

International Women's Day and the right to health: a view from the clinical frontline

As this issue of the *MJA* is published, the world will be celebrating International Women's Day on 8 March 2025 and the rights of women continue to be critical to health. As a general practitioner working in the sphere of women's health for several years now, I have seen the gradual shift towards a more conservative view of women's health and a lack of equity around the management of chronic health issues. Hormone replacement therapy to treat menopause, for instance, continues to be out of reach for many due to high costs and poor access. More broadly, women continue to have experiences with a health system that is often invalidating and traumatic. The impacts of these are especially worse for women from socially disadvantaged backgrounds, Indigenous women, immigrants and refugees, and women with disabilities.

Menstrual issues are a common presentation in primary care and, despite their high prevalence and impact on daily functioning, they continue to be under-reported and undermanaged. In this issue of the *MJA*, Wilson and colleagues (<https://doi.org/10.5694/mja2.52596>) report on heavy menstrual bleeding in a cohort of women participating in the Australian Longitudinal Study on Women's Health from young adulthood to midlife. The prevalence of heavy menstrual bleeding increased from 17.6% at age 22 years to 32.1% at 48 years. Almost a third of the cohort reported heavy menstrual bleeding by middle age that has a significant impact on mood and social and physical functioning. Mean health-related quality of life scores for women who reported heavy menstrual bleeding were lower in all domains and for the summary mental health and physical health scores than for women who reported never or rarely experiencing the condition; the differences were greater for women who often experienced heavy menstrual bleeding. Although the study was unable to examine conditions such as a history of fibroids or adenomyosis as a cause for heavy menstrual bleeding, most middle-aged women in Australia struggle to access progesterone-producing implants due to the cost and lack of access to the service (<https://www.bayer.com.au/en/womens-health-collaboration>). Worse, if the condition fails to respond to hormonal measures, as noted by my colleagues and I, women struggle to access gynaecological care for further treatment in the current cost-of-living crisis.

Kirkman and colleagues (<https://doi.org/10.5694/mja2.52602>), in their research article in this issue of the *MJA*, found that of the 80 clinical guidelines in Australia they examined, there were varied levels of inclusiveness in dealing with sex and gender matters in health care and most guidelines were at the lower end of the inclusiveness scale. The majority of the 80 guidelines (46 of them) made no mention of clinical practice concerning gender. Only 12 developed ideas of gender in any detail, including discussion of topics such as gender inequality, transgender health and intersectionality. The remaining 22 either implied aspects of gender awareness without stating this or mentioned "psychosocial" or "cultural" considerations that could relate to gender, demonstrating at least awareness of the contexts within which people live. This has been a persisting issue for vulnerable populations that most guidelines are developed with a heteronormative focus on cisgender males. The lack of



gender- and sex-specific guidelines has likely impacted the understanding of the pathophysiology underpinning common clinical conditions in women such as endometriosis and adenomyosis.

The *MJA* continues to publish important and innovative research into issues affecting marginalised and vulnerable communities. In this issue, Dissanayake and colleagues (<https://doi.org/10.5694/mja2.52593>) have published research examining the impact of Hope for Health, a culturally sensitive four-month program supporting self-managed health improvement based on dietary and lifestyle change for a community in northeast Arnhem Land. The program was led by a local steering committee of Yolŋu women, supported by a small Balanda (non-Indigenous) team. The program, delivered in Yolŋu language and concepts, provided knowledge about metabolic health and the causes of modern lifestyle diseases. This information was shared in a supportive setting to encourage and allow people to make informed choices about how to manage the challenges of dietary and lifestyle improvement in their own way. Participants made tangible changes to their weight, but, most importantly, health behaviours that are linked to better health outcomes were improved. The intake of breads and cereals and sugar-sweetened beverages declined, and the amount of walking and moderate and vigorous physical activity increased by a median of 103 minutes per day. The program's focus on integrating healthy bodies and networks of kin, healthy governance, vibrant language and ceremony, and a healthy environment were seen as central to its value and benefit.

Clinical research is unlikely to provide long-lasting improvement in health outcomes if it does not consider the needs and voices of the most marginalised and disadvantaged people. Doing so needs to become a national priority, as an increasing number of Australians struggle to maintain good health in these financially trying times. ■

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