes (vapes), diet and physical activity – and are common priority areas for health promotion and prevention efforts (GRPHU 2024; State Government of Victoria 2023). A social determinants of health approach (see Box 6) reminds us that while these are individual behaviours, they are shaped by a range of other factors including:

- socioeconomic factors such as income, employment and education levels,
- geography (rurality and remoteness),
- systemic factors such as health and social policy and service provision, urban design, transport policy, and government policy towards and regulation of the food, alcohol and tobacco industries.

Alcohol-Related Harm

Alcohol consumption is now recognised as a risk factor for a range of health conditions including cancer, heart and liver disease, brain damage (including dementia), mental health, and fertility problems. It is also a significant contributing factor to family and sexual violence, therefore in Fig. 26 below we include the proportion of both females and males whose consumption puts them at increased risk of alcohol-related harm.

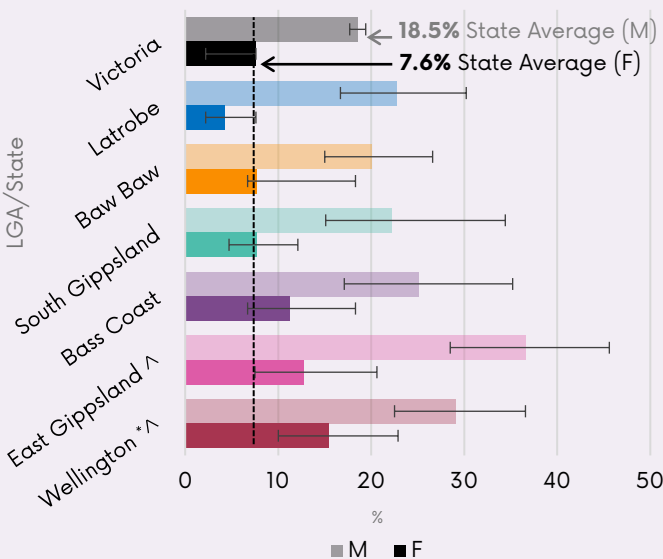
In Wellington, East Gippsland and Bass Coast, the percentage of women at increased risk of alcohol-related harm is higher than the Victorian average, while for men this is the case in all six LGAs.

Tobacco Smoking and E-cigarette Use (Vaping)

Tobacco smoking is a risk factor for respiratory diseases including lung cancer and COPD. The health impacts of e-cigarette smoking, which has rapidly increased in recent years in Australia, are not fully known but include potential nicotine poisoning, lung injuries and trauma and burns from faulty parts. Vaping may also lead to tobacco smoking (Better Health Channel 2025).

The percentage of daily tobacco smokers / e-cigarette users is higher than the Victorian average of 11.8% in 5 of 6 Gippsland LGAs (Fig. 27) and as high as 21.6% in Wellington.

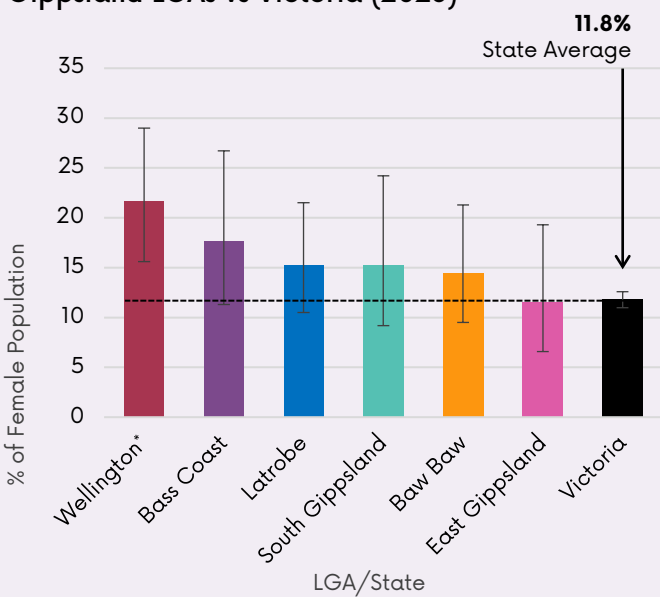
Fig. 26: Proportion of adults at increased risk of alcohol-related harm (females vs males): Gippsland LGAs vs Victoria (2023)



Key: * Female estimate is statistically significantly different to the female state average. ^ Male estimate is statistically significantly different to the male state average. Black vertical lines represent 95% confidence intervals.

Source: Victorian Population Health Survey (VPHS) (2023)

Fig. 27: Proportion of adults who are daily tobacco smokers / e-cigarette users (females) - Gippsland LGAs vs Victoria (2023)



Key: * Estimate is statistically significantly different to the state average (dashed line). Black vertical lines represent 95% confidence intervals.

Source: Victorian Population Health Survey (VPHS) (2023)

Diet and Physical Activity

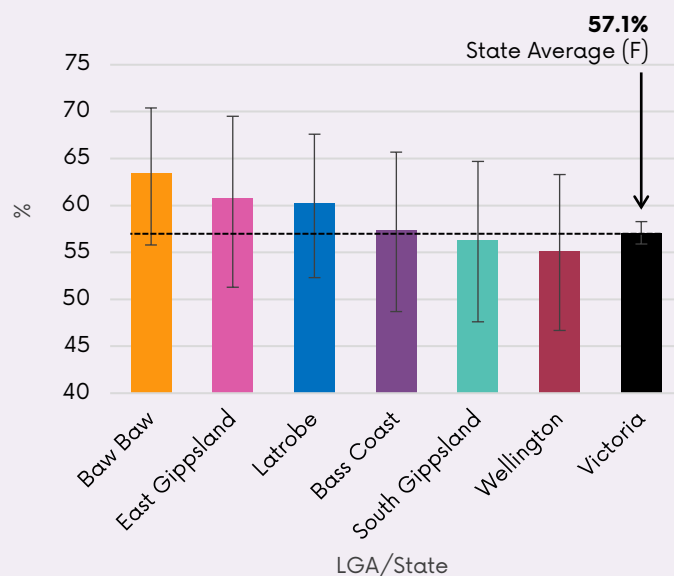
The percentage of adults who do not meet recommended fruit and vegetable consumption guidelines is high throughout Victoria (57.1% on average), and Gippsland is no exception (Fig. 28). A diet low in fruit and vegetables is a risk factor for a range of illnesses including diabetes, heart disease and cancer. Although the proportions in South Gippsland and Wellington are beneath the state average, they are still over 50%.

Physical activity is also important for good health. 2023 data from the Victorian Population Health Survey suggests that Gippsland women may be less sedentary than Victorian women as a whole – the percentage sitting for 7 or more hours a day is lower than the statewide average in all 6 LGAs (Fig. 29).

Cancer Screening

National screening programs exist for breast, bowel, cervical and, as of July 2025, lung cancer. Recent data at the LGA level suggests that across most of Gippsland, breast and bowel cancer screening participation has been higher than the statewide average, even during the decline during the COVID-19 pandemic, though less so in the case of breast cancer more recently in some LGAs (Figs. 30 and 31). **Cervical screening coverage (now measured over five years) is lower than the state average, with the exception of Baw Baw and South Gippsland (Fig. 32) (see Box 5 to find out how GWH is supporting efforts to increase cancer screening rates in Gippsland).**

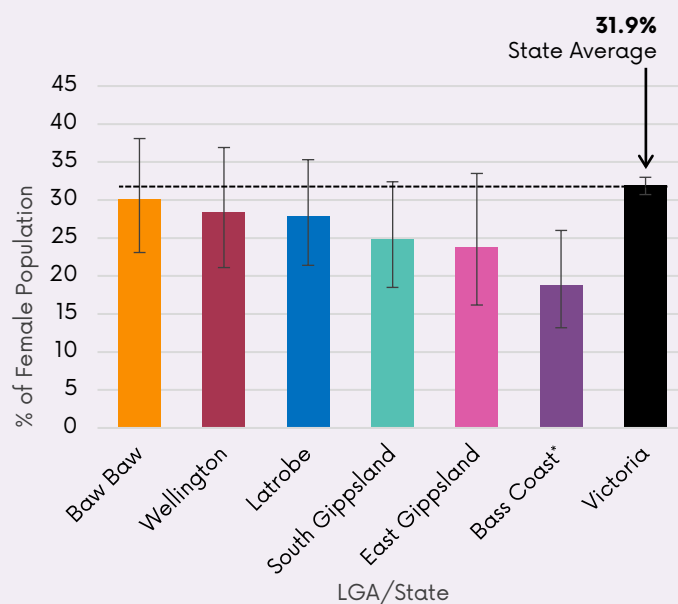
Fig. 28: Proportion of adults who do not meet recommended fruit and vegetable consumption guidelines (females): Gippsland LGAs vs Victoria (2023)



Key: None of the regions are statistically significantly different to the state average. Black vertical lines represent 95% confidence intervals.

Source: Victorian Population Health Survey (VPHS) (2023)

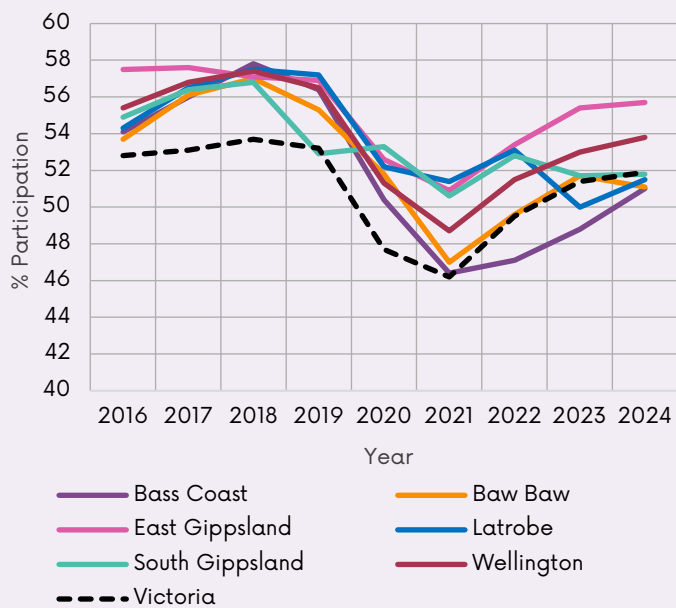
Fig. 29: Proportion of adults who sat for 7 or more hours a day on a weekday (females): Gippsland LGAs vs Victoria (2023)



Key: * Estimate is statistically significantly different to the state average. Black vertical lines represent 95% confidence intervals.

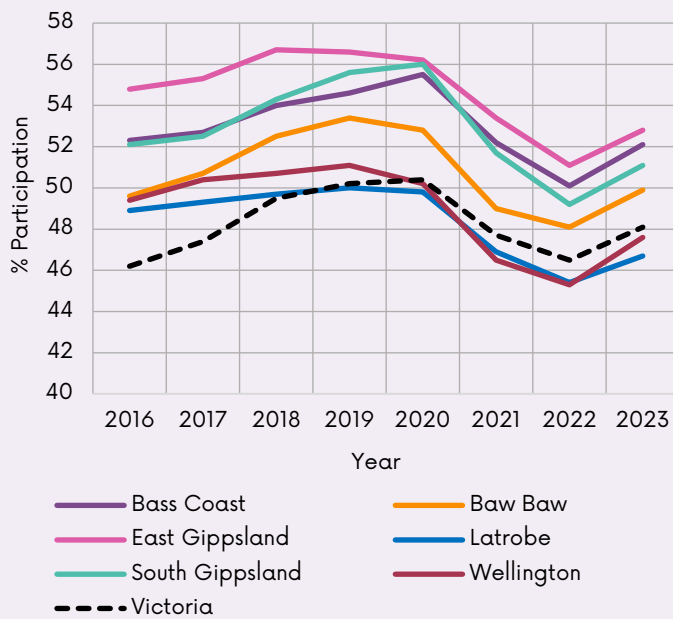
Source: Victorian Population Health Survey (VPHS) (2023)

Fig. 30: Breast screening – 2-year participation
 %: Gippsland LGAs vs Victoria (2016 – 2024)



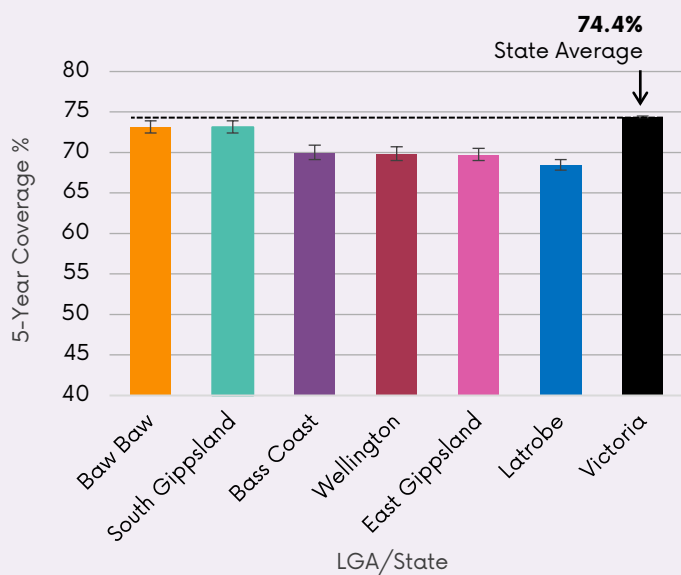
Source: Victorian Women's Health Atlas

Fig. 31: Bowel screening – 2-year participation
 %: Gippsland LGAs vs Victoria (2016 – 2023)



Source: Victorian Women's Health Atlas

Fig. 32: Cervical screening – 5-year coverage
 %: Gippsland LGAs vs Victoria (2023)



Source: Victorian Women's Health Atlas / Australian Centre for the Prevention of Cervical Cancer (ACPPCC)

Box 7: How GWH is helping improve women and gender diverse people's health literacy and awareness of services in Gippsland

GWH is committed to improving health literacy and knowledge of available services among women and gender diverse people in Gippsland by sharing information and creating safe, inclusive spaces for learning and discussion.

Community education is a key element of GWH's health promotion work. Through our **Women's Wellbeing Groups** and **'In The Know' sessions**, GWH is building health literacy and informing women and gender diverse people about available services in their towns and LGAs.

- **Women's Wellbeing Group** events have focused on mental health, menopause, and preventative health, empowering participants with knowledge about health conditions and how to manage them as well as available services. Feedback from the sessions highlights the value of normalising health experiences, reducing stigma, and providing practical tools such as symptom checklists and pathways to care. Participants also report increased confidence in navigating the healthcare system and making informed choices.
- Our **'In The Know'** sessions, aligned with the **BreastScreen Victoria Mobile Clinic** schedule, provide vital information about both health topics as well as local health services, screening options and how to access care. These sessions are tailored to each town and LGA ensuring relevance and accessibility.

GWH's social media presence and publications including the annual **'Are You Covered' (AYC)** magazine is written for and by Gippsland women, gender diverse people and health professionals. Each edition's theme is developed through a consultative process undertaken by GWH to reflect the current focus and needs of Gippsland women. AYC magazine themes have included healthy relationships, perimenopause, service navigation, and menstrual health and pain with the next edition committed to disability. The magazine aims to address health knowledge gaps and improve awareness of and access to local services.

GWH also builds health literacy in the community via partnerships and promoting useful resources developed by other organisations:

- We partnered with Gippsport to deliver **Periods, Pain and Endometriosis Program (PPEP Talk®)** for people involved in community sport – coaches, team managers, and parents – to create supportive sporting environments and understanding of the health needs of girls, women and people with a cervix so they can continue participating in sport.
- We widely share the **menopause checklist from Jean Hailes** to increase community capacity to self-advocate within Gippsland.

By developing plain language resources and promoting evidence-based information, GWH ensures that women and gender diverse people across Gippsland are better equipped to understand their health and advocate for their needs. By addressing gaps in service knowledge and promoting pathways to care, GWH is also helping ensure people know what services exist and how to access them, reducing barriers and improving health outcomes.

3.3 Gippsland Women's Health Status and Inequities

Key Finding 6: Women in Gippsland experience poorer health outcomes than both other Victorian women and Gippsland men in a range of areas. Key health inequities experienced by women in Gippsland exist in relation to mental health, sexual and reproductive health, chronic disease, and cancer.

Remoteness, access to healthcare, and health outcomes

As detailed in the *Forgotten Health Spend* report (NHRA and Nous 2025), increasing rurality and remoteness is associated with less access to healthcare and health workers (and related services and workers), relative socioeconomic disadvantage, and poorer health outcomes. With permission, we have reproduced two of the report's charts on the next page..

Box 8: Remoteness classifications in Gippsland

Two measures of remoteness are used in the *Forgotten Health Spend* report – the Modified Monash Model or MMM classifications, and the Australian Statistical Geography Standard (ASGS) Remoteness Areas.

The MMM classifications range from 1 (metropolitan city) through to 7 (very remote communities). Much of Gippsland is classified as MMM 5 (small rural towns). The largest towns such as Traralgon and Morwell are classified as MMM 3 (large rural towns), while Leongatha, Wonthaggi, Sale and Bairnsdale are MM4 (medium rural towns). The easternmost corner from Bellbird Creek to the border is classed as MMM6 (remote communities).

In contrast, the ASGS Remoteness Areas comprise 5 classes of relative geographic remoteness from major cities (RA1) through to Very Remote Australia (RA5). As shown on Fig. 10 in Chapter 2, much of southwest Gippsland is classed as Inner Regional (RA2), while central Gippsland and the easternmost corner (Mallacoota and surrounds) are Outer Regional (RA3). The parts of Gippsland that are classified as Remote (RA4) are lightly populated and include from the Nooramunga Coastal and Marine Park to near Woodside Beach and a central band of East Gippsland shire from the coast to the NSW border.



As shown in Fig. 33, small rural towns (MM5) - which comprise the majority of Gippsland's towns - have the lowest ratios of health professionals to population across medicine, nursing and allied health. There is also a relatively heavy reliance on the nursing workforce in large and medium rural towns (MMM3 and MMM4) and remote communities (MMM6).

As Fig. 34 illustrates, women in Gippsland (predominantly RA2 and RA3 with a small proportion in RA4) face a risk of premature death 1.2 to 1.7 times higher than metropolitan women, and in RA4 areas higher than men's elevated risk as well.

What the quantitative data shows

In this section we share some of the outcome and related data for health conditions across the following Gippsland Women's Health priority areas:

- mental health,
- sexual and reproductive health, and
- chronic disease (including cancer).

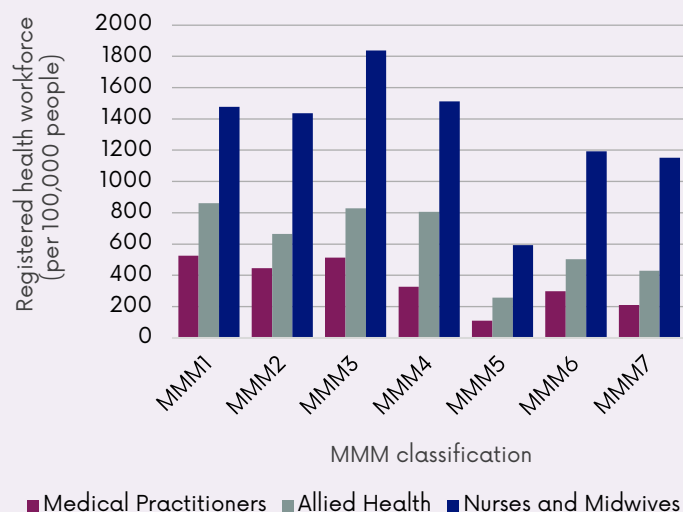
As well as providing **insights into the health status of women in Gippsland**, the data enables **comparison between their health outcomes and those for Gippsland men and / or Victorian women as a whole**, highlighting key gendered or place-based inequities.

Based on the latest year of data available, **compared with Gippsland men**, Gippsland women:

- have worse mental health outcomes, but more of them seek help for their mental health,
- have higher rates of arthritis, asthma and dementia, but lower rates of heart disease and diabetes, and
- are less likely to be at increased risk of alcohol-related harm themselves but are exposed to Gippsland men's greater risk of alcohol-related harm.

Fig. 33: Health workforce ratios by MMM area, Australia (2023)

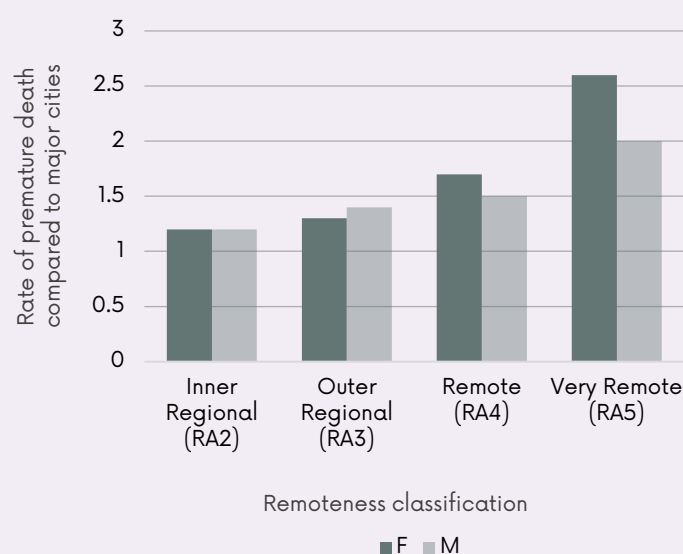
Small rural towns have the smallest per capita workforce across medicine, nursing and allied health



Source: NMHRA and Nous Group (2025) *The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia / National Health Workforce 2023*

Fig. 34: Rate of age-standardised premature deaths compared with major cities (2023)

Rates of premature death increase with increasing remoteness.



Source: Nous Group (2025) *The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia / Age-standardised premature deaths (per 100,000) by remoteness in 2023, MORT 2019-2023*

Compared with Victorian women overall, Gippsland women:

- have worse mental health outcomes, but more of them seek help for their mental health,
- have lower rates of chlamydia and gonorrhoea and similar rates of syphilis,
- have higher rates of arthritis, asthma, diabetes and heart disease, but lower rates of dementia,
- are more likely to be at increased risk of alcohol-related harm and to be a daily smoker or e-cigarette user, but are less likely to sit for 7 or more hours a day,
- have higher rates of bowel and lung cancer and melanoma (and are more likely to die from these cancers), but lower rates of breast and uterine cancer (and are no more likely to die from these cancers), and
- are more likely to undergo screening for bowel cancer but less likely for cervical cancer.

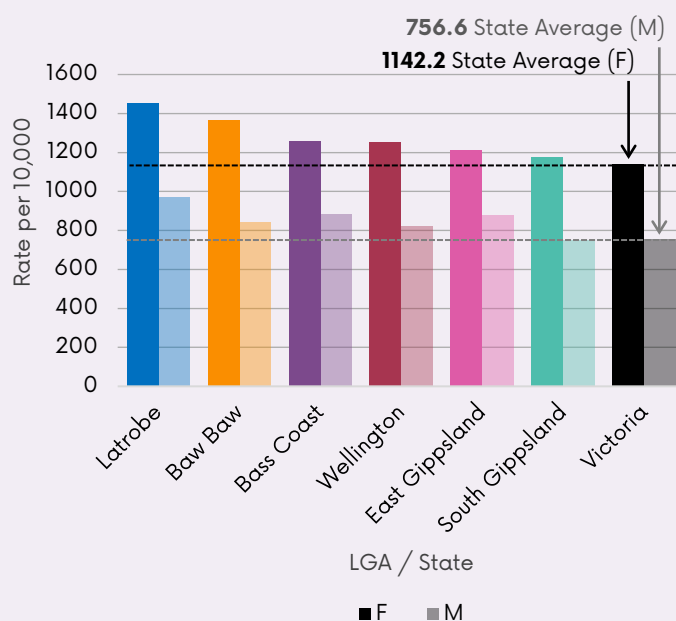
Mental health

Mental health was in the top three services that *Healthy Women Healthy Gippsland 2025* survey respondents travelled outside the region for (Fig. 20). It is a significant challenge for women in Gippsland overall as figs.35-38 illustrate; rates of psychological distress are even higher among many women in underserved communities (see Section 2.5).

2021 Census data (Fig. 35) indicates women had higher rates of diagnosed mental health conditions than men both in Gippsland and at a statewide level, and Gippsland women in every LGA had higher rates than the Victorian average, with particularly high rates in Latrobe and Baw Baw.

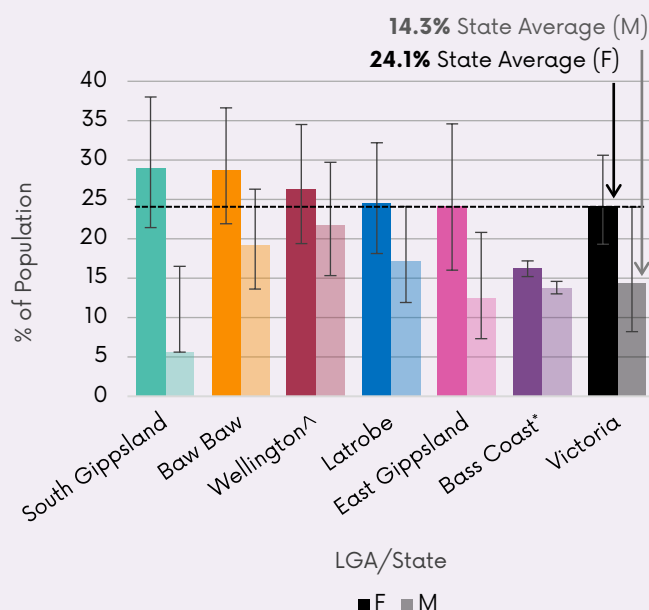
Similarly, rates of seeking professional mental health support over the last year show a clear gendered pattern (Fig. 36). Across the region, a higher proportion of women sought professional help for a mental health problem than men, and at or above the state average in 5 out of 6 LGAs.

Fig. 35: Mental health conditions ever diagnosed per 10,000 (female and male): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas, ABS Census (2021)

Fig. 36: Proportion of population who sought professional help for a mental health problem in last 12 months (females and males): Gippsland LGAs vs Victoria (2023)



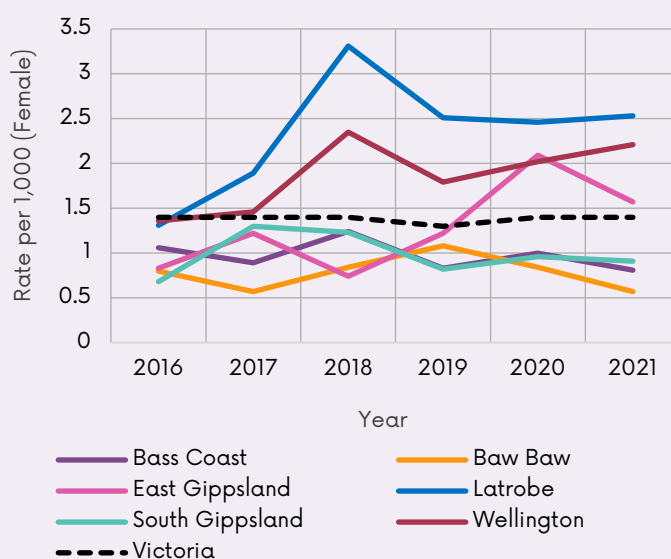
Key: * Female estimate is statistically significantly different to the female state average (dashed line). ^ Male estimate is statistically significantly different to the male state average. Black vertical lines represent 95% confidence intervals.

Source: Victorian Population Health Survey (VPHS) (2023)

The following chart (Fig. 37) shows trends in rates of hospitalisation for self-harm across Gippsland from 2016 to 2021, compared with the Victorian average rate. Rates in Latrobe and Wellington have been well above the state average for most of this period and are trending upwards in recent years while declining in other Gippsland LGAs. Latrobe and Wellington ranked 7th and 8th respectively out of all 79 LGAs across Victoria in 2021 for hospitalisations for self-harm.

Although there is an understandable community and policy focus on men's higher rates of suicide relative to women's, this discussion often obscures the reverse pattern seen in self-harm – in all Gippsland LGAs, female rates of hospitalisation for self-harm are higher than male rates (Fig. 38). Across Gippsland, the average gender ratio is 1.75 females to every male being hospitalised for self-harm.

Fig. 37: Hospitalisation for self-harm – rate per 1,000 (females): Gippsland LGAs vs Victoria (2016 - 2021)

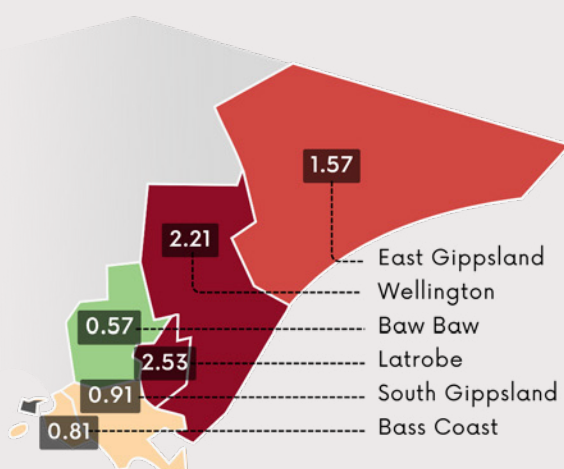


Source: Victorian Women's Health Atlas / Victorian Agency for Health Information

Fig. 38: Hospitalisation for self-harm - rate per 1,000 (females and males): Gippsland LGAs (2021)

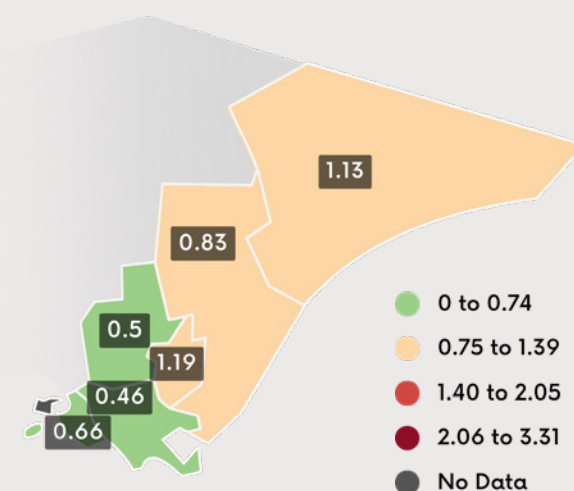
Rate per 1,000 Female

Victoria Statewide F 1.4



Rate per 1,000 Male

Victoria Statewide M 0.6



Source: Victorian Women's Health Atlas / Victorian Agency for Health Information

Sexual and reproductive health

As noted under Key Finding 2 above, sexual and reproductive health (which participants often termed 'women's health') was an area of healthcare that many participants found hard to access or perceived as being of poor quality – indeed, it was the main reason 4 in 5 survey respondents sought healthcare outside the region (Fig. 20).

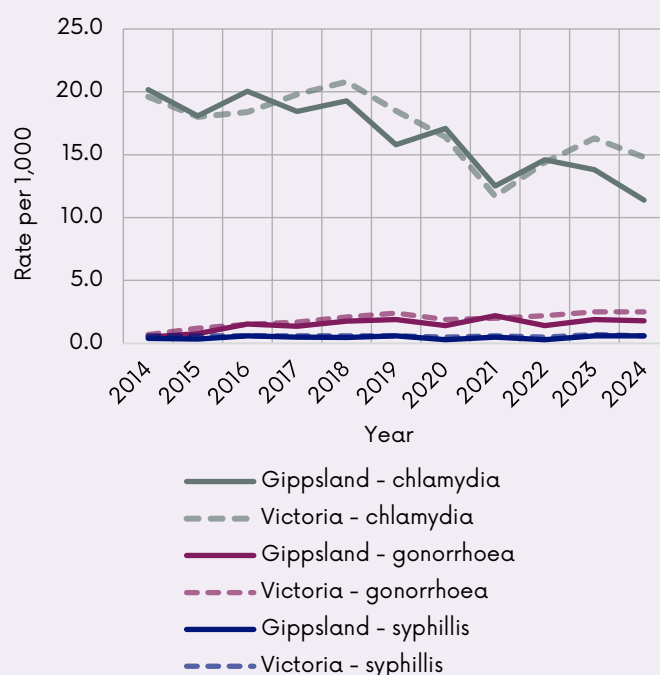
Sexual and reproductive health (SRH) includes healthcare for conditions such as endometriosis, PCOS, menstrual disorders, contraception and abortion, pregnancy and maternity care, and menopause. Medication abortion access data was included in the previous chapter (Figs. 21 - 24). Here we include a selection of other sex-disaggregated SRH data available at the LGA or regional level – on STIs, endometriosis, hysterectomy and adolescent birth – to highlight differences between Gippsland LGAs and the state average, and trends over time.

STIs are rising across Australia after a fall during the COVID-19 pandemic, albeit at a faster rate in men than women. However, for women in Gippsland over the period 2014 – 2023, only gonorrhoea rates have increased and they remain below the Victorian average (Fig. 39). Rates of chlamydia among women in Gippsland are much higher than rates of gonorrhoea and syphilis, though they have declined over the time period shown and are currently lower than the statewide average.

Endometriosis can take up to 10 years to be diagnosed due to health professionals dismissing women's pain, social norms that normalise menstrual pain, and lack of research and understanding of reproductive conditions (Victorian Women's Health Atlas 2025).

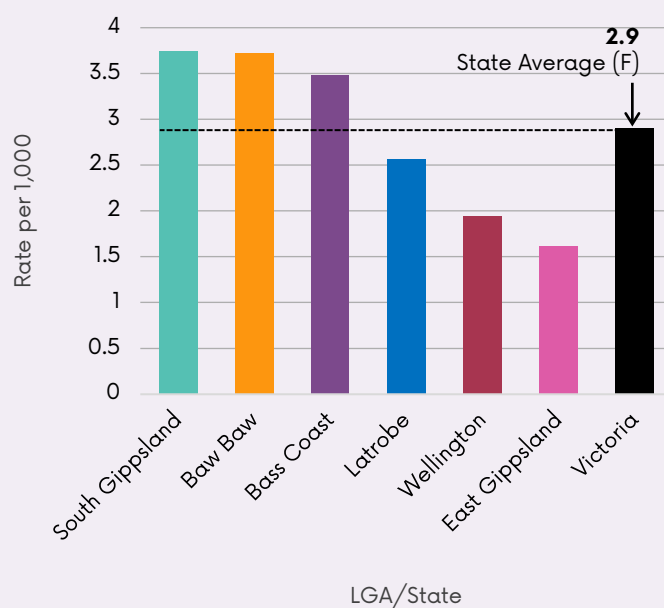
2022 data shows that rates of hospitalisations for endometriosis were above the statewide average in South Gippsland, Baw Baw and Bass Coast, and below in Latrobe, Wellington and East Gippsland (Fig. 40). The reasons for the differences between LGAs are unknown but may reflect variation in health service availability or capability for diagnosing endometriosis or levels of community awareness of the condition.

Fig. 39: Chlamydia, gonorrhoea and syphilis - rate per 1,000 (females): Gippsland regional vs Victorian state estimates (2014 - 2023)



Source: Victorian Women's Health Atlas, Victorian Government Department of Health

Fig. 40: Endometriosis – rate per 1,000 (females): Gippsland LGAs vs Victoria (2022)



Source: Victorian Women's Health Atlas, Victoria. Department of Health, Victorian Admitted Episodes Dataset

Hysterectomy rates are higher in Australia than many comparable countries, where rates are declining, and updated clinical standards recommend less invasive treatments for some of the conditions that hysterectomy was previously indicated for. As the 2022 data illustrates (Fig. 41), in most Gippsland LGAs the rates are lower than the Victorian average rate, except for Bass Coast and Baw Baw

A final sexual and reproductive health indicator is adolescent births. Becoming a parent is usually a positive experience for young women and gender diverse people, however younger parents usually face more challenges including difficulty accessing antenatal care, financial insecurity, and emotional distress if they lack support (Victorian Women's Health Atlas 2025).

Although data is only available to 2020, as Fig. 42 illustrates adolescent births declined steadily over this period in Victoria as a whole and across all Gippsland LGAs, although rates remain higher than the state average in Latrobe, East Gippsland and Wellington..

Chronic disease

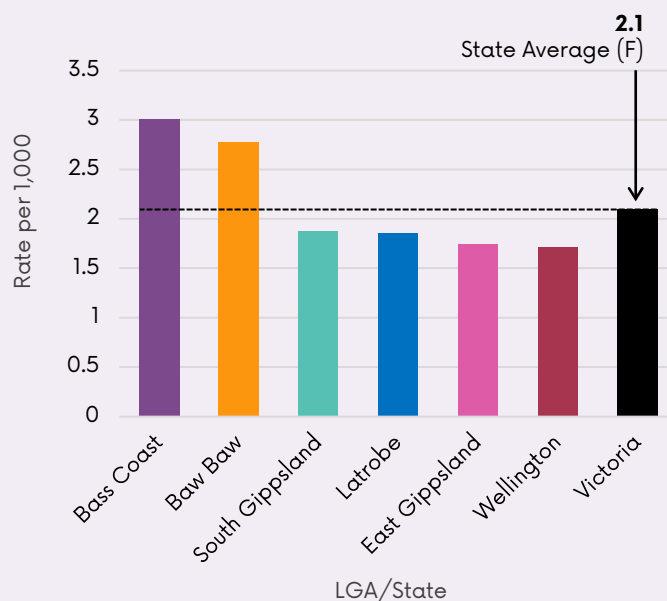
Although not widely recognised, there are sex and gender differences in many common chronic diseases in terms of health outcomes. Rates of arthritis (all kinds), asthma and dementia for example are much higher in women than men as the 2021 data for Gippsland and Victoria shows (Figs. 43- 46). **Indeed, in 2021 women comprised 65% of Victorians with arthritis, 60% of those with dementia, and 55% of those with asthma.**

In contrast, diabetes and heart disease rates are higher in men (though the latter tends to be under or misdiagnosed in women, which may play a role in lower rates). Arthritis and asthma are also more common in women from some underserved communities, including First Nations women (ABS 2022b).

Rates of arthritis and asthma are higher in Gippsland women than the Victorian average, while dementia is lower.

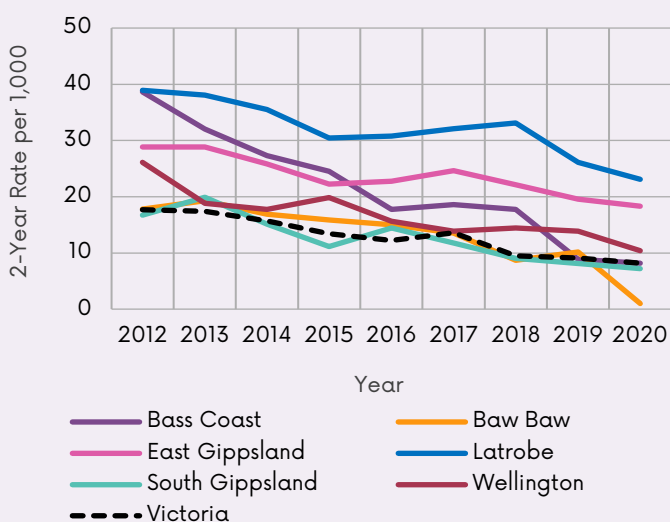
The particularly high rates of asthma in Latrobe – the 5th highest of all LGAs (Fig. 44) – are notable in view of the power industry and Hazelwood Mine fire. Lower dementia rates are likely to reflect lower diagnosis rates given high percentages of older women in some LGAs (Fig. 14).

Fig. 41: Hysterectomy – rate per 1,000 (females): Gippsland LGAs vs Victoria (2022)



Source: Victorian Women's Health Atlas, Victoria. Department of Health, Victorian Admitted Episodes Dataset

Fig. 42: Adolescent Birth – 2-year rate per 1,000 people: Gippsland LGAs vs Victoria (2012 – 2020)

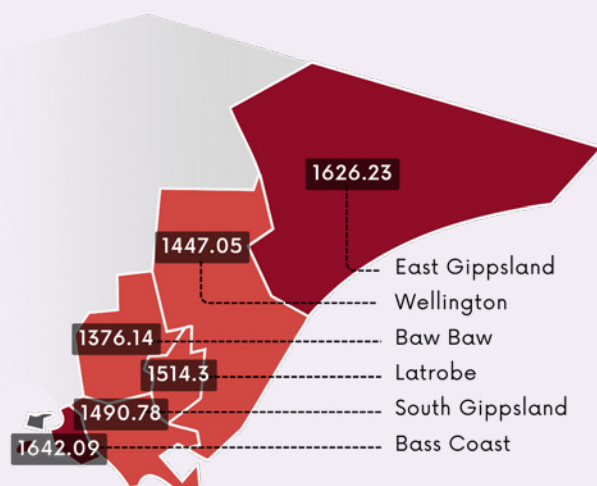


Source: Victorian Women's Health Atlas / Victorian Department of Health. Consultative Council on Obstetric & Paediatric Mortality & Morbidity (CCOPMM)

Fig. 43: Map showing arthritis – rate per 10,000 (females and males): Gippsland LGAs (2021)

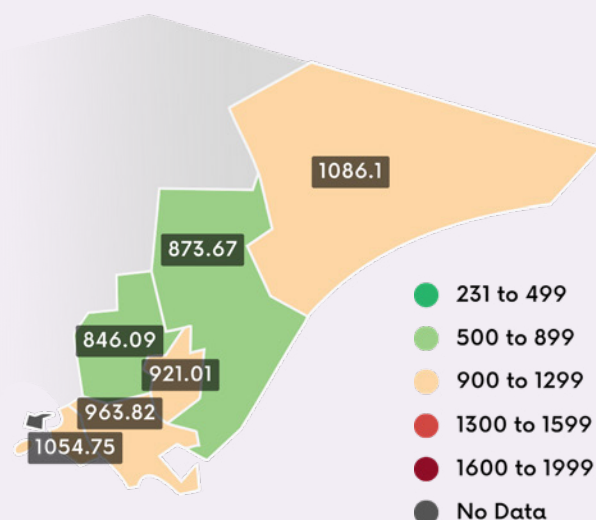
Rate per 10,000 Female

Victoria Statewide F 1240.4



Rate per 10,000 Male

Victoria Statewide M 764.3

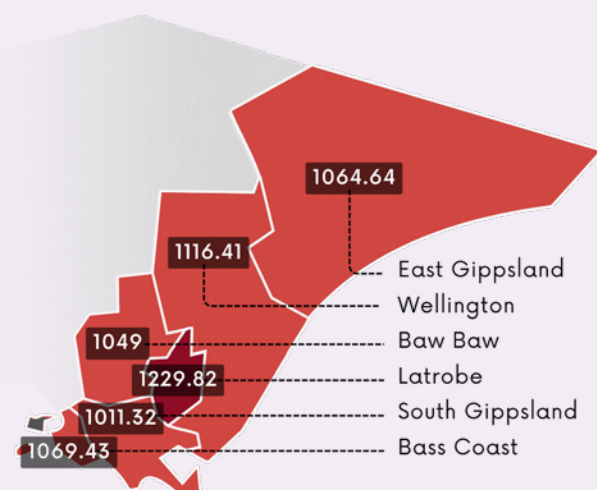


Source: Victorian Women's Health Atlas / Victorian Agency for Health Information

Fig. 44: Map showing asthma – rate per 10,000 (females and males): Gippsland LGAs (2021)

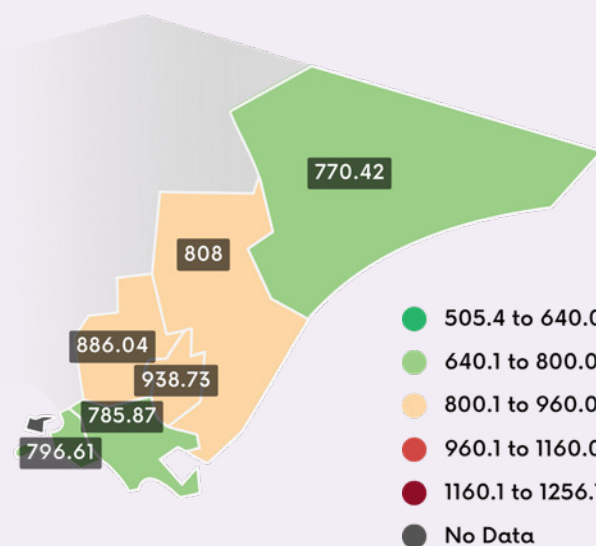
Rate per 10,000 Female

Victoria Statewide F 987.9



Rate per 10,000 Male

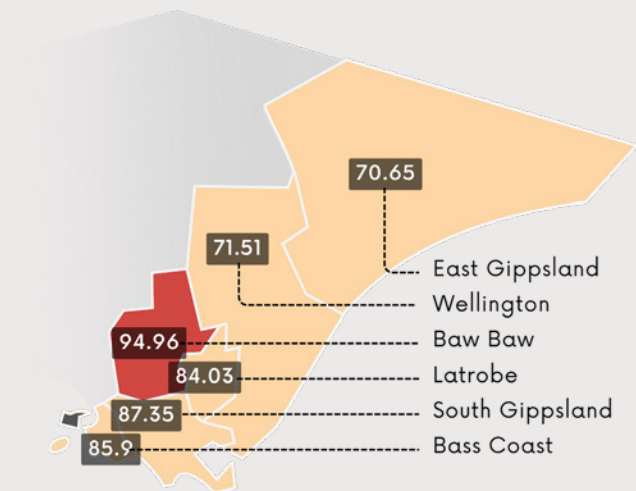
Victoria Statewide M 805.1



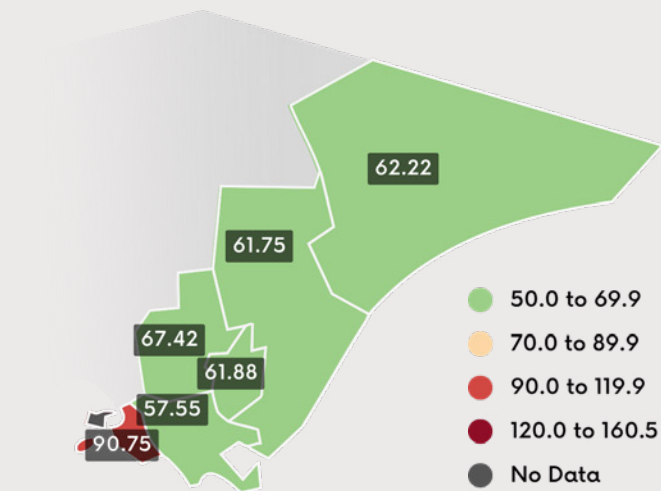
Source: Victorian Women's Health Atlas / Victorian Agency for Health Information

Fig. 45: Map showing dementia – rate per 10,000 (females and males): Gippsland LGAs (2021)

Rate per 10,000 Female
Victoria Statewide F 88.6



Rate per 10,000 Male
Victoria Statewide M 62.5

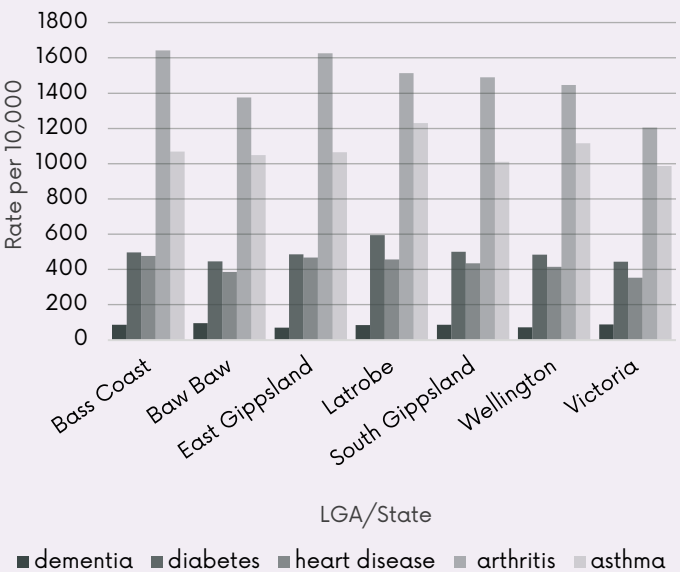


Source: Victorian Women's Health Atlas, ABS Census (2021)

Fig. 46, which shows rates of arthritis, asthma and dementia as well as diabetes and heart disease among Gippsland women compared with Victorian women, highlights that:

- rates of arthritis and asthma are significantly higher than for other chronic diseases, while dementia rates are the lowest,
- rates of arthritis, asthma, diabetes and heart disease among Gippsland women are higher than for Victorian women as a whole, and
- rates of dementia among Gippsland women are lower than for Victorian women as a whole.

Fig. 46: Arthritis, asthma, dementia, diabetes and heart disease rate per 10,000 (female): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas, ABS Census (2021)

Cancer

Although cancer survival rates have significantly improved over the last 30 years, cancer remains a serious and life-limiting condition for many people. According to the Victorian Cancer Registry, in 2023 an average of 49 women per day were diagnosed with cancer, with the most common cancers for Victorian women being:

1. Breast (28.7%)
2. Bowel (9.7%)
3. Lung (9.2%)
4. Melanoma (7.4%)
5. Uterine (5.2%)

Cancer Council Victoria data sheds light on trends in cancer incidence rates (age-standardised per 100,000) among Victorian women since 1982.

Cancer incidence rates have declined for:

- bowel cancer (from 55.9 in 1982 to 40.2 in 2023)
- cervical cancer (from 12.3 to 6.4,
- ovarian cancer (from 13.6 to 7.2,

In contrast, incidence rates have increased for:

- breast cancer (from 86.6 to 128.5)
- uterine cancer (from 14.0 to 22.3)
- lung cancer (from 19.0 to 36.5)
- melanoma (from 19.8 to 31.7)

Source: Victorian Women's Health Atlas, Victorian Cancer Registry (2023)

Gippsland compared with Victoria

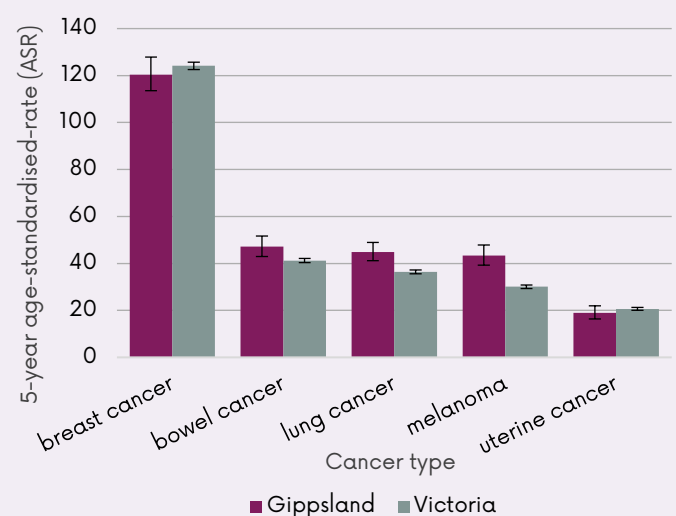


Fig. 47 shows the estimated 5-year age standardised rates (ASR) per 100,000 for 2023 for breast, bowel, lung, melanoma and uterine cancer incidence for Gippsland and Victoria, highlighting the much higher rates of breast cancer compared with the other four cancers.

Also evident from Fig. 47 is that **bowel cancer, lung cancer and melanoma rates among women were higher in Gippsland than Victoria in 2023, while breast and uterine cancer rates were slightly lower.** Overall, Gippslanders of all genders are 7 times more likely to be diagnosed with cancer and 19% more likely to die of cancer overall than those living in metropolitan cities (GRICS 2024).

More detail on these regional / metropolitan disparities is provided in Table 3 on the following page, which summarises the likelihood over the period 2001 – 2023 of Gippsland women compared with Victorian women being diagnosed with or dying from the most common cancers affecting women. While Gippsland women are no more likely than Victorian women to be diagnosed with or die from breast or uterine cancers, they are more likely to be diagnosed with or die from bowel cancer, lung cancer and melanoma, and far more likely to die from ovarian cancer.

Fig. 47: Estimated 5-year ASR rate of breast, bowel, lung, melanoma and uterine cancers per 100,000 (females): Gippsland vs Victoria (2023)



Source: Victorian Women's Health Atlas

Table 3: Relative likelihood of being diagnosed with and dying from key cancers: Gippsland vs Victorian women (2001 – 2023)

Cancer type	Relative likelihood of Gippsland women being diagnosed with	Relative likelihood of Gippsland women dying from
Breast cancer	Similar likelihood	Similar likelihood
Uterine cancer	Similar likelihood	Similar likelihood
Bowel cancer	14% more likely	14% more likely
Lung cancer	20% more likely	31% more likely
Melanoma	47% more likely	60% more likely
Ovarian cancer	Similar likelihood	70% more likely

Source: Cancer Council Victoria (2025)





4. GENDERED AND FAMILY VIOLENCE IN GIPPSLAND

Survey and focus group respondents identified violence as a critical community safety issue for women and gender diverse people requiring urgent action along the spectrum of intervention from prevention through to response and recovery.

A number of participants shared their lived experience of family or sexual violence. Even though these experiences occurred in the past and were willingly shared, to protect participants' identities we have chosen either to exclude these accounts in this report or have provided extracts with no attribution and changed key details. We have also included selected accounts they provided of the experiences of others in their social networks.

Key Finding 7: Gendered violence is a critical and persistent issue for women in Gippsland, with rates among the highest in the state and at record levels in some parts of the region

As the 2015 Victorian Royal Commission into Family Violence found, rates of family violence are higher in regional and rural areas, attributed to geographic and social isolation, the position of the person using violence in the community, victim-survivors' economic dependence, conservative cultural norms, presence of firearms, and the impact of natural disasters (State Government of Victoria 2016).

What We Heard

Among survey and focus group participants, there was a relatively strong level of awareness that rates of family and sexual violence are high and rising in Gippsland, particularly in East Gippsland, Latrobe and Wellington. In Figs. 48 – 57 on the following pages we report data by calendar year, but the most recent Crime Statistics Agency data for financial year **2024-25 reveals a record 9,845 family violence incidents and 2,086 sexual violence incidents across the region** (GFVA 2025) – profoundly concerning numbers.

"It is an epidemic; I am disturbed by the rates of sexual violence and domestic violence in East Gippsland. It is an embarrassment and a critical health emergency."

Woman, 36 - 50 years, East Gippsland (Survey)

"East Gippsland has a poor record re: domestic violence and youth suicide. Community is adverse to change and vast majority are very conservative. High levels of anxiety. Low socioeconomic status."

Woman, 66 - 80 years, East Gippsland (Survey)

"It's a huge issue. I've experienced it myself. I don't know any woman that in one way or another has not been a victim of some kind. It's just so prolific. I think that people probably don't understand how far-reaching it is, I mean we know the stats show that, but I think they don't even show the whole picture really. And I think that there's never enough services that can support the amount of women that experience violence in some way."

Woman, 44, Baw Baw (Focus Group 1)

Other reflections participants shared about the prevalence of family and sexual violence in Gippsland included the **greater risk faced by women and gender diverse people living in isolated locations** (due to lack of supports and access to services), and the **intergenerational nature of violence** and its flow-on effects on other family members.

"FV services are extremely important in rural and remote towns such as Orbost and Mallacoota as there is a limited police presence. Women are at higher risk in rural and remote locations."

Woman, 51 - 65 years, East Gippsland (Survey)

"It is apparent that during COVID the violence went up. I notice that it is easier for men to get away with this on larger country properties."

Non-binary / genderqueer person, 51 - 65 years, Baw Baw (Survey)

"Well, when it happens it doesn't just affect the parents and the children, it affects the whole family – the grandparents, aunts and uncles. We need to treat it as a holistic approach. Because it's not just the parents and the children. And as for the violence, it's the drugs and the alcohol, and mental health and the issues all stem from – it's generational. Culturally, ancestors, their parents, if they had issues, it becomes a vicious cycle. Or, it may have stopped, the wheel didn't keep turning. And it makes them like, 'Nah, I've seen my parents do that. No way am I gonna put my kids through it.'"

Woman, 61, East Gippsland (First Nations Women Focus Group)

Kim Adams, Principal Strategic Advisor, Gippsland Family Violence Alliance (GFVA), reiterated the observation that family violence was 'an intergenerational problem' and agreed that geographic isolation was a key risk factor.

"Family violence has been so prevalent in Gippsland for so many generations... [In remote communities] you have that element of 'nobody sees what happens in the bush' and some people actually move there as a tactic of isolation."

Kim Adams, Principal Strategic Advisor, GFVA

Aggression in public spaces was also noted as a concern for some women and gender diverse people, depending on where they lived. They described feeling unsafe walking alone, particularly at night, and experiencing harassment, cat-calling and unwanted contact that made some fearful of participating in their communities.

"I don't feel safe walking alone or with just one other female at night, even at dusk."

Woman, 36 - 50 years, Baw Baw (Survey)

"Health and safety isn't just access to support services. It's the ability to walk safely down the street. The mental load of bracing myself each time is exhausting -- being cat-called, followed, brushed up against or being forced into polite conversation with creepy people, makes me not want to leave my house, for work, study, survival or support services. I'd rather put up with feeling unwell than having to dodge the many obstacles to recovery."

Woman, 36 - 50 years, Latrobe (Survey)

"I know Gippsland Pride does things in Gippsland on occasion, but when they do, they essentially have to hire out the entire venue, have it ticketed and security at the door kind of deal. Because of the redneck mentality around those areas."

Non-binary / genderqueer person, 26 - 35 years, East Gippsland (Focus Group 7)

In contrast, others reported that they did feel safe, some drawing comparisons to Melbourne or, in the case of some refugee women, their countries of origin.

"In Iraq, I can't go out walking, but here, I can go anywhere I want."

Woman, 44, Bass Coast (Migrant and Refugee Women Focus Group)

"The difference between living in Melbourne and living in the country - obviously, smaller communities, a lot of people know people. And so if I walk around my block, I pass someone, they'll acknowledge you. If you're doing the same thing in Melbourne, they won't even look at you or acknowledge you. So that in itself is awareness of others."

Woman, 56, Baw Baw (Focus Group 1)

What the quantitative data shows

Rates of family violence and sexual violence against women in some Gippsland LGAs are among the highest in Victoria and have been for much of the past decade, as shown in Figs. 48 -57. While family and sexual violence is particularly acute in East Gippsland, Latrobe and Wellington, it is important to note that rates are considerably higher than the Victorian average in most Gippsland LGAs

Ranking of Gippsland LGAs among Victorian LGAs

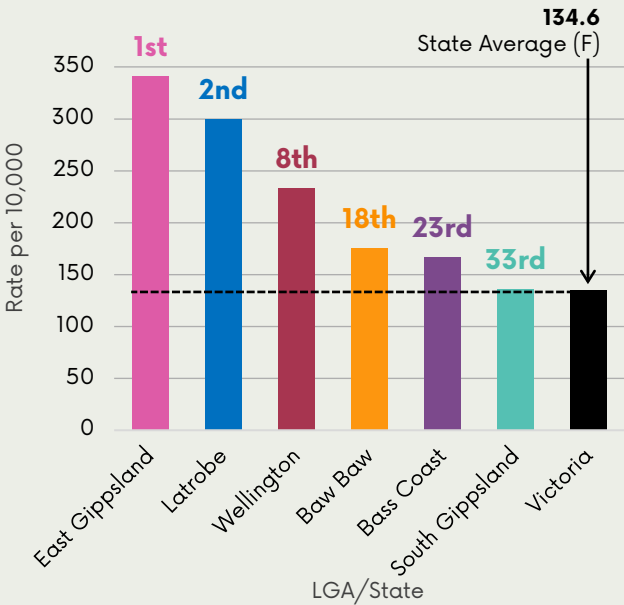
Figures 48 to 50 show where Gippsland LGAs ranked as compared with the Victorian average in 2024 for three measures of family violence per 10,000 population:

- family violence (female Affected Family Member or AFM)
- family violence (female, First Nations AFM)
- family violence (female AFM, child present)

East Gippsland and Latrobe are ranked 1st, 2nd or 3rd, and Wellington 7th or 8th (of 79 LGAs) for all three measures.

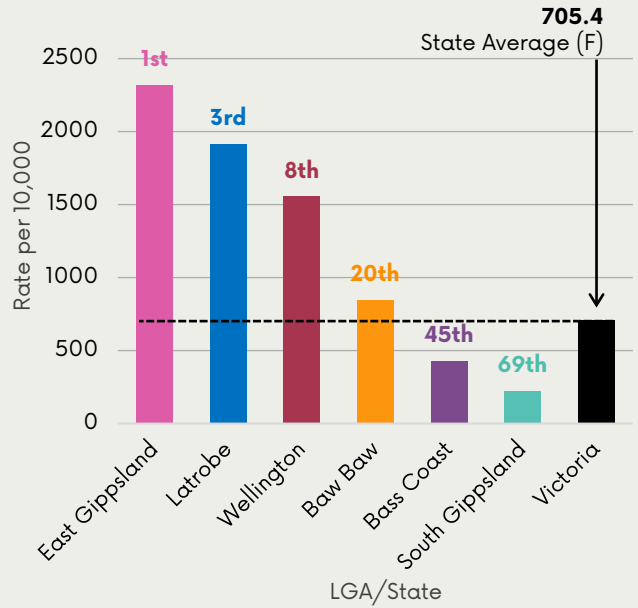
Finally, comparing all three indicators (Fig. 51) shows the magnitude of rates of family violence against First Nations women as compared with rates for all women both in Victoria and by Gippsland LGA. As outlined in the Victorian Women's Health Atlas (2025), it is important to interpret this chart in the context of colonisation, systemic racism and their combined impacts, and to understand that family violence against First Nations women is perpetrated by non-First Nations and First Nations people and has never been part of First Nations cultures. Dispossession, child removal, intergenerational trauma, and structural disadvantage 'intersect with the gendered drivers of violence, increasing the severity and disproportionate impact of family violence on First Nations peoples' (Respect Victoria, 2023).

Fig. 48: Rate per 10,000 of family violence incidents (female AFM): Gippsland LGAs vs Victoria (2024)



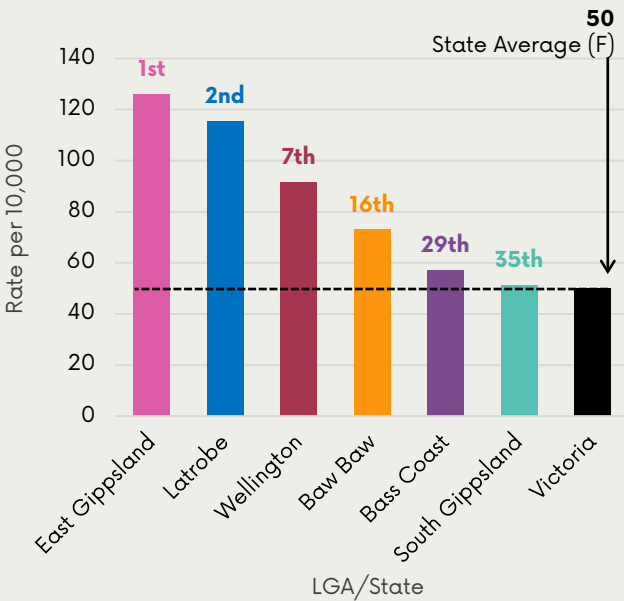
Source: Victorian Women's Health Atlas / Crime Statistics Agency

Fig. 49: Rate per 10,000 of family violence incidents (female, First Nations AFM): Gippsland LGAs vs Victoria (2024)



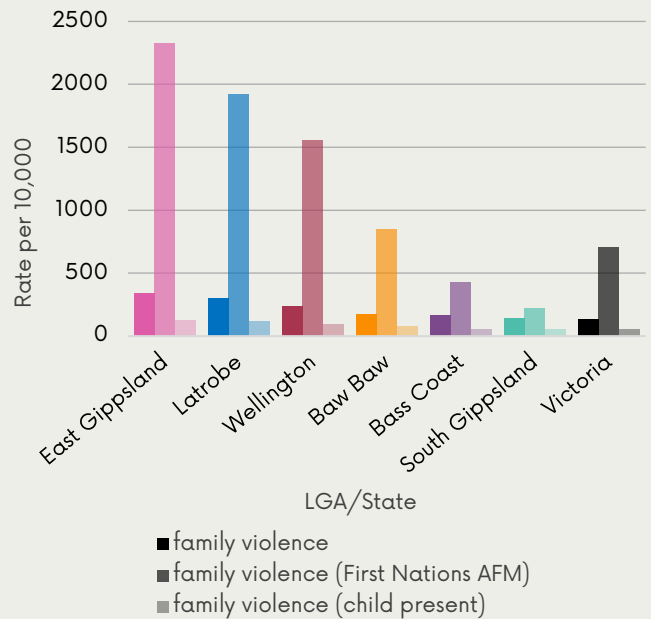
Source: Victorian Women's Health Atlas / Crime Statistics Agency

Fig. 50: Rate per 10,000 of family violence incidents (female AFM, child present): Gippsland LGAs vs Victoria (2024)



Source: Victorian Women's Health Atlas / Crime Statistics Agency

Fig. 51: Rate per 10,000 of family violence incidents (female AFM): Gippsland LGAs vs Victoria (2024) - Selected indicators



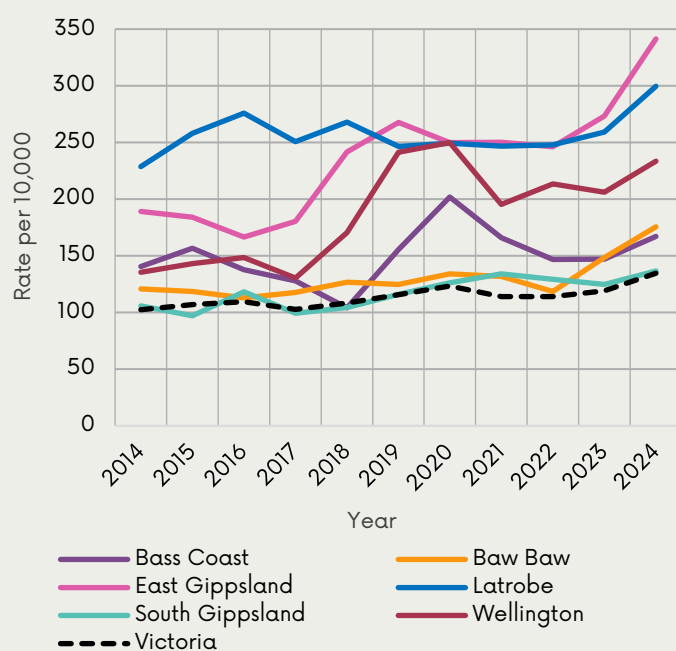
Source: Victorian Women's Health Atlas / Crime Statistics Agency

Trends over time

As Figs. 52 – 54 show, rates of family violence against women in Gippsland have been variable over the last decade, increasing in several LGAs in the lead up to the COVID-19 pandemic, then dropping slightly before continuing to rise again, reaching new records in 2024 in East Gippsland and Latrobe. All 6 LGAs and Victoria have seen an increase from 2023 to 2024 and into 2025.

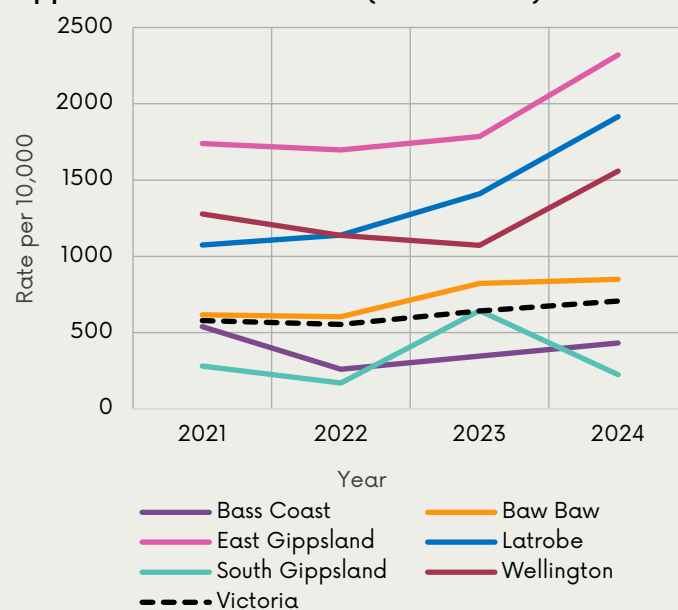
Rates of family violence against First Nations women are only available from 2021 but show a broadly similar pattern though at a far higher rate (Fig. 53), except for South Gippsland.

Fig. 52: Rate per 10,000 of family violence incidents (female AFM): Gippsland LGAs vs Victoria (2014 - 2024)



Source: Victorian Women's Health Atlas
/ Crime Statistics Agency

Fig. 53: Rate per 10,000 of family violence incidents (female, First Nations AFM): Gippsland LGAs vs Victoria (2021 - 2024)



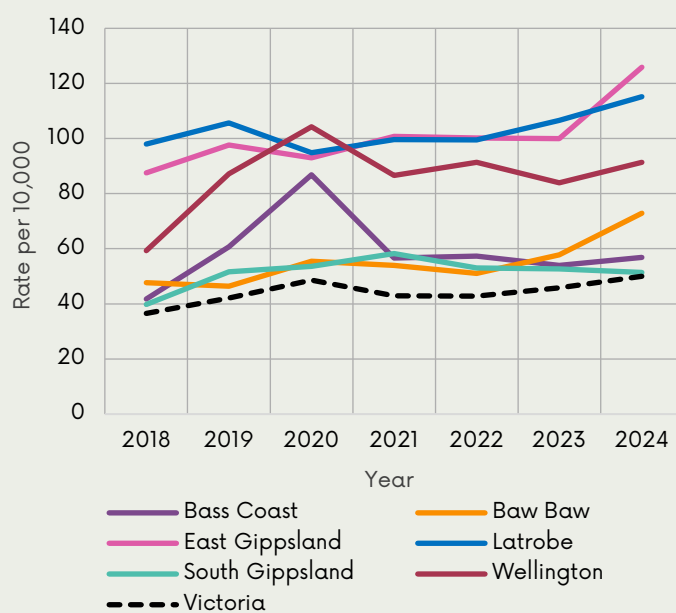
Source: Victorian Women's Health Atlas
/ Crime Statistics Agency

Having a child present during an episode of family violence is significant given how prevalent intergenerational family violence is in Gippsland. Fig. 54 illustrates a similar pattern to other family violence measures over the period 2018 – 2024 – higher rates than Victoria overall, and an upward trend in several LGAs.

A 2021 study by the Centre of Research Excellence in Child and Family Welfare found that an average of 3 in 4 children aged 0-17 who witnessed family violence had future contact with the justice system as either victims or offenders. Seventy-seven per cent of children who witnessed a police-reported family violence incident had a future interaction with the justice system within five years of witnessing an incident.

The report highlighted how experiences of family violence in childhood can lead to negative short-term and long-term outcomes in a child's health and wellbeing. Impacts may include impaired cognitive functioning, mental illness, behavioural issues, learning difficulties, and low self-esteem.

Fig. 54: Rate of family violence incidents (female AFM, child present) per 10,000: Gippsland LGAs vs Victoria (2018 - 2024)



Source: Victorian Women's Health Atlas / Crime Statistics Agency



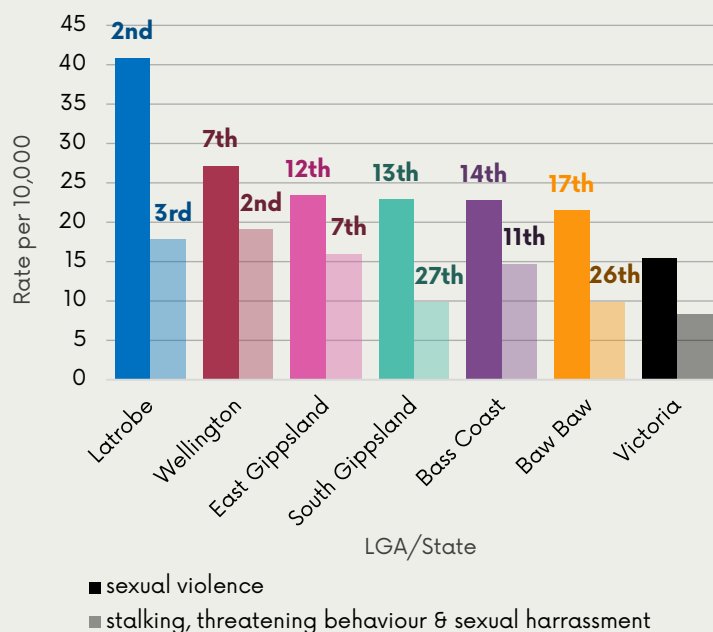
Sexual violence, stalking, harassment and threatening behaviour

Ranking of Gippsland LGAs among Victorian LGAs

Rates of sexual violence and stalking, harassment and threatening behaviours (female victims) are significantly lower across all parts of Gippsland as compared with rates of family violence (Figs. 48 vs 55). However, these crimes are also notoriously under-reported so actual rates are likely to be significantly higher than shown.

Even so, as Fig. 55 illustrates, 2024 rates of sexual violence were higher than the Victorian average in all 6 LGAs, and rates of stalking, harassment and threatening behaviours were considerably higher in 4 LGAs. Reflecting patterns of family violence rates, Latrobe, Wellington and East Gippsland ranked between 2nd and 12th for sexual violence rates and between 2nd and 7th for stalking, harassment and threatening behaviour rates.

Fig. 55: Rates of sexual violence and stalking, harassment and threatening behaviours (female victim) per 10,000: Gippsland LGAs vs Victoria (2024)



Source: Victorian Women's Health Atlas
/ Crime Statistics Agency

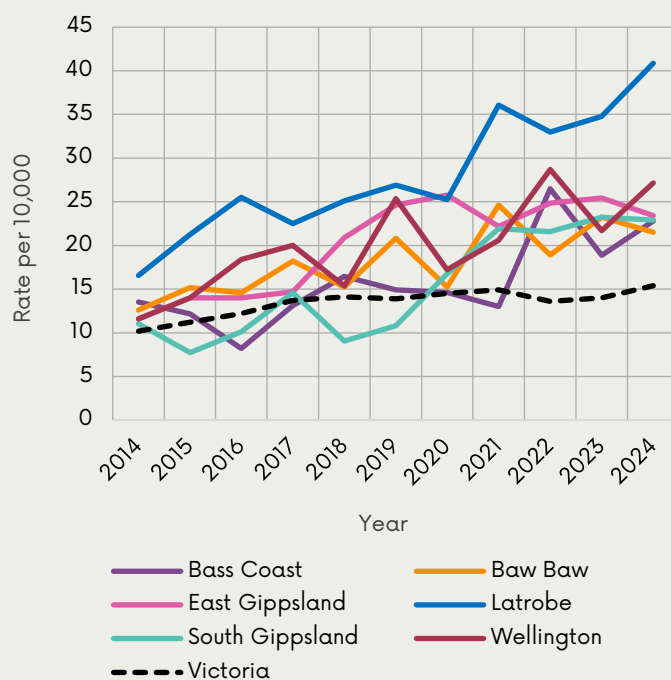


Trends over time

When we look at Gippsland sexual violence data over the period 2014 – 2024 (Fig. 56), we also see a similar pattern as for family violence, just on a smaller scale, with a new record set in Latrobe in 2024.

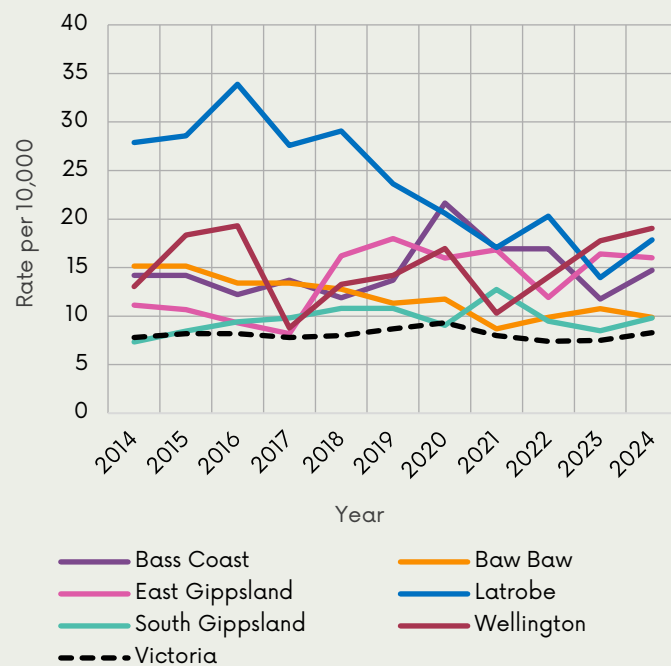
There is a less clear trend in rates of stalking, harassment and threatening behaviours apart from a notable decline in Latrobe. Nonetheless, rates increased among 4 LGAs last year (Fig. 57).

Fig. 56: Rate of sexual violence incidents (female victim) per 10,000 - Gippsland LGAs vs Victoria (2014 - 2024)



Source: Victorian Women's Health Atlas
/ Crime Statistics Agency

Fig. 57: Rates of stalking, harassment and threatening behaviours (female victim): Gippsland LGAs vs Victoria (2014 - 2024)



Source: Victorian Women's Health Atlas
/ Crime Statistics Agency

Key Finding 8: Women and gender diverse people have variable experiences with the quality and availability of family and sexual violence support services

What We Heard

Participants who had accessed or were familiar with family and sexual violence support services reported that service quality and availability vary widely across the region. Several shared positive experiences with family violence support services, while others were more critical.

"I accessed some counselling through Orange Door, which was specific for domestic violence and for women, that was really good. I did some counselling sessions and then I did a program through Orange Door again and it was basically like a support group for women to go and discuss strategies for or what's the best way to keep living when you've been in situations where you feel threatened and unsafe."

Woman, 56, Baw Baw (Focus Group 1)

"...one thing that we're starting to get better at is actually designing services and putting services in place that are designed with their lived experience in mind around what works and what doesn't work and how important that actually is. We need to listen to victim-survivor advocates on what works and what doesn't and what's helpful and what's not."

Woman, 41, Bass Coast (Focus Group 2)

"I have been supporting a friend to seek support about family violence, and they have gone to all the 'right channels' but essentially been told that there isn't anything that can be done until he does something. This scares me to think that women and gender diverse people have to wait in fear until a physical act happens before being taken seriously / action can be taken to prevent further harm."

Woman, 18 – 25 years, Wellington (Survey)

"I used Orange Door and was made to feel like it was my fault. Never again. It affected my mental health a lot."

Woman, 36 – 50 years, South Gippsland (Survey)

More broadly, participants' comments indicate that geography, funding constraints, coordination challenges and lack of privacy in small communities

limit access to services. Although we understand the Victorian Government's formula for funding family and sexual violence services considers factors such as rates of violence, population density, rurality and remoteness and priority populations, most participants perceived that services were inadequate to need.

Services were seen as concentrated in certain population centres, and as under-resourced. Participants perceived that services were managing their limited capacity in the face of enormous need by setting time limits on how long clients could access a service for, thresholds for access, waitlists, and closing their books. Other evidence of under-resourcing mentioned included under-staffing and a lack of timely referrals from The Orange Door.

"Really limited supports in Baw Baw, most services seem to base themselves out of Latrobe"

Woman, 26-35 years, Baw Baw (Survey)

"I don't think there are services, honestly. Maybe there is in Bairnsdale, but I don't think there are. I know there is some in Bega (NSW). The Bega hospital does have a pretty on-the-ball group at the hospital for like the more emergency end of things. But I don't know about here. I mean, I know like the Gippsland Centre Against Sexual Assault (GCASA) exists, but again – do they do things online? I know they do trauma-informed yoga and all that kind of stuff, but it's usually during working hours and also 5-6 hours away. It's definitely a very real issue up here, out here. There doesn't really seem to be any kind of consequences or support. Not really."

Non-binary / genderqueer person, 26 – 35 years, East Gippsland (Focus Group 7)

"Ongoing recovery support services are missing. Continuity of care is particularly important for young children. The programs that have greatly supported me and the kids have stopped, and this impacts the kids. They are impossible to replace, and the kids are impacted by people coming into and out of their lives. It makes it difficult for them to form close connections with the next therapist, because they are going to stop after a while..."

Woman, 36 – 50 years, Baw Baw (Survey)

"People who work [at the service I accessed] are clearly overworked and have too many clients."

Woman, 26 – 35 years, South Gippsland (Survey)

"And that's one of the other big problems too – what happens if your partner sees you going into [ACCHO name] - 'What are you doing there? What are you telling them?' Like, why isn't there a place [you can go to for help] that no-one knows about?"

Woman, 38, East Gippsland (First Nations Women Focus Group)

When asked about service gaps, participants named:

- programs for people who use violence,
- therapeutic or recovery services including counselling,
- transport assistance and emergency financial support,
- better coordination with child protection services,
- support for tech-based abuse, and
- ongoing or longer-term support.

Programs for people who use violence such as Men's Behaviour Change Programs or case management do exist but fall far short of need – in 2020-21 it was estimated that across Victoria, perpetrator interventions were available for just 10 per cent of the total number of perpetrators (Family Violence Reform Implementation Monitor 2023). Investment has increased since, but lengthy waiting lists persist, particularly in regional areas.

Gippsland has several recovery and therapeutic programs including TRAK Forward, victim-survivor support groups, the Shark Cage program and the Supporting Recovery Program (funded via the Gippsland PHN for Latrobe and Bass Coast residents) as well as family violence and sexual assault counselling services. However, these are limited in their reach or duration, or people simply aren't aware of them. As one participant noted, 'there's a lot of groups and supports in the local area that can help but I don't think they're widely talked about so not everyone knows.'

The overall feeling was that more was needed given the levels of family and sexual violence in Gippsland. A barrier associated with small communities that First Nations women mentioned was 'conflict', or the inability to access a violence support service because another family member was accessing it.

"... [community health service] was good for referrals but it felt like a checklist so once you had a few things in place you were dropped. There seems to be no ongoing support network, only the immediate crisis management."

Woman, 36 – 50 years, East Gippsland (Survey)

"Lack of men's behaviour change programs or workers that work with men using violence."

Woman, 26 – 35 years, Wellington (Survey)

"The government needs to give remote and rural services access to more funding for brokerage and crisis support. We have two family violence workers in Orbost but limited brokerage to assist with emergency accommodation, food, bedding and other crisis support options."

Woman, 51 – 65 years, East Gippsland (Survey)

"DFFH Child Protection are too quick to take children away when families should be provided with opportunities to support the family unit to help make the changes needed to keep families together – if the survivor chooses to do so – with support to engage in programs and help with security and safety options instead of placing children with other family members or foster parents. Child Protection should be looking at these options of holistic family support to keep families together. And if the survivor is taking steps to leave, they should be keeping the kids with the non-violent parent rather than take them away and causing more childhood trauma."

Woman, 51 – 65 years, Wellington (Survey)

When asked about the gaps across the region, Kim Adams, Principal Strategic Advisor, GFVA named case management (including for people who use violence) and family violence counselling as areas of particular need.

"We need greater case management and we have almost no family violence counselling. Family violence counselling has not had any increase to funding since 2004 when it was created. So we have woeful FTE for that. Even in East Gippsland where we have highest rates in the state."

Kim Adams, Principal Strategic Advisor, GFVA

Key Finding 9: Women in Gippsland need more effective housing and criminal justice system responses to family violence in their community

What We Heard

Housing

Around half of Victorian women who seek support from specialist homelessness services do so because of family violence (CHP 2022). While LGA-level, sex-disaggregated data on the causes of homelessness was not available at the time of publication, given the high rates of both female homelessness and family violence (female affected family member) in East Gippsland, Latrobe and Wellington (Figs. 6, 48) it would be surprising if these were not linked.

Many of the women and gender diverse people we spoke to raised the shortage of emergency and affordable housing in Gippsland as a critical roadblock to better support for victim-survivors of family violence, confronting them with the impossible choice between staying in a dangerous relationship or risking homelessness.

"Having worked in the family violence response space there isn't enough housing support options to support women to leave or who have left, and then 'after' services e.g. counselling, are often dependent on people having stable housing. Targets and funding limit the time people can work with women, pressure to close."

Woman, 26-35 years, Baw Baw (Survey)

"Emergency housing for 6 days, what a joke. If I didn't have my mother to support me through my [experience with] family violence I don't know what I would have done."

Woman, 51 – 65 years, Wellington (Survey)

GFVA's Kim Adams highlighted the longer-term impacts of lack of affordable or emergency housing for people experiencing family violence, using young members of the LGBTQIA+ community as an example.

"... We've got a massive shortage of affordable, safe and secure housing. Particularly for women, but in terms of gender diverse people, we've got an ever-increasing amount of young people between say the age of 15 and 25 who are part of the LGBTQIA+ community who are self-placing themselves out of home because the home is unsafe due to violence – it's usually classed as family breakdown. There's no housing for them, not even a share house that Youth Allowance will cover. So that is a massive, massive issue and without that start to life, you're continuing that intergenerational cycle because they're often unable to finish school, or to get qualifications."

Kim Adams, Principal Strategic Advisor, GFVA

Participants also commented on who should be required to move out of the shared residence, with most expressing the view that victim-survivors (usually women) were the ones to lose out, even if this decision was made for safety reasons.

"I've known someone whose family member was in a domestic violence situation to the point that she had to sell her home and move interstate and pretty much go into witness protection, totally off the grid so he couldn't find her 'cause he had threatened to kill her in front of her daughter. I don't understand how is it that he can be arrested and charged and go to jail but she had to sell her home and relocate interstate away from all of her family and friends, and she was the victim."

Woman, 51, Latrobe (Focus Group 3)

Role of the Criminal Justice System

The criminal justice system – primarily the police and legal system – is another key part of the family and sexual violence service system and was mentioned numerous times by survey respondents and focus group participants.

Some people had positive feedback, notably some of the First Nations women we heard from (acknowledging that they also shared negative experiences). One First Nations family violence worker mentioned looking forward to seeing the impact of new protocols for police dealing with family violence involving Aboriginal community members and reported witnessing some police who had *'shown they care and genuinely want to see a positive outcome'*. Others suggested that higher reporting rates reflected women *'feeling stronger'* to report violence, and several praised a law firm based in the Latrobe Valley with an excellent reputation for representing Aboriginal and Torres Strait Islander clients.

"We're really big on, 'if you hear something, say something', 'say no to gendered violence, violence against women.' We have more people calling up."

Co-facilitator, First Nations Women Focus Group (East Gippsland)

From a sector perspective, Kim Adams, Principal Strategic Advisor, GFVA reflected on positive signs she'd observed in relation to policing of family violence.

"I think how Victoria Police have implemented the changes due to the [family violence] reforms has been really positive. They have a local family violence training officer who also takes a lot of feedback from the agencies about what has worked, where things have gone wrong and addresses that directly where things have not gone well. Not saying it's a perfect system or that there isn't still work to do, but at least we have a local mechanism that is dedicated to addressing it, but also that those family violence units report to a statewide function, not to a local unit. ... And even just the way they are monitoring risk through their internal processes, that's been a positive change."

Kim Adams, Principal Strategic Advisor, GFVA



More broadly, most participants with experience or knowledge of the criminal justice system expressed critical views, sharing **negative experiences with frontline police, lawyers and magistrates** including not being believed, not being taken seriously, and being judged according to outdated, sexist ideas.

The view that **the justice system favours people who use violence over victim-survivors** was commonly held, as illustrated by one participant's experience of trying to report a former housemate's friend covertly filming her in the bathroom. She reported that initially she was incorrectly advised this was not illegal, and when she tried a second time, she was told, *'Oh no. Another woman went down this track last year and got nowhere with it. Just drop it.'* Nonetheless she pursued charges, only for the accused to receive a non-recorded conviction, which she said was justified by the court on the basis that *'he'd been 'good' otherwise. He worked at [organisation name] and it would affect his employment prospects, and his mother lived overseas and he might not be able to travel. So – very naughty boy, and no doubt he did it and was found guilty, but we'll just move on with that.'*

"All major police stations need dedicated staff. [Town 1] police were great. [Town 2] was absolutely horrible to deal with, a very pro-male experience."

Woman, 36 – 50 years, Latrobe (Survey)

Another participant who worked in family violence described witnessing a woman *'who looked like she'd had a tough life'* being physically assaulted by two men and kicked to the ground in public in her local town. After the police arrived, the men who assaulted her went into a nearby pub while the police began questioning the woman *'like she was the problem.'*

Because of her professional experience, the participant intervened to suggest the officers speak to the men witnessed assaulting the woman instead of treating her *'like a criminal'*. She went on to express how frustrating these situations were after years working in the sector and said *'police need to stop thinking about [...] what a victim 'should' look like. We know that women who are homeless, who are sex working, who are using substances are more likely to experience really, really bad outcomes from family violence perpetrated against them.'*

A number of participants also raised **concerns about Family Violence Intervention Orders (FVIOs)**, including difficulties applying for them, respondents (recipients) who breached orders, or police orders being issued too readily.

FVIO breaches made up the largest share of family violence offences across Gippsland in 2024 by a considerable margin (Crime Statistics Agency 2025), and in the decade from 2011 to 2020, Gippsland accounted for 9.1% of final FVIOs in Victoria despite comprising only 4.3% of its population – the largest such disparity in any region of Victoria (Sentencing Advisory Council 2022).

One participant shared how her efforts to apply for a FVIO to protect herself and her children from her ex-partner ultimately came to naught: *'It got dragged out and dragged out and dragged out. Originally, he didn't turn up to court. The police kept making excuses for him. They had no evidence that they delivered any paperwork to him. It was just an absolute mess. The final hearing in court for the intervention order was dismissed because they said that I was – the policewoman's words were something like I was "too emotional". And in the end, he was put on a good behaviour for six months.'*

"I think [police] need to get more serious. Especially repeat offenders, breaches of intervention orders and things like that. The numbers are extremely high for breaches. So if they keep breaching, put them away like or provide them with the programs that are going to maybe help support them, the user of violence to change their ways. Let them know that it's a serious offence... 'cause the numbers are from those reoffenders. I can tell you that now. It's not like the one-offs or whatever. It's the repeat ones that are breaching and hurting people."

Woman, 51, Wellington (Focus Group 3)





Key Finding 10: Women and gender diverse people in Gippsland continue to experience harmful community attitudes and norms and want continued and expanded efforts to prevent gendered violence

Prevention of gendered and family violence

Primary prevention is a long-term agenda that aims to prevent violence from ever happening in the first place. Primary prevention works by identifying the deep underlying causes of violence – the social norms, structures and practices that influence individual attitudes and behaviours – and acting across the whole population to change these, not just the behaviour of perpetrators.

Family Violence Reform Rolling Action Plan 2020 – 2023 (Victorian Government)

Primary prevention, or preventing violence before it occurs, has been a key focus in Victoria following the 2015 Royal Commission which found that family violence funding had historically focused on response, with only short-term and limited funding of prevention activities (State Government of Victoria 2022).

Important and increased investments have since been made, including the Free From Violence Strategy, the establishment of Respect Victoria, and funding for the specialist primary prevention sector (of which women's health services such as GWH are part) at a statewide, regional and local government level. Respectful Relationships education is a key program, along with initiatives in workplaces, sporting clubs, online, and in the general community.

Although a more strategic approach has been applied to prevention since the Royal Commission reforms and resourcing has increased, **funding remains on short-term cycles and is low compared to the disproportionately high levels of family and gendered violence in Gippsland.** These constraints make future planning and building a specialist prevention workforce difficult, particularly when the purpose of primary prevention is to drive population-level, generational change.

Many *Healthy Women, Healthy Gippsland 2025* participants linked gendered and family violence to community attitudes and gender inequity,

and expressed support for primary prevention initiatives, particularly in relation to education. They also reflected on evidence of both a backlash against gender inequity and signs of hope.

What We Heard

Community Attitudes

Community attitudes towards gender equality and violence against women were frequently raised by survey respondents and focus group participants in relation to family or sexual violence.

Some felt that there had been a positive shift in attitudes in Gippsland over time, in line with the results of the National Community Attitudes Survey (NCAS) findings for Victoria between 2013 and 2021 (Coumarelos et al. 2023)⁹. Highlighting the link between culture and attitudes, Karen women from Myanmar in the multicultural women's focus group explained that family violence was 'not really a problem' within their community due to their patriarchal and matrilineal culture, whereby families were headed by women.

"... what's important is a general shift amongst people's attitudes in general. My daughter who is in primary school, last year she came home one day a bit upset and she said that one of the boys in her class was basically looking up her skirt and pulling it up and thinking it was a big joke. My husband and I spoke to the teacher who said, 'That is absolutely unacceptable. I will not tolerate it.' She didn't do anything publicly, but she arranged a meeting with the boy and the mother to discuss it and said that she will not tolerate this any further and did nip it in the bud and that was the end of it, and it didn't happen again.

And I think that was really good. And I do think that as a child myself, if I went home and said that, it might have been a bit more, 'Oh, he's probably just being a bit silly and having a laugh, just let it go. Don't worry about it.' But I feel that's the time to jump in, when they're little, to let them know. So once they get to adulthood, they know about respecting women and how to treat women and not just blowing things off as a joke and 'Don't worry about it' and 'Ignore it.'"

Woman, 37, Wellington (Focus Group 5)

Several participants perceived attitudes supportive of family and sexual violence as still prevalent, as highlighted by conservative attitudes being amplified online and in the broader political discourse.

"It has been fascinating to see how embedded sexism is within the community. The Baw Baw 'gender wars' is a good case study that shows the community dislikes women, particularly ones that are in leadership roles and which challenge the status quo. It makes it difficult to seek change. We have a real problem in our community when it comes to attitudes towards women, and we need to change this. ASAP."

Woman, 36 - 50 years, Baw Baw (Survey)

Other violence-supporting impacts of conservative community attitudes that participants mentioned included preventing people from recognising or reporting violence, and shaping attitudes towards accountability for perpetrators.

"I struggle to understand what support we provide as a community. Where do legislation or policies need to change to better protect victims? Because I just feel like it doesn't seem to be a lot of consequences. [In a case I am familiar with, after he served time in prison] the man re-offended and then injured a baby, so the system is letting us down. I just - I'm struggling to piece together how we as a community are okay with this?"

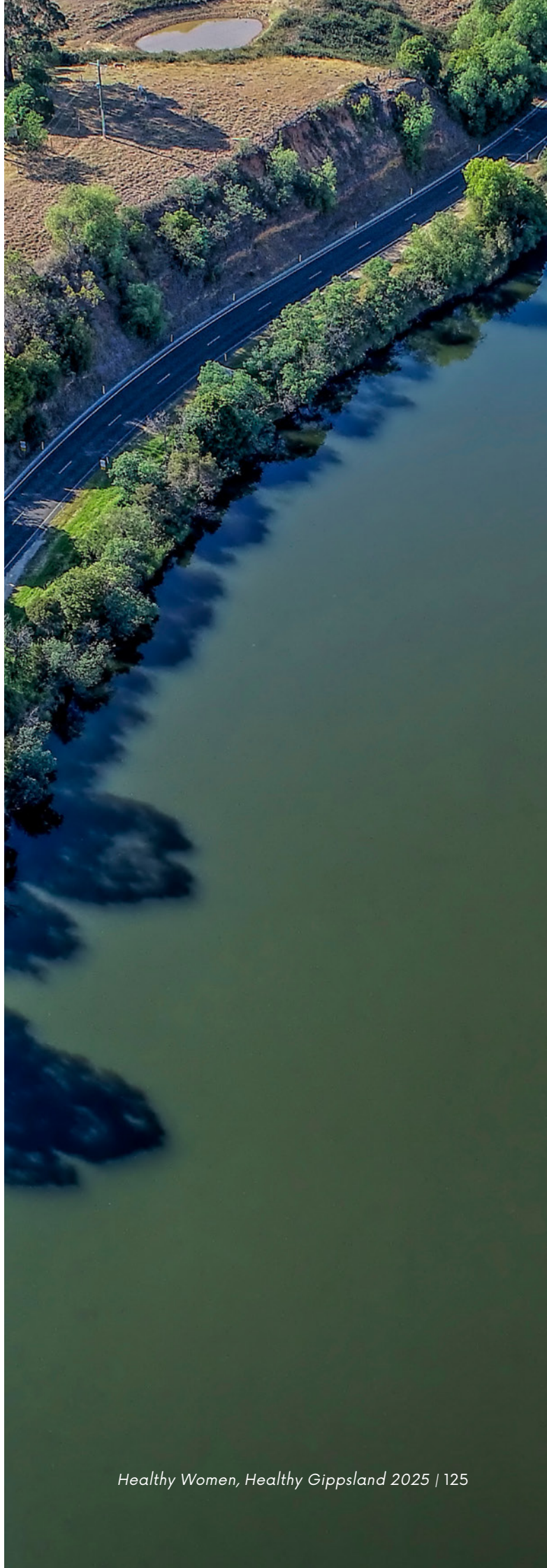
Woman, 50, Latrobe (Focus Group 3)

"Yeah, you get blamed [for sexual assault]. They're like, 'Oh what did you do to deserve that? How were you dressed? How were you acting? How drunk were you? Were you making yourself available?' No-one wants to be blamed for something happening to them, so they just shut up."

Woman, 38, East Gippsland (First Nations Women Focus Group)

"I think there's probably a lot of people who endure [family violence] and don't realise that they don't have to be living their life like that, but you know, that's something that is perhaps intergenerational. But I think it's normal [for them]."

Woman, 55, Baw Baw (Focus Group 7)



Importance of Primary Prevention

Strikingly, **almost all HWHG survey and focus group participants highlighted the importance of gendered and family violence prevention initiatives, often without being directly asked.** They also shared their reflections on existing initiatives and what they thought needed to change.

By prevention initiatives, participants meant community education about family violence, coercive control and tech-facilitated abuse, men's behaviour change programs, school-based initiatives and community safety improvements. They also called for better awareness of available violence support services.

"There are so few resources for positive, prevention activities to support wellbeing and tackle family violence."

Woman, 36-50 years, East Gippsland (Survey)

"...money does need to go to creating more [family violence response] services, but actually we still need to keep money in prevention. I think all the time to keep working at that to get people more aware. And earlier and have conversations earlier with younger people and so that we don't keep repeating because working in services like GCASA you see that it's intergenerational."

Woman, 44, Baw Baw (Focus Group 1)

"I would like to see much, much more done in primary, primary, primary prevention. So starting at school, I think that a lot of the work that we can do in ending gendered violence against women and queer people is massaging that attitudinal change. So Love Bytes, which is a program that is run in school, and the whole idea behind them is teaching [kids] about consent and rights. ... I think that planting the seeds with young children is a really effective way of creating that attitudinal change. Realistically do I think that that's going to happen in one generation? No, but I've worked in behavioural change programs with people who use violence, and I think that working with adults around attitudinal change and shifts in their behaviours is really, really hard. But I think that if you target a much younger generation of people, when their brains are open, they're like little sponges, they're thinking about things, they're navigating relationships for the first time. I think that that's really the key place to start."

Woman, 42, Bass Coast (Focus Group 2)

Some of the Gippsland prevention initiatives participants mentioned included:

- The Orange Round, a sporting round and collaboration between Gippsland Centre Against Sexual Assault, AFL Gippsland, Gippsport, GWH and Netball Victoria aimed at raising awareness of family violence and promote gender equality in sport
- initiatives connected to the annual 16 Days of Activism such as Let's Chat Gippsland, led by GWH (see Box 10), and the Walk Against Family Violence
- Baby Makes 3, a respectful relationships initiative for new parents
- Boorai bags, a resource for new Aboriginal babies (boorai) and their families
- Respectful Relationships education in schools and gender equality training in workplaces
- Candlelight Vigils, also held annually across Gippsland to raise awareness of family violence

Most respondents saw these activities as engaging and capable of reaching a wide spectrum of people in the community.

"We've been developing some boorai (baby) bags, so when you're in hospital ... we provide information and resources in a bag for Aboriginal families having new babies and welcoming them to country and giving them that great start in life... We've been doing a lot around the Baby Makes 3 education as well, having those conversations with your partners around who's going to do what jobs when baby comes and not being stereotypical either, you know - 'I can get out and mow lawns,' and just things like that. Just making sure those conversations are being had and we've implemented a couple of resources and you know to make sure that they're in the bag and that those conversations are being had and that people are being healthy and respectful of each other."

Woman, 51, Wellington (Focus Group 3)

The EmpowerED course [by GCASA] that the ladies did covered off on consent in all sorts of relationships – family, sexual, financial, peer relationships, all sorts. And making them aware that there's more than one way that somebody might be trying to take advantage of you.

*Co-facilitator, Women with Disabilities
Focus Group, East Gippsland*

However, others questioned if initiatives focused on awareness-raising were enough, particularly if men were not present or fully engaged.

"...the candlelight vigils in Sale are really great. We've been to the last two. The last one was one of the most powerful ones. And it did spark some conversations at my workplace. But there was the sentiment that the people that needed to hear it weren't there. So that's disheartening. There were lots of females in the crowd."

Woman, 24, Wellington (Focus Group 5)

"...as successful as some of the things are, like I remember my friend telling me recently they had had Orange Round at their sporting clubs, but the feeling was that men that had been part of this had gone through the motions, but then it didn't really change the jokes or didn't change the attitudes later on when they had a few beers. All that stuff still came out."

Woman, 44, Baw Baw (Focus Group 1)

Participants who worked in schools or primary prevention or who had school-aged children shared their views about Respectful Relationships education. Most had positive views, but expressed concerns about its implementation, including the need for teachers to receive training to deliver it effectively, and resistance among parents based on misinformation leading their children to disengage. Some participants felt that external, specialist providers were more effective. Underlining the sometimes slow pace of prevention work, one woman reported that Respectful Relationships education had only just commenced at her child's school this year.

"I think there is also a lot of stigma around what that program is and there's a lot of people going, 'Oh, it teaches about this,' and it's like, 'No, if you actually go and read the doc...' But I think that also that stigma doesn't help because then the kids also might say something and then all of a sudden, they've got that gang mentality of what it actually is. And then, 'I don't actually care about it, and I don't - '. It needs to be taught in a way that is helpful to them. They have designed the lesson plans for a teacher to walk in and teach it, but in this day and age, you cannot just walk into a classroom and teach it the way they've written it to be taught, like it is that bloody boring. I normally rewrite it myself, but I'm not paid to do that."

Woman, 28, Wellington (Focus Group 2)

Overall, responses indicated a desire and need for prevention approaches, particularly **locally adapted initiatives that improve community safety and respectful relationships**. Community-based approaches (e.g., camps, peer support, culturally safe spaces) were seen as effective ways to raise awareness and foster healing.

"Not enough positive support programs. Very little in way of men's behaviour change, women's and family programs in Sale. Often required to travel to Latrobe or East Gippsland shires for these supports and programs. Need more in Sale or have capacity to deliver online. Get creative and find out what might be working in other regions or successful programs and adapt to suit local needs. Allocate more transitional family violence housing options for both men, women and children to create and foster positive healthy relationships."

Woman, 36 – 50 years, Wellington (Survey)

"... having camps here where you can actually talk about it openly, without the partners being around [is a good way to raise awareness of family violence]. That's where need your partnership with the males and doing a men's group at the same time. ... So they'll go out to their men's camp and the women come to this one. And if the women have to bring the kids to this one, so they can come – do it. Because you have a lot of us that have our Working with Children's checks and all that sort of stuff that are safe to be around. And then when you put it out there to the women, it's, 'You're going to be learning to cook damper. You'll be doing basket weaving. And we can all be still doing that. But starting those conversations [about violence].'"

Woman, 38, East Gippsland (First Nations Women Focus Group)

Backlash and Signs of Hope

A number of the women and gender diverse people we heard from reported experiencing or witnessing backlash to gender equality or violence prevention initiatives or campaigns. As examples already provided indicate, backlash or resistance was noted in relation to public events such as vigils, in local government politics, and in the context of education initiatives such as Respectful Relationships or workplace gender equality training.

"... workplace training is sometimes some of the most uncomfortable - you always get mixed group of people, which they paint as a positive thing, but I get a bit of anxiety going in because some of the comments you hear and being, 'Oh, people still think that way.' And it's hard because you want to educate people. But sometimes they walk out and they're just so defiant in their views. They don't walk out saying, 'Oh, I need to think about this differently.' They just complain about the training and still think the way they think. And I don't know how you address that. It's really disheartening because we have some really great presenters."

Woman, 24, Wellington (Focus Group 5)

"... our councils have a lot of bickering and discussions about particularly the "anti-woke" element and it's sometimes framed in that city-country divide as if 'we don't want those city ideas here.' And that's just terribly off-putting to me."

Woman, 44, Baw Baw (Focus Group 1)

"I hear a lot of jokes when people are asked to nominate their gender, and I hear a lot of sarcastic comments around the 'woke generation'. It's tragic. We really need to see a lot more understanding and tolerance, in general."

Woman, 59, East Gippsland (Focus Group 5)

GFVA's Kim Adams shared her thoughts on what was needed to combat what she characterised as systemic backlash against gender equity.

"... systemic backlash is increasing violence towards women and gender diverse people, and we're seeing that worldwide - it's not just a Gippsland problem. What do we do about it? I think you just have to keep investing into all areas of the sector, whether it's prevention, early intervention, response, and recovery services and wrap-around services like housing. The only solution that has ever worked in any kind of large-scale social movement to systemic backlash is systemic resistance. You can't give up. So for every 2 steps backwards you have to take one step forward. You just have to keep pushing despite the backlash."

Kim Adams, Principal Strategic Advisor, GFVA

Amongst these concerns, many participants also shared stories of prevention initiatives or interventions that they felt were making an impact, or examples of positive changes in attitudes.

"... it's really important to nip it in the bud, educate young. I worked in a high school, and I still remember some Year 7 boys were mucking around, and one started yelling out, "Rape, rape, rape!", and laughing, making a joke of it. And the PE teacher, I've never seen him turn around so quickly, he asked the boy to come into the office and had a conversation with him basically saying, "Do you want to talk about this further? Is there anything you need to report?" And the kid just didn't know how to take it. He was, "What do you mean?" And the teacher said, "This is something I take really seriously - why are you yelling this word in the yard?" And that I think that was just such a powerful way to tackle it, rather than call him out in front of his friends and then he'd try and make a joke out of it and diffuse the situation."

Woman, 24, Wellington (Focus Group 5)

*"There's a mental health nurse who does a lot of advocacy and work with young people through the Man Cave program... I think he's absolutely fantastic. I love his energy, I love his work, just all about having those conversations with young boys about what it means to be a man and how to step outside of the man box. And I really love that he focuses a lot on normalising conversations to be like it's OK to speak up and say how you're feeling. Because that can be an issue with young boys in particular, that they don't want to say that they're feeling sh*t or that they're angry or they feel worthless, or they don't feel good enough... So I think he's a really great asset and what he preaches is fantastic and I really would love to see more of that and I feel like it's just a stepping stone in a very long battle for us to reach gender equality, but I do think particularly with addressing issues and really getting in there early days with young men, young boys, facilitators like him and programs like his seem to be quite effective."*

Woman, 30, Wellington (Focus Group 2)

Box 9: How GWH is helping prevent gendered violence in Gippsland

GWH is leading regional efforts to prevent gendered violence through strategic partnerships, education, and leadership initiatives. Central to this work is the **Respectful Gippsland partnership**, which provides regional leadership, advocacy and evaluation of primary prevention activities. This collaborative approach strengthens place-based and regional actions to address gender inequity and promote safety.

The **Men in Leadership Governance Group - Champions of Change initiative** engages male leaders in Gippsland to take responsibility for driving change to prevent and eliminate violence against women. These programs encourage reflection, accountability, and action among men in positions of influence, reinforcing the message that preventing gendered violence is everyone's responsibility.

GWH also leads the annual **Let's Chat Gippsland campaign** during the 16 Days of Activism against Gender Based Violence, which aims to encourage open conversations about gender equality and empower communities to take action to address gendered violence. Initiated in 2021, last year the campaign involved 61 partners, 26 events, and 5 Walks Against Family Violence attended by over 560 people.

Capacity and capability building are critical activities undertaken with the regional prevention workforce. Leading up to key awareness campaigns like **16 days of Activism** in November – December and **Domestic and Family Violence Prevention Month** in May, GWH leads workshops for communications, primary prevention, social and community planning and community leaders to increase their knowledge and skills in engaging with these campaigns.

Other initiatives include the new **eAware** program, which builds awareness and understanding of tech-facilitated coercive control across community and organisational settings. Through tailored education and engagement, eAware empowers individuals and groups to challenge harmful norms and support cultural change.

Through these efforts, GWH is fostering a culture of respect, equity, and safety across Gippsland, helping to reduce the incidence of gendered violence and build stronger, more inclusive communities.

A woman with reddish-brown hair in a ponytail, wearing a white quilted vest over a black long-sleeved shirt and grey cargo pants, is using a green surveying instrument mounted on a silver tripod. She is standing on a grassy hillside, looking through the instrument towards a valley. The background shows rolling hills with sparse trees and some buildings in the distance. A large orange arrow graphic points upwards from the bottom left corner.

5. WOMEN'S ECONOMIC PARTICIPATION

Key Finding 11: Women in Gippsland face higher economic disadvantage relative to men and are underrepresented in leadership positions

What the Quantitative Data Shows

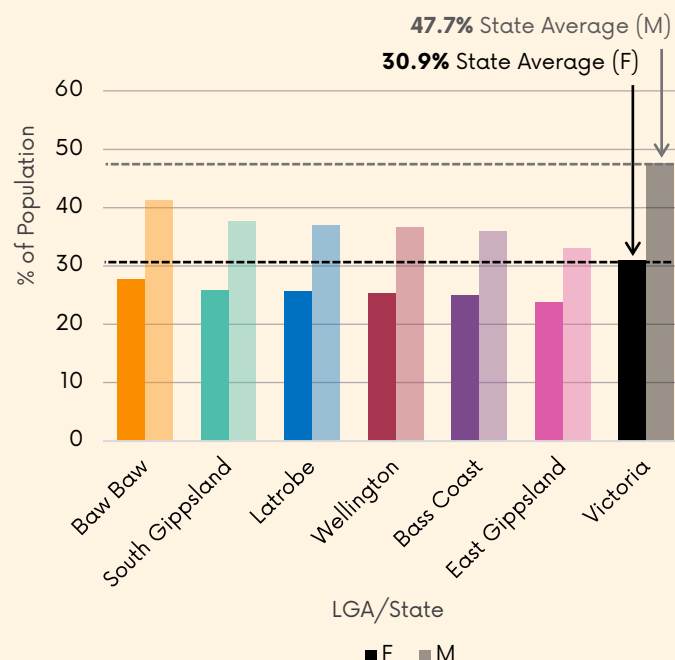
Income and Employment

In all Gippsland LGAs in 2021, a **lower proportion of women earned above the minimum wage** relative to men, while the proportions of both women and men earning above the minimum wage in Gippsland were lower than for the state overall, underlining the lower socioeconomic status of the region (Fig. 58).

In all Gippsland LGAs, a lower proportion of women earn above the minimum wage relative to men, while the proportions of both women and men earning above the minimum wage in Gippsland were lower than for the state overall, underlining the lower socioeconomic status of the region (Fig. 58).

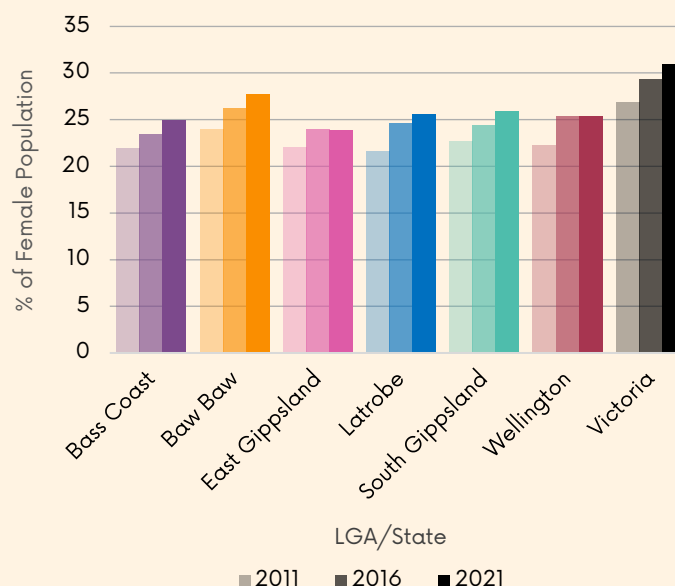
Encouragingly, over the decade from 2011, the share of women earning above the minimum wage increased in all LGAs consistent with the statewide trend, although growth plateaued in East Gippsland and Wellington from 2016 – 2021 (Fig. 59).

Fig. 58: Proportion of population earning above the minimum wage (females and males): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas / ABS Census (2021)

Fig. 59: Proportion of population earning above the minimum wage (females): Gippsland LGAs vs Victoria (2011 – 2021)



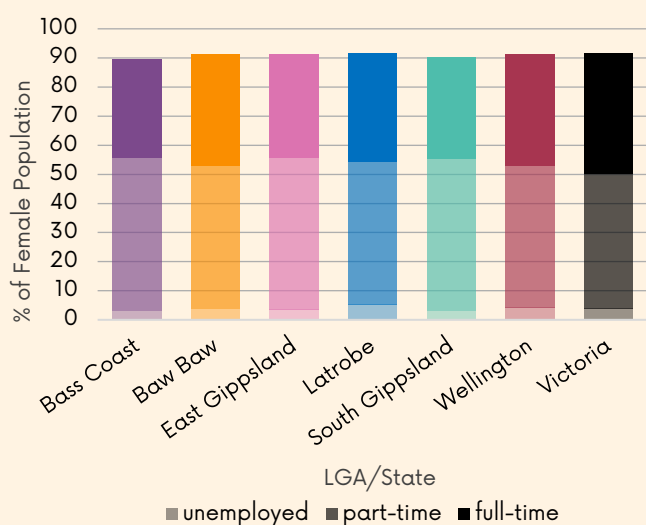
Source: Victorian Women's Health Atlas / ABS Census (2011 - 2021)

Looking at employment data, Figs. 60 and 61 show that in 2021 **Gippsland women were over-represented in part-time work while men were over-represented in full-time work, contributing to women's overall lower wages.** Men were more likely to be unemployed than women, though this remains a small percentage relative to those working.

These disparities in income and employment reflect factors such as **occupational gender segregation and gender discrimination** which contribute to the over-representation of women in industries where part-time work is more common and/or wages are lower, women's disproportionate engagement in unpaid domestic work and caregiving relative to men, and the gender wage gap.



Fig. 60: Proportion of population in full-time vs part-time work vs unemployed (females): Gippsland LGAs vs Victoria (2021)¹⁰



Source: Victorian Women's Health Atlas / ABS Census (2021)

Fig. 61: Proportion of population in full-time vs part-time work vs unemployed (males): Gippsland LGAs vs Victoria (2021)¹¹



Source: Victorian Women's Health Atlas / ABS Census (2021)

Unpaid Care Work

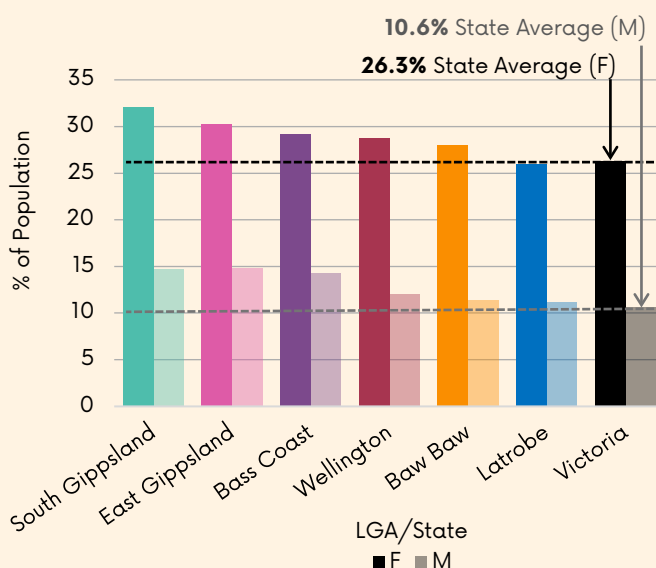
Unpaid care work comprises all forms of unpaid domestic work (e.g., cooking, cleaning, washing) and informal caregiving (WGEA 2016) and is predominantly undertaken by women, impacting on their participation in paid employment. As Figs. 62 and 63 show, this is true in **Gippsland as well as across Victoria as a whole – women are performing significantly more hours of unpaid domestic work and informal caregiving than men.** The charts also show that:

- a higher percentage of Gippsland women undertake 15+ hours a week of unpaid domestic work than for Victorian women as a whole in 5 out of 6 LGAs, and in all 6 LGAs for informal caregiving, and
- a higher percentage of Gippsland men undertake 15+ hours a week of unpaid domestic work than for Victorian men as a whole in all 6 LGAs, and in 4 out of 6 LGAs for informal caregiving.

The difference in the relative share of women and men undertaking unpaid care work is closely linked to women's lower participation in full-time work relative to men.

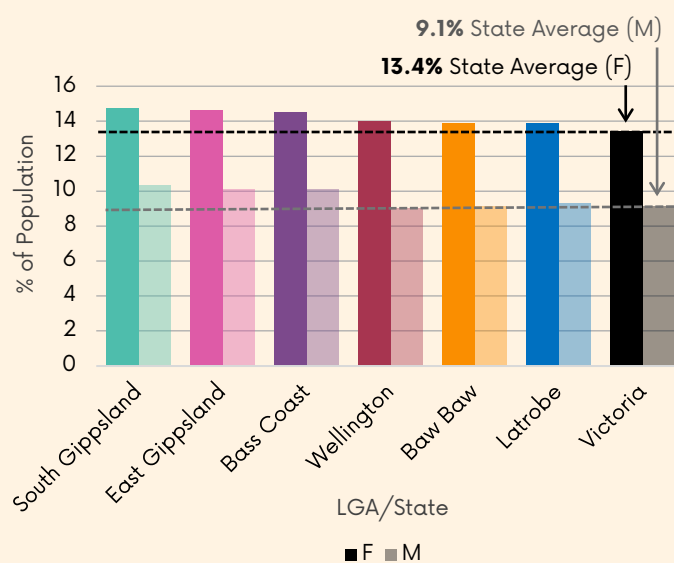


Fig. 62: Proportion of population undertaking 15+ hours per week of unpaid work (females and males): Gippsland LGAs vs Victoria (2021)



Source: Victorian Women's Health Atlas / ABS Census (2021)

Fig. 63: Proportion of population undertaking informal caregiving (females and males): Gippsland LGAs vs Victoria (2021)¹²



Source: Victorian Women's Health Atlas / ABS Census (2021)

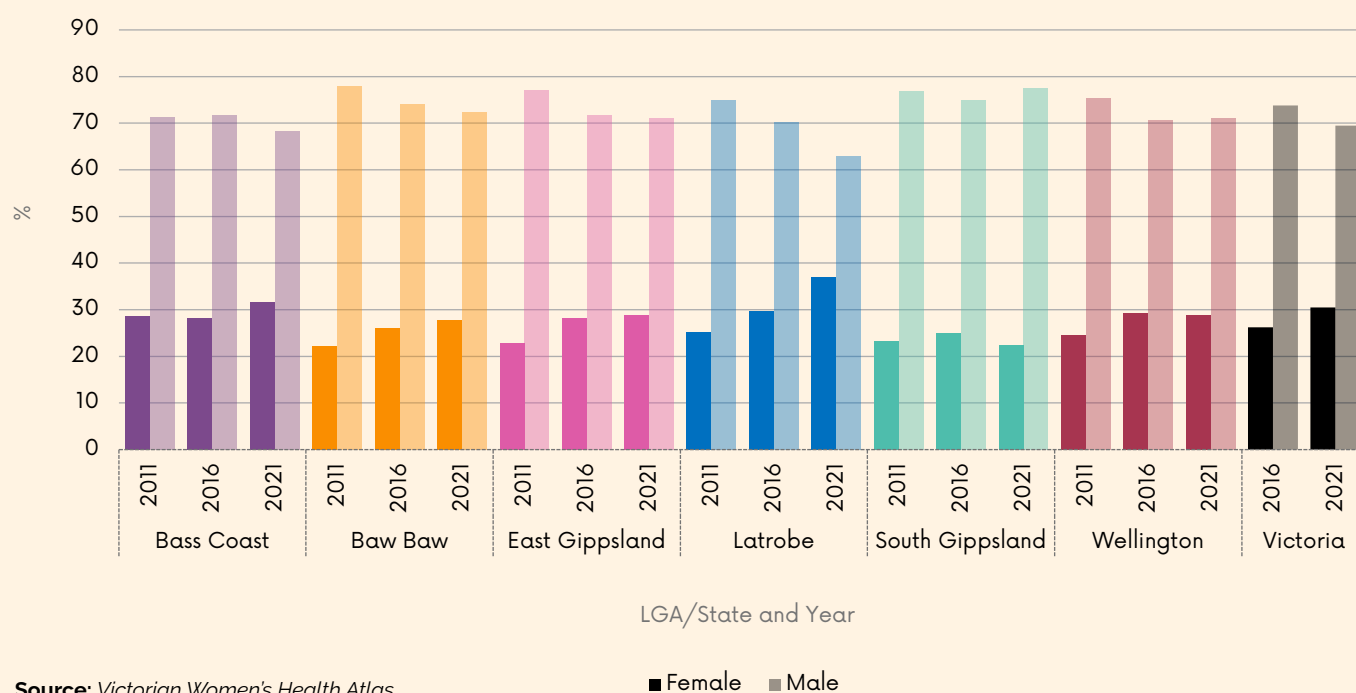
Leadership

Although the proportion of women in senior leadership positions has risen in most Gippsland LGAs over the 10 years to 2021 (with a corresponding decrease in the proportion of male leaders), the change has been modest, and overall women remain under-represented.

Latrobe is leading the region with 37% of CEO, General Manager and Legislator positions held by women in 2021, up from 25% in 2011, while South Gippsland has the lowest proportion at just 22.4%, slightly down from 23.2% 2011 (Fig. 64).



Fig. 64: Proportion of CEOs, General Managers and Legislators (females and males): Gippsland LGAs vs Victoria (2011 – 2021)¹³

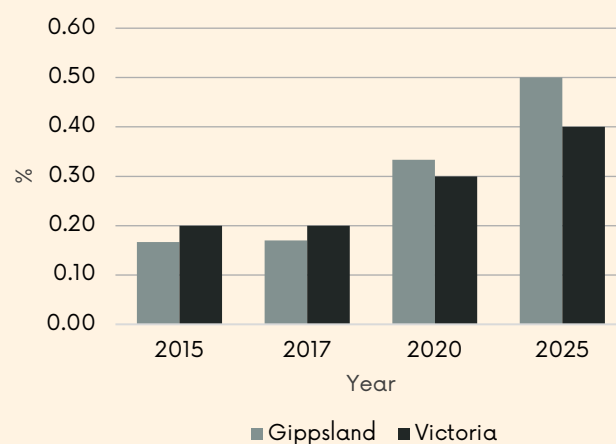


Source: Victorian Women's Health Atlas

The proportion of council CEOs who are female has increased over the last decade (Fig. 65). In 2015 and 2017, only one of 6 Gippsland councils had a female CEOs, increasing to 2 in 6 (33%) in 2020, and reaching parity in 2025, surpassing the statewide figure of 40%.

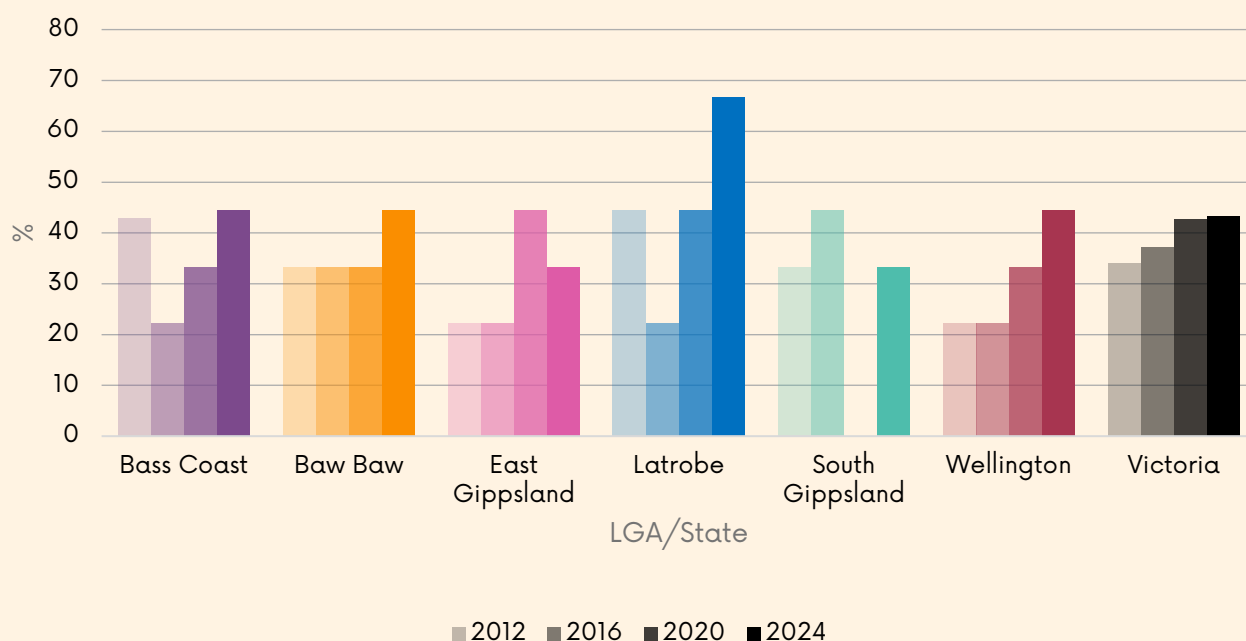
Finally, while the proportion of female local councillors has increased at a statewide level from 2012 – 2024, the direction of change has been less clear across Gippsland (Fig. 66). Representation has increased in Baw Baw and Wellington, while in 2024 two thirds of councillors in Latrobe were female. The trend in the other 3 LGAs has been more variable.

Fig. 65: Proportion of Council CEOs (female): Gippsland region vs Victoria (2015 – 2025)



Source: Victorian Women's Health Atlas

Fig. 66: Proportion of female local councillors: Gippsland LGAs vs Victoria (2012 – 2024)



Source: Victorian Women's Health Atlas



6. GENDER AND CLIMATE CHANGE ADAPTATION, DISASTERS AND EMERGENCIES

We rolled out of years of drought, straight into bushfires, straight out of bushfires and literally had a breather of about 3 weeks and then COVID hit. So it was smack after smack after smack.

*Co-facilitator, Women with Disabilities
Focus Group, East Gippsland*

In addition to **climate-related and other disasters affecting Gippsland over the past 20 years** (see Chapter 1), the **COVID-19 pandemic also had a significant impact** on the region. In March 2020, a State of Emergency was declared in Victoria with social distancing rules and closure of non-essential services. Victoria experienced significant 'lockdowns' until mid-2022, including at one stage the longest continuous lockdown worldwide. These lockdowns had significant cumulative implications for women and gender diverse people including:

- increased isolation and worsening mental health,
- increased carer burden for women required to homeschool children and work from home,
- severe economic hardship and job loss,
- an increase in family violence and women being trapped in violent relationships, and
- an inability to access health services when needed, often resulting in poorer health outcomes and in some cases premature death.

Key Finding 12: Women and gender diverse people in Gippsland experience gendered impacts in times of disaster and are often excluded from disaster planning

What We Heard

Several participants noted the **differential impact of disasters and emergencies on women and gender diverse people**, including an increase in family violence, a heavier mental load (responding to the crisis and supporting others on top of their usual caregiving roles), the greater financial impact of disasters and flow-on impacts such as loss of housing given women's more vulnerable pre-existing financial circumstances, and greater representation of women in unpaid caregiving roles.

"... just the support services, I don't know the stats off the top of my head, but a lot of those care roles are usually filled by females. And I just think of that mental load that women take on, when primarily they also are a primary carer for their families, often their parents as well as children. And I just think that mental load, I know there's some research going on at the moment and in and around that space, but I just think emergencies exacerbate that because they're usually already providing that care and role and that extra support, going through a traumatic event - it's a lot."

Woman, 24, Wellington (Focus Group 5)

"It's definitely like a struggle to start again - I know a few people who have lost everything. I worked with women who, their husbands and their kids defended their farms during Black Saturday, which would be a really difficult decision to me, I wouldn't put my kids in that, but that's what they decided to do."

Woman, 51, Latrobe (Interview)

"... the other compounding issue is when there are those kinds of natural disasters family violence does increase the stress on the family. And so women and children will bear the brunt of that. And the burden of that and families that go through losing their homes in a fire or, the financial cost of that, if they don't have insurance, it keeps people that may have otherwise been able to leave a really bad situation. It sometimes keeps them together, so I think it's a really, really complicated thing."

Woman, 44, Baw Baw (Focus Group 1)

Women from underserved communities were particularly impacted, including the migrant and refugee women, women with a disability and First Nations women we heard from. They described the impacts of isolation during COVID, being discouraged from using mainstream services, the challenges of being evacuated, and disasters triggering traumatic memories. Concerningly, the 2023 Rainbow Brick Road project found that around half of LGBTQIA+ people surveyed felt their health and mental health was in a poorer state because of the COVID-19 pandemic (Gippsland Pride Initiative and CERG 2023).

"Not really much for Aboriginal people. It's, 'oh, you've got an Aboriginal service to go to. Go to that.'"

Woman, 38, East Gippsland (First Nations Women Focus Group)

"[Fellow participant name] is scared of fires. Even the fireworks scares her, too, she was saying. Because of past experience [with the conflict in Myanmar]."

Woman, 35, Bass Coast (Migrant and Refugee Women Focus Group)

"... I could see the bushfire from [where we were]. So my sister stayed home defending our house and we stayed in a motel for a week. It was hard."

Woman, 21, East Gippsland (Women with Disabilities Focus Group)

"Sometimes we didn't know what was going on [during COVID]. We had nothing to do [during lockdowns]."

Woman, 22, East Gippsland (Women with Disabilities Focus Group)

Based on participants' accounts, **the gendered and intersectional impacts of disasters seemed to have rarely been taken into account in emergency planning and support.** Participants mentioned poorly communicated or missing information, traumatic and isolating temporary relocations (e.g., to Melbourne or Traralgon), and failure to ensure access to essential medications, noting these were particularly impactful for priority population groups. For example, one participant described warnings to 'vulnerable groups' including pregnant women to relocate during the Hazelwood mine fire without any guidance as to where they could go. A First Nations participant who was a kinship carer reported being told by DFFH during a bushfire that if she didn't evacuate, the children would be taken from her, which she described as 'very stressful'.

"[Group member from Myanmar] had only been here a little while, and on TV, there was bushfires, there was bushfires everywhere. And she worked out that they were telling you that you had to be prepared to leave, right? So I went to visit and there she was, had all the cases packed and all the children ready – because the TV was showing bushfires. It's very hard to tell from the TV where it is. I mean, at the moment they're showing floods, but it's not in Wonthaggi."

Co-facilitator, Migrant and Refugee women focus group, Bass Coast

"[For our participants] with asthma, the fires were shocking. And then when that happens – and it was the same with COVID on the subject of asthma – you couldn't get your ventolin, it was running out because people were bulk-buying. Yeah, shocking."

Co-facilitator, Women with Disabilities Focus Group, East Gippsland

The experience of the family from Myanmar described above is not uncommon – research by the Multicultural Centre for Women's Health (2024) indicates that authorities seeking to support migrant and refugee women and families during disasters need to ensure in-language information is available, understand that visa restrictions may prevent some people from accessing financial support or even relocating, and be aware that disasters can be re-traumatising based on past experiences.

In other cases, the safety of women volunteers wasn't factored into emergency response planning.

"I signed up to be able to help out the Emergency Relief Centres and did the training, we did sort of a simulation thing, which was great... And then probably within 12 months, we activated an ERC for floods. Luckily there wasn't too many people impacted that needed to come to the facility, but my first shift was 3:00 am till 12 midday. So you got there really middle of the night sort of hours, in the dark and - it's actually frightening to be in the dark at a very empty facility waiting for people to come in. We're lucky that because the floods were so widespread, that there was a police presence quite constantly, even though there wasn't many people accessing the facility and we were able to get them into accommodation rather than have to stay there. But there's so many safety concerns, I think. And then just being female and being in a location that, it's on your mind of, 'OK, I have to then go walk to my car if the police aren't there when I've changed over shifts, I'm walking in the dark,' and you know, 'Who's going to be out there?' Those sorts of things."

Woman, 24, Wellington (Focus Group 5)

When women were able to attend community preparedness information sessions, they found them helpful and reassuring.

"I went to a very good talk at the library by a fire officer from Melbourne, he'd just come to Wonthaggi. And he explained about fires... and he said reporting them quickly is terribly important, and the other thing he said was radiant heat, direct heat from the fire. Direct heat is very, very dangerous and if it's near your house, go out of your house and go 2 blocks down and get behind a building. Don't take your car because you will be in the way of emergency services. I thought we might be asked to go to an emergency place down in Wonthaggi. And he said no – two blocks away from the radiant heat. So, I feel a bit calmer about that. I thought he spoke extremely well. If you ever had a chance to go to the library and listen to such a talk by the CFA, it calms you down."

Woman, 83, Bass Coast (Migrant and Refugee Women Focus Group)

Key Finding 13: Challenges accessing disaster recovery support across the region disproportionately impact women

What We heard

In addition to the challenges with emergency preparedness and response already noted, participants shared other **difficulties with accessing disaster recovery support**, including:

- the limitations of short-term funding,
- unevenly distributed support, and
- the complexity for some members of the community to navigate available supports.

While these issues affect everyone, they can be particularly impactful for women. Women are more likely to be involved in 'caring' volunteering after the initial emergency subsidies, help others navigate support programs, and pick up the slack when formal supports are missing.

"[My elderly relatives who lost their home in the 2019 bushfires] had access to a lot of grants and financial help, but without their daughters there, who were all healthcare workers, there's no way knowing they could have navigated that access that on their own."

Woman, 59, East Gippsland (Focus Group 5)

"So it's really hard building an initiative from scratch. You've got to fit it into the box of federal government funding and what they think you need. They don't understand rural areas like Wellington and East Gippsland in particular. The areas are so massive to cover and with limited amounts of money. It's tough and I've worked quite closely with people in East Gippsland on some projects for young people and it's really hard to get young people along to sort of the first session to get their ideas because what they need or seek is consistency and if you're coming in and you have an 18 month to 3 year project, it might take you 6 months, even 10 months to build any relationships with the young people and you are there and then you're gone again. It's my biggest pet peeve working with young people. Everything is temporary funding, and for emergencies in particular."

Woman, 24, Wellington (Focus Group 5)

"... there was a lot done in [Sarsfield], but there are other communities who might not have had the fires touching them, but were really affected as well, but just got nothing. You know, there was a lot of impact, that just sort of went unnoticed, I thought."

Woman, 66, East Gippsland (Focus Group 5)

Pockets of good practice did exist, **where emergency support was designed with particular communities' needs in mind.**

"With the Aboriginal Co-ops and other services within the region, if you got COVID and you let them know, they would come out and deliver you some shopping. Some food and masks and different essential products that you would need because obviously you're not allowed to go anywhere, so I found that was a really good support for community to have that happen. When you got COVID, it was really helpful."

Woman, 51, Wellington (Focus Group 3)

A few people commented on the **lack of support for those suffering the longer-term impacts of disasters.** A staff member at a disability support service in East Gippsland noted that staff and participants driving from Bruthen to Bairnsdale through the 'devastation' of severely fire-affected areas afterwards had a 'huge impact' on their mental health.

"And sometimes people don't need the assistance in the event because they're going with the adrenaline pumping, all that. But you know, 12 months, 18 months down the track, that's when it actually might hit them. And I think that's something that a lot of this temporary funding doesn't take into account."

Woman, 24, Wellington (Focus Group 5)



Community Resilience and Informal Support

On a positive note, several participants also commented on communities 'rallying' during emergencies and disasters and shared their own experiences of both volunteering and informal support. These experiences suggest that **there is a strong foundation of community resilience and willingness to provide support that can be strengthened to become more gender-responsive and inclusive** of all groups within the Gippsland community.

"I would say in the Wellington area when we experience devastation through different types of natural disasters, I feel like the community is actually really good at stepping up and offering a helping hand. Whether that's through donating foods or our showgrounds where quite a lot of people will set up their tents and campers and all of that, and people just offering to help wherever they can. So I feel like it's dependent on what's happening but it is one of the very few times that you actually see people like all the community really wanting to help out and assist however they can and I know with the Wellington Shire Council every now and again they're pretty good with running programs for free, like I remember a couple of months back they were teaching people how to utilise a chainsaw. So being able to cut up a fallen tree or large stump."

Woman, 30, Wellington (Focus Group 2)

"I was working in a school with Black Saturday. The school asked for staff who would volunteer, so I volunteered for the Red Cross during that time in which we made food for the emergency services. And my sister used to work for Relationships Australia, Victoria. She ran a huge amount of programs through drought relief, bushfire, all those kind of things. So we always get roped into doing whatever she is, whatever project she's running!"

Woman, 51, Latrobe (Interview)

"Some small communities have really good little support networks and things like that."

Woman, 56, Baw Baw (Focus Group 1)

Key Finding 14: Women are at risk of being left behind in Gippsland's clean energy transition, but a 'gender just' energy transition can mitigate the impacts

"Success is often measured in megawatts and market growth, but true progress is defined by who we empower along the way. Equality isn't philanthropy; it's a strategic advantage that strengthens our collective performance. Diverse leadership and balanced teams drive innovation, resilience, and better outcomes for all."

Claire Gardner, Marketing Manager, Solis

Our final key finding emerged from GWH's existing work in this area and a brief literature review (Chapter 1) rather than specific survey responses and focus group discussions.

Just as the 'old' energy industry is male-dominated, so too will 'new energy' be unless leaders across industry, research and government make a concerted effort to change this. Without intervention, **not only will the workforce remain overwhelmingly male, but the side effects of a large influx of predominantly male surge workers will adversely impact Gippsland women and gender diverse people**, deepening the inequities they already experience.

Conversely, taking active steps to ensure women can participate equally in a **'gender just' energy transition will have transformative effects on gender dynamics in Gippsland – and lead to better economic outcomes at the same time.**

As the quote from Claire Gardner from solar and energy storage solutions company Solis reminds us, inclusion and performance go hand in hand

To learn more about **what GWH is doing to support women to adapt to climate change and take a more active role in the energy transition**, see Box 10.

Box 10: What GWH is doing to support women and gender diverse people to adapt to climate change and the energy transition

GWH is working with local and regional authorities to **apply a gender lens to emergency management** through the following planned activities:

- Developing:
 - a Community Preparedness Resource and
 - a Local Government Preparedness and Gender Inclusive Planning Resource, which provides practical resources for Emergency Relief Centres (ERCs)
- Supporting local councils to undertake Gender Impact Assessments (GIAs) on emergency management plans
- Mapping emergency management review of plans and timing engagement with the plans
- Creating a gender equity checklist for emergency relief centres and currently testing with local governments
- Joining each council's Relief & Recovery Committee

We are also building on our **Equitable Leadership learning & development program with energy industry leaders** including building a leadership and leadership mentoring program

Through collaboration and partnership work, the **Gippsland Environment Agencies collective are now part of the Respectful Gippsland** prevention of violence partnership led by GWH.

A collaboration has been established with the Gippsland Climate Change Network to identify **opportunities to apply a gender lens across climate change and new energy stakeholders** including panel participation in the annual Gippsland New Energy conference. helping to reduce the incidence of gendered violence and build stronger, more inclusive communities.



REFERENCES

- Aboriginal Cultural Heritage Register and Information System (ACHRIS) (2025) [Victoria's Registered Aboriginal Parties](#).
- Australian Bureau of Statistics (ABS) (2025a) [Regional population 2023-24](#). ABS: Canberra.
- ABS (2025b) [Australian Statistical Geography Standard, 3rd edition](#). ABS: Canberra.
- ABS (2024) [Disability, Ageing and Carers, Australia: Summary of Findings](#). ABS: Canberra.
- ABS (2022a) [Census](#). ABS: Canberra.
- ABS (2022b) [Aboriginal and Torres Strait Islander people: Census, 2021](#). ABS: Canberra.
- Australian Human Rights Commission (2024) [Statistics about Aboriginal and Torres Strait Islander Women and Girls](#). AHRC: Sydney.
- Australian Institute of Family Studies (AIFS) (2024) [Births in Australia: Facts and figures 2024](#). AIFS: Melbourne.
- Australian Institute of Health and Welfare (AIHW) (2025) [Deaths in Australia](#). AIHW: Canberra.
- AIHW (2025a) [Housing Assistance in Australia](#). AIHW: Canberra.
- AIHW (2025b) [Specialist Homelessness Services Annual Report 2023-24](#). AIHW: Canberra.
- AIHW (2024a) [Health and wellbeing of First Nations people](#). AIHW: Canberra.
- AIHW (2024b) [People with disability in Australia](#). AIHW: Canberra.
- AIHW (2024c) [Older Australians](#). AIHW: Canberra.
- AIHW (2024d) [Timeliness of access to aged care services in Australia](#). AIHW: Canberra.
- Baker E, Beer A and Blake M. (2022) [Look where Australia's '1 million empty homes' are and why they're vacant – they're not a simple solution to housing need](#). The Conversation. 1 September 2022.
- Better Health Channel (2025) [Fact sheet: E-cigarettes and vaping](#). Department of Health: Melbourne
- Briggs C, Atherton A, Gill J, Langdon R, Rutovitz J and Nagrath K. (2022) [Building a 'Fair and Fast' energy transition? Renewable energy employment, skill shortages and social licence in regional areas](#). Renewable and Sustainable Energy Transition. 2: 100039.
- Cancer Council Victoria (2025) [Disability and Cancer Care](#).
- Cancer Council Victoria (2025a) [Data Explorer](#)
- Cancer Council Victoria (2025b) [Breast Cancer Statistics and Trends](#)
- Cancer Council Victoria (2025c) [Bowel Cancer Statistics and Trends](#)
- Cancer Council Victoria (2025d) [Lung Cancer Statistics and Trends](#)
- Centre of Research Excellence in Child and Family Welfare (2021) [Child witnesses of family violence in the Victorian context](#).
- Charman M and O'Connor C. (2023) [The Gendered Impacts of Boomtowns: How Financial Dependence, Family, and Victimization Intersect with Hegemonic Masculinity](#). International Journal of Rural Criminology. 7(3):289-312.
- CHP (2022) [Homelessness and domestic and family violence - Factsheet - Victoria 2022](#).
- Climate Change Authority (2025) [2035 Targets Advice](#). CCA: Canberra.
- Coates B, Wiltshire T and Reysenbach T. (2023) [Short-changed: How to stop the exploitation of migrant workers in Australia](#). Grattan Institute: Melbourne.
- Commonwealth of Australia (Productivity Commission) (2025) [Closing the Gap Information Repository](#).
- Commonwealth of Australia (Department of Social Services) (2024) [National Carer Strategy 2024 – 2034](#)
- Coumarelos C, Weeks N, Bernstein S, Roberts N, Honey N, Minter K & Carlisle E. (2023). Attitudes matter: [The 2021 National Community Attitudes towards Violence against Women Survey \(NCAS\). Findings for Australia](#). (Research report 02/2023). ANROWS.
- Crime Statistics Agency (2025) [Family Violence Dashboard](#).
- East Gippsland Catchment Management Authority (EGCMA) (2025) [East Gippsland Regional Catchment Strategy](#). East Gippsland Catchment Management Authority: Bairnsdale.

Egede L, Walker R and Williams J. (2024) [Addressing Structural Inequalities, Structural Racism, and Social Determinants of Health: A Vision for the Future](#). Journal of General Internal Medicine. 39(3): 487-491

Ending Loneliness Together (ELT) (2020). [Ending Loneliness Together in Australia](#). ELT: Sydney.

eSafety Commissioner (2025) [Gendered Violence](#). eSafety Commissioner: Canberra.

Family Violence Reform Implementation Monitor (2023) [Monitoring Victoria's family violence reforms Service response for perpetrators and people using violence within the family](#). Office of the Family Violence Reform Implementation Monitor: Melbourne.

Farhalla K, Tyler M and Fairbrother P. (2020) [Labour and regional transition: sex-segregation, the absence of gender and the valorisation of masculinised employment in Gippsland, Australia](#). Gender, Place & Culture. 28(12): 1755–1777. <https://doi.org/10.1080/0966369X.2020.1858031>

Gippsland Homelessness Network (2022) [Recommendations to address the Housing and Homelessness crisis in Gippsland](#)

GLaWAC (2025) [Our Country | Gunaikurnai Land and Waters Aboriginal Corporation](#). GLaWAC: Kalimna West.

Gippsland Family Violence Alliance (GFVA) (2025) [What do we know about Gippsland's Family Violence Statistics? July 2024- July 2025.](#)

Gippsland Pride Initiative and CERG (2023) [Gippsland Rainbow Brick Road Report 2023.](#)

Gippsland Primary Health Network (2025) [Health Insights: Multicultural Health and Wellbeing](#). 2 August 2025.

Gippsland Region Public Health Unit (2024) [Gippsland Population Health Strategy 2024-2029](#). GRPHU: Traralgon.

Gippsland Regional Integrated Cancer Service (2024) [GRICS Annual Report 2023-24](#)

Gippsland Women's Health (2023) [Healthy Women, Healthy Gippsland: The state of Women's Health and Safety in Gippsland 2022-23 Report Card](#)

Heslop J. (2024) The impact of female leadership on the energy transition. Masters Thesis. Warwick Business School. University of Warwick, UK.

Hill A, Bourne A, McNair R, Carman M & Lyons A. (2020). [Private Lives 3: The health and wellbeing of LGBTIQ people in Australia](#). ARCSHS Monograph Series No. 122. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.

I.d Informed Decisions (2025) [Place Data](#).

Jaimathang (2025) [Jaimathang Country](#).

Jenkinson B, Dobson A, Hockey R, Martin S, Ferguson M and Mishra GD. (2024) #EndGenderBias Survey Detailed Report. National Women's Health Advisory Council, Department of Health and Aged Care, Australian Government: Canberra.

KPMG (2017) [The cost of family violence in Victoria: Summary Report.](#)

Lees O. (2023) [How it takes just a party of five to sponsor and help resettle refugee families in dire need of a home](#). ABC Gippsland. 10 November 2023.

Multicultural Centre for Women's Health (MCWH) (2024) [Best practice guide for migrant and refugee inclusive disaster preparedness, response, and recovery](#). MCWH: Melbourne.

MCWH (2021) [Data Report: Sexual and Reproductive Health 2021](#). MCWH: Melbourne.

Nous Group and NRHA (2025) [The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia.](#)

Orsatti J and Dinale D (2024) Livelihoods, work, women and climate change: women's voice in just transition. Labour and Industry: A Journal of the Social and Economic Relations of Work. 34(1): 27–49.

Orille E, Steck M and Brannan G. (2025) [Determinants of Health](#). StatPearls. StatPearls Publishing: Treasure Island (FL).

OurWatch (2025) [Types of Violence Against Women](#). OurWatch: Melbourne.

PALM Scheme (2025) [PALM Scheme Data Report – March 2025.](#)

Paton D, Horton J and Marden B. (2020) [Telling the truth about Gippsland's history](#). Overland Literary Journal. 6 October 2020.

RANZCOG (2025) Clinical Guideline for Abortion Care: An evidence-based guideline on abortion care in Australia and Aotearoa New Zealand (2025). Melbourne: Australia.

Refugee Council of Australia (2023) [Statistics on refugees settling in Australia over the past 10 years.](#)

Regional Development Victoria (2025) [Gippsland Regional Partnership.](#)

Renzaho A. (2023) The Lack of Race and Ethnicity Data in Australia—A Threat to Achieving Health Equity. *International Journal of Environmental Research and Public Health*. 20, 5530.

Respect Victoria (2023) [Aboriginal Family Violence Prevention Evidence Review](#). Respect Victoria: Melbourne.

Sarder M, Mogharbel C and Kalman T (2024) [Realising access: abortion and contraception inequities and enablers in Victoria](#). *Women's Health Victoria*. Melbourne. (Women's Health Victoria Knowledge Paper; 6).

Sentencing Advisory Council (2022) [Sentencing Breaches of Family Violence Intervention Orders and Safety Notices: Third Monitoring Report](#). Sentencing Advisory Council: Melbourne.

Sibly C and Anderson C. (2024) [Building the evidence base for the National Carer Strategy: A Rapid Evidence Review](#). Australian Institute of Family Studies.

Snowden N. (2024) [‘There was still a bit of that paternalistic crap going on’: Revealing the ‘Forgotten’ Labour of Working-Class Women in an Australian Industrial Coal Region](#). *Studies in Oral History: The Journal of Oral History Australia*. 46: 22-53.

State Government of Victoria (2025a) [2025 Victorian Transmission Plan](#). Department of Energy, Environment and Climate Action: Melbourne.

State Government of Victoria (2025b) [History of Petroleum Exploration in Victoria](#). Resources Victoria: Melbourne.

State Government of Victoria (2025c) [Wellbeing in Victoria: A strategy to promote good mental health 2025 - 2035](#). Department of Health: Melbourne.

State Government of Victoria (2025d) [Victorian Population Health Survey 2023 dashboard](#). Victorian Agency for Health Information: Melbourne.

State Government of Victoria (2023a) [Pride in our future: Victoria's LGBTIQ+ strategy 2022–32](#). Department of Families, Fairness and Housing: Melbourne.

State Government of Victoria (2023b) [Gippsland 2035 - Latrobe Valley and Gippsland Transition Plan](#). Regional Development Victoria: Melbourne.

State Government of Victoria (2023c) [Victorian public health and wellbeing plan 2023](#) – 2027. Department of Health: Melbourne.

State Government of Victoria (2023d) [Family Violence Reform Rolling Action Plan 2020-2023 – Primary Prevention](#). Department of Families, Fairness and Housing: Melbourne.

State Government of Victoria (2022) [Monitoring Victoria's family violence reforms: Primary prevention system architecture](#). Office of the Family Violence Reform Implementation Monitor: Melbourne.

State Government of Victoria (2021) [Victoria's Climate Change Strategy](#). Department of Environment, Land Water and Planning: Melbourne.

State Government of Victoria (2018) [Dhek Dja: Safe Our Way 2018-2028](#). Department of Health and Human Services: Melbourne.

State Government of Victoria (2016) [Royal Commission into Family Violence: Report and recommendations. Vol V, Parl Paper No 132 \(2014–16\)](#). Royal Commission into Family Violence: Melbourne.

Tamim Asset Management (2025) [Gridlocked Growth: Why Australia's Energy Transition Needs Infrastructure Urgency](#).

Taylor J, Valodia I, Lehmann-Grube K, Cook S and Cerise S (2024) [Climate change: women's role in the economy is key to a just transition](#). *The Conversation*. 15 November 2024.

Tran G, Ansari D, Labra-Odde C, and Tong A. (2023) [Building Bridges: Promoting Mental Health and Wellbeing for Migrant Women](#). Multicultural Centre for Women's Health: Melbourne.

Victorian Cancer Registry (2023) [Cancer in Victoria 2023](#). Cancer Council Victoria, East Melbourne, Victoria.

Victorian Public Service Commission (2024) [Age, gender and sexuality 2024](#).

Walk P (2023) [From parity to degrowth: Unpacking narratives of a gender-just transition](#). *Energy Research & Social Science*. 112: 103513.

WELA (2024) [Gender, climate and environmental justice in Australia](#). Women's Environmental Leadership Australia.

Women Deliver (2021) [The Link Between Climate Change and Sexual and Reproductive Health and Rights: An Evidence Review](#).

Women's Health Victoria (2025) [Victorian Women's Health Atlas](#)

Women's Health Victoria (2023) [In My Prime](#).

Wood T. (2025) [Victoria's energy challenge explained in 7 charts](#). Grattan Institute, Melbourne, Australia.

Workplace Gender Equality Agency (2016) [Unpaid care work and the labour market: Insight Paper](#).

World Health Organisation (2023) [Social Determinants of Health](#).

UN Women Australia (2025) [Types of Violence Against Women and Girls](#).

ENDNOTES

- 1** 'Cisgender' means anyone whose gender identity matches their sex as registered at birth. 'Transgender' describes those whose gender is different from the sex they were assigned at birth. Non-binary or genderqueer refers to people who do not identify with binary gender (male or female).
- 2** 2024 population x % population female or male in 2021 Census
- 3** In January 2025 the Victorian Government introduced a Vacant Residential Land Tax to reduce the number of unoccupied dwellings as part of a suite of reforms to increase housing supply and affordable housing.
- 4** Based on 2021 Census data, around 81.5% of the population across Gippsland (all LGAs) is aged 16 and over.
- 5** 164 of the 166 survey participants responded to this question.
- 6** NB: The number of respondents per LGA is too small for these figures to be statistically significant – they should be interpreted as suggestive only.
- 7** Since our interview with Catherine Bateman, the Victorian Government announced they would fund on-site ultrasounds at Victoria's SRH Hubs.
- 8** Multi Agency Risk Assessment and Management Framework, introduced after the 2015 Family Violence Royal Commission to support coordination of family violence risk assessment and management across a range of government agencies.
- 9** The 2025 NCAS results are due to be published in 2026.
- 10** Values do not add to 100% as exclude women who are not in the labour market nor seeking paid employment.
- 11** Values do not add to 100% as exclude men who are not in the labour market nor seeking paid employment.
- 12** Informal caregiving is defined as provision of unpaid help or supervision to another person to assist them with daily activities because of a disability, a long-term illness or for problems related to old age in the two weeks prior to the 2021
- 13** 2011 data for Victoria was not accessible at the time of publication.

APPENDIX 1: RESEARCH APPROACH

A key focus of this report was to give voice to Gippsland women and gender diverse people's views and experiences of health, wellbeing and safety in their region. To this end, we adopted a mixed methods approach, combining both qualitative and quantitative data and insights derived from

- publicly available statistical data
- a community online survey
- community focus groups
- key informant interviews

Publicly Available Statistics

Descriptive statistical data were obtained primarily from the Victorian Women's Health Atlas, Victorian Population Health Survey, Cancer Council Victoria, the Census, and the Australian Institute of Health and Welfare, disaggregated by sex and reported to the LGA level, on the following topics:

- Mental health and wellbeing
- Sexual and reproductive health
- Chronic disease and lifestyle behaviours
- Cancer
- Gendered and family violence
- Health service access
- Gender equity (employment, income, unpaid care work, leadership)
- Socioeconomic and demographic data

For some indicators, available time series data has been included to make visible trends and patterns over a longer period. Other data is presented to show variation over place or comparisons among Gippsland LGAs or between Gippsland LGAs and the rest of the state. As noted on page 5, most publicly available health and violence data sources to date have collected and/or reported by binary sex and gender only which means the experiences and needs of trans and gender diverse and intersex people in Australia are poorly understood.



Community Online Survey

An online community survey was open for 10 weeks (April – mid-June 2025) to women, girls and trans and gender diverse people living in Gippsland. GWH promoted and advertised the survey via its socials, newsletter and flyers and posters across the region.

The survey design expanded on a 2023 survey conducted by GWH, repeating some questions and adding others. It comprised the following three sections:

- I. **A bit about you:** brief demographic questions
- II. **Women, girls and gender diverse people's health in Gippsland:** perceptions of health issues facing women, girls and gender diverse people in Gippsland and experiences of health services
- III. **Women, girls and gender diverse people's safety in Gippsland:** perceptions of safety issues facing women, girls and gender diverse people in Gippsland and experiences of violence services

The survey comprised 19 questions, including 9 open-ended questions and took participants on average approximately 15 minutes to complete.

In total there were 166 responses. Incomplete responses have been included in the analysis as most questions were optional. This aspect of the survey design was intentional, recognising that not all respondents would have experience or knowledge of some of the survey topics, family violence services in particular – only 49 respondents completed these open-ended questions as compared with 158 who completed the health service open-ended questions.



Community Focus Groups

To add depth to the qualitative responses to the online survey, eight community focus groups were held over four weeks from late June to late July 2025, open to women and gender diverse people currently living in Gippsland aged over 18. An expression of interest was advertised across a range of platforms, and as noted, survey participants could express interest in joining a focus group as well.

The focus group question guide covered four main topics:

- I. health issues facing women and gender diverse people in Gippsland and experience of health services,
- II. gendered violence and experiences of services (both prevention of and response to gendered violence),
- III. experiences of support during disasters and emergencies, and
- IV. reflections on Gippsland's strengths and what is working well.

Facilitators also pursued lines of inquiry that emerged in the discussions.

In total, 41 people participated in the focus groups, which lasted on average 1.5 to 2 hours. Five general focus groups were held and three groups with members of underserved communities – First Nations women, migrant and refugee women, and women with a disability. Consultation with the LGBTQIA+ community was attempted but was

not possible within the timeframes – however, the community was represented by individuals both in the survey and other focus groups. The 2023 Rainbow Brick Road report, based on extensive consultation with LGBTQIA+ Gippslanders, has a wealth of relevant information that we also draw on through this report.

Participants in the general focus groups were recruited via the community as described above and underwent a screening process to confirm eligibility and availability. Reflecting the preference of most participants, general focus groups were conducted online, with one individual in-person interview conducted with a community member who was unable to join online. In total, 18 people participated.

Focus groups with underserved communities were arranged through partner organisations (YooWINna Wurnalung and Distinctive Options Noweyung in East Gippsland, and Wonthaggi Neighbourhood House in Bass Coast). Question guides for these focus groups were reviewed in advance by partner organisations and adjusted for appropriateness based on feedback (including from group members).

Other adjustments included having facilitators known to the members lead the discussion while a GWH staff member took notes (First Nations women focus group), making time for informal interpreting provided by fellow group members (migrant and refugee women focus group), having a preliminary discussion the previous week to help members prepare for the focus group (women with a disability focus group); and having staff or volunteers known to the group co-facilitate the discussion. In total, 23 people participated.

Key Informant Interviews

Interviews were conducted with 4 Gippsland-based experts working in GWH priority areas – sexual and reproductive health, mental health and wellbeing, chronic disease, and gendered and family violence, with the aim of supplementing community members' input with that of professionals working in and familiar with the region. Interviewees were asked three main questions:

- I. perceptions of Gippsland women and gender diverse people's needs in their area of expertise and any changes over time;
- II. perceptions of services in this area and any changes over time; and
- III. reflections on strengths and sources of hope or optimism.

Analysis

Survey: We exported community survey response data from Qualtrics to Microsoft Excel for analysis. For the closed questions we used Excel to create data displays to communicate findings, which are presented throughout the report. For open-ended questions, we used a thematic analysis approach to identify and analyse common themes that emerged across responses. This method allowed us to identify patterns of meaning within the dataset and provided insight into participants' experiences and perspectives on health and safety issues in the Gippsland region. We initially identified codes then created a coding framework and refined these through an iterative process into a series of broader themes. We then compared these with focus group themes to develop a final, combined list.

Focus groups: All focus groups were recorded, transcribed using confidential AI functionality within Microsoft Teams or Word, and checked against recordings by GWH staff and de-identified. Two GWH staff undertook thematic analysis of the de-identified transcripts. Responses to each question were coded and illustrative quotes identified. Next, codes were reviewed, modified and aggregated into themes. These were compared with the themes identified based on the survey data and a final list compiled for reporting.

Ethical Considerations

To acknowledge their time and contribution, focus group participants were reimbursed, and survey participants had the opportunity to enter a prize draw. Participants' data was stored in accordance with GWH's privacy policy. All analysis was conducted in de-identified data sets and transcripts and participants have been given unique ID codes to protect anonymity. Certain potentially identifying details in participants' quotes have been modified for the same reason, taking care to preserve the meaning of the quote. During the project, focus group and interview recordings, transcriptions and survey responses were securely held by GWH for the purposes of analysis and reporting, with information kept confidential in accordance with our Privacy Policy. Recordings were deleted on publication of the report.

Limitations

Given the size of the overall sample, survey and focus group participants' views and experiences are not a statistically significant representation of Gippsland women and gender diverse people. People already interested in health, safety and gender equity likely were drawn to participate and are over-represented within the sample, while people who lack convenient internet access, the ability to navigate online environments, or English fluency would not have been able to participate. As noted, trans and gender diverse people's experiences are also not represented in the quantitative data due to existing data collection and reporting approaches.



APPENDIX 2: WHO WE HEARD FROM

Community Members

In total 197 community members participated in the *Healthy Women, Healthy Gippsland 2025* Report Card project – 166 completed the survey and 41 joined a focus group, including 10 people who participated in both (Fig. 67).

Gender

The overwhelmingly majority of participants were women (96.5%) with the remaining 3.5% identifying as non-binary or genderqueer.

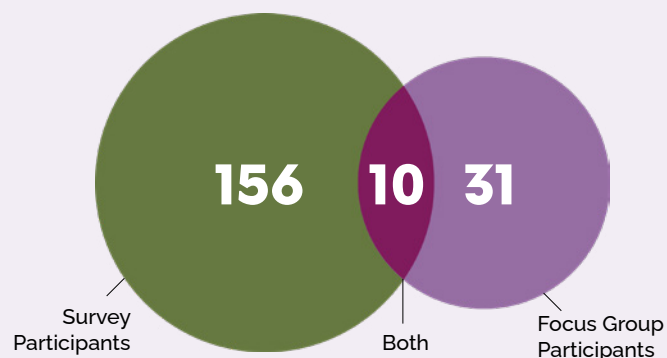
Age

While participants were aged from under 18 to 83 years, most were between 26 and 65 years of age (Fig. 68).

LGA of Residence

Participants were relatively evenly divided among Gippsland's 6 LGAs (Fig. 69).

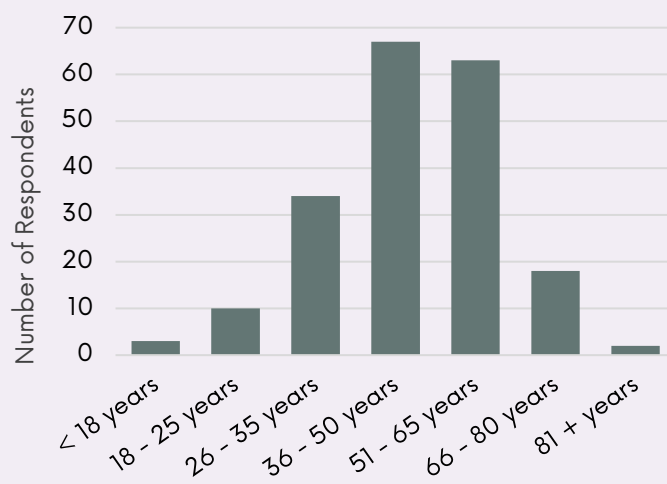
Fig. 67: HWHG 2025 Report Card – community member participants



Source: GWH HWHG 2025 survey and focus groups

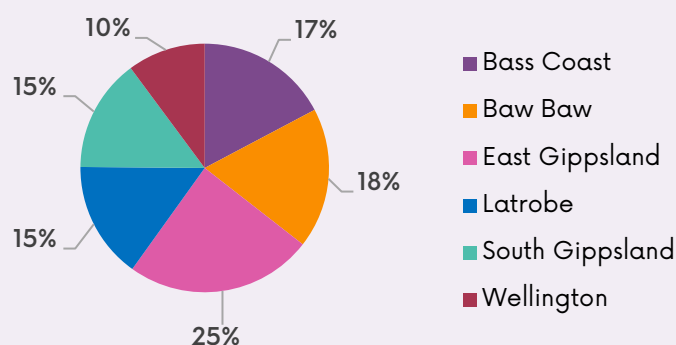
N=197

Fig. 68: HWHG 2025 Report Card community participants – age distribution



Source: GWH HWHG 2025 survey and focus groups

Fig. 69: HWHG 2025 Report Card participants – LGA of residence



Source: GWH HWHG 2025 survey and focus groups

Work and Other Activities

When asked if they were engaged in paid work, domestic duties, volunteering or studying, most participants (77%) nominated one activity, while the other 23% nominated at least two. Fig. 70 shows the sole or primary activity of all 197 participants.

Compared with Gippsland women as a whole (Fig. 60), a slightly higher percentage of HWHG participants were in full-time work (39% vs 36%) and a lower percentage were in part-time and casual work (37% vs 51%). The 2% who indicated 'other' were a mix of people who were self-employed, carers or living with a disability. No participants who indicated 'other' reported that they were unemployed (seeking paid work).

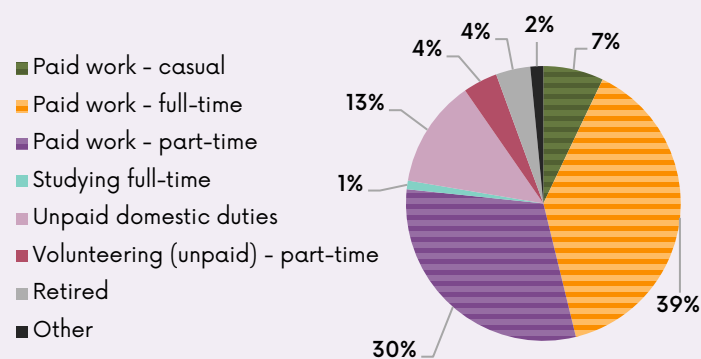
Caregiving Responsibilities

Around half (48%) of the women and gender diverse people we spoke to had caregiving responsibilities (Fig. 71). Most were caring for children still at home (31%) with another 5% caring for older relatives or friends, and 4% caring for an unwell or disabled relative or friend. Eight percent of participants had more than one caregiving responsibility, while the remaining 52% did not have any caregiving responsibilities currently.

Relationship Status

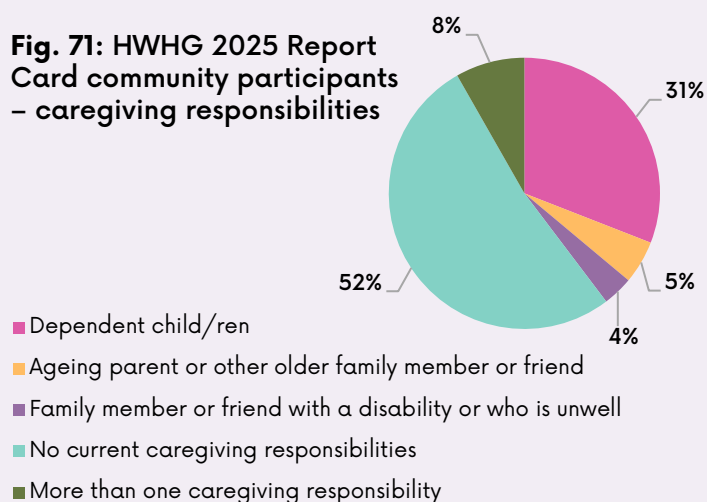
As shown in Fig. 72, seven in 10 of the women and gender diverse people we heard from were partnered, and most (65%) lived with their partners. A further 11% were separated, divorced or widowed, and 19% were single.

Fig. 70: HWHG 2025 Report Card community participants - primary activity (work, study, domestic duties, volunteering)



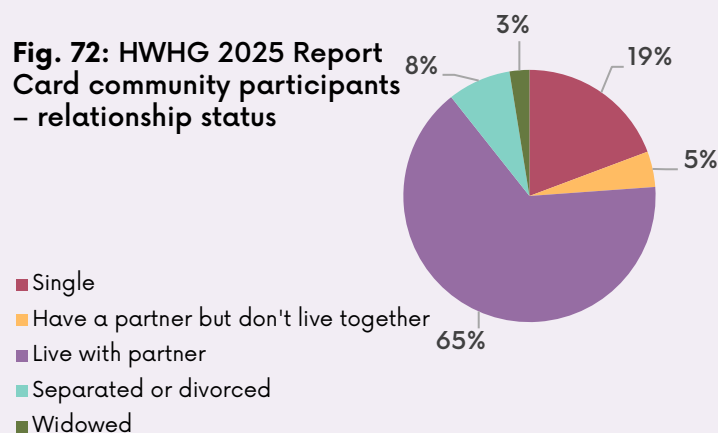
Source: GWH HWHG 2025 survey and focus groups

Fig. 71: HWHG 2025 Report Card community participants - caregiving responsibilities



Source: GWH HWHG 2025 survey and focus groups

Fig. 72: HWHG 2025 Report Card community participants - relationship status



Source: GWH HWHG 2025 survey and focus groups

Key Informants

We spoke with the following four regional sector experts in relation to their areas of expertise:

GWH priority area	Key informant interviewee
Chronic illness	Andi Connell , A/Deputy Director, Gippsland Regional Public Health Unit
Gendered violence	Kim Adams , Principal Strategic Advisor, Gippsland Family Violence Alliance
Mental health	Susanne Lampitt , Mental Health Promotion Officer, Latrobe Regional Health (RN / MHN, Principal Master MHFA Instructor)
Sexual and reproductive health	Catherine Bateman , Sexual Health Nurse, GP Services, Latrobe Community Health Services (Nurse Practitioner Candidate)





