



10 point plan

For Victorian Women's Health 2010-2014

Developed by Victorian Women's Health Services

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1 Introduction

Victorian women and Victorian women's health services have a notable history of successfully advocating for, and acting to improve, women's health outcomes.

In 2006 Victorian women's health services developed a comprehensive document, *Women's Health Matters: From Policy to Practice – Setting an Agenda for Victorian Women's Health 2006-2010* that included a 10 point plan. This was endorsed by almost 30 women's services and other organisations and was used to influence government and other political parties in the lead up to the November 2006 elections.

The 2006 document was influential in driving priority setting for women's health within government, and in developing a common set of agreed priorities across the women's health sector. It argued for a new approach integrating women's health policy with other areas of government policy in a coordinated way, embedding gender in the 'social determinants' approach to health policy and practice.

Much of the argument and rationale behind the priority setting for the 2006 plan remains relevant for 2010 and beyond. There has been progress in many areas, and there remains significant scope for continuing improvement in women's health outcomes – for instance ensuring that key women's health programs and services are accessible and responsive to the diversity of women across Victoria.

The 10 point plan 2010-14 builds on the 2006 document and reiterates the call for a whole of government strategy and action plan for improving women's health. The plan is cognisant of existing state policies and service systems as well as emerging state and national policies. It is imperative that these initiatives are developed in close collaboration with the women's health sector, with a strong emphasis on measurable, transparent outcomes.

2 Victorian and National Women's Health Policies

Background

More than twenty years ago (in 1987) Victoria adopted a 'dual strategy' approach to women's health, which involved the development of independent health services for women alongside the reforming and re-orienting of existing health services to consider gender in planning and service delivery. This approach led to the establishment of nine regional women's health services and three state-wide services, focussing on advocating for women's health.

Since that time there have been a number of Victorian women's health initiatives, each with their own priorities and action plans. The most recent is the Women's Health and Wellbeing Strategy (WHWS), launched in 2002 and updated in 2006. The 2006 WHWS acknowledged the importance of taking a social determinants approach to health policy, and established three priority areas for action – mental health and wellbeing, sexual and reproductive health, and social connectedness. The 2006 WHWS also saw the creation of a Gender and Diversity Lens for use by the Department of Human Services (DHS) in policy and program development. This is an important tool that should be implemented across the departments of health and human services, as well as all publicly funded services.

The election of a new Federal Government in 2007 signalled a positive change for women's health services, with a commitment to re-establishing a national women's health policy. The Victorian women's health services have been active in the development of the policy, which is due for release in mid 2010.

Alignment of Victorian strategies to the National Women's Health Policy

State and national women's health policies should be aligned with the 10 point plan 2010-14, highlighting the importance of gender equity in health, health equity between women, a focus on prevention, and a strong and emerging evidence base, which are all outlined as key in the national policy discussion paper.

While the national policy recognises the importance of health equity between women, given that some groups of women are at higher risk of poor health and wellbeing than others, it contradicts this approach with a proposal to adopt a 'lifecourse approach' to women's health. This is a narrow and simplistic way of responding to the diversity and complexity of women's lives and their health needs.

Instead, it is suggested that a 'diversity approach' be adopted that aligns with a social determinants approach to health and can be more inclusive of factors including age - such as Aboriginality, cultural, religious and linguistic diversity, disability, sexual identity, geographic location and socioeconomic status.

Once the National Women's Health Policy is finalised and adopted, alignment between national priorities and the approaches and priorities of all state and territory health plans will support positive outcomes for women and national standards of best practice. Substantial synchronicity between the proposed directions of the NWHP and the priorities outlined in this paper already exist.

3 Snapshot of Women's Health in Victoria

In August 2006, there were 2,512,007 women in Victoria comprising 50.9 percent of the state population. Thirty percent were born overseas and 15,397 women identified as Indigenous.¹

Despite living in a prosperous state and having access to a wide range of generalist and specialist health services, there are still many areas of social, economic and health inequities faced by Victorian women. Some of the differences and inequities that must still be redressed are outlined below:

Women's health outcomes

- Unlike men who experience more fatal injuries and diseases, women experience a higher prevalence and incidence of non-fatal health problems, resulting in higher rates of disability burden for women. This means that even though women live longer, often more of their lives are lived in ill-health and disability.²
- For Victorian women under the age of 45, violence is still the leading contributor to death, disability and illness.³
- The greatest burdens of disease for women across Australia in 2006 were heart disease, stroke, Alzheimer's and other dementias, depression, and breast cancer.⁴
- In 2001 the leading cause of disability burden for both men and women in Victoria was depression.²
- Estimated Indigenous life expectancy in Victoria is much lower than non-Indigenous at only 65.1 years for females born between 1996 and 2001⁵ – unfortunately information reported from the 2006 Census is not sex-disaggregated, therefore updated statistics are not available.

Some factors that impact on women's health

- Only 57 percent of women participate in the paid workforce (compared to 72 percent of men).⁶
- Across Australia, women's average full-time weekly earnings are 17.4 percent less than men's, with the gap increasing over the last year. When part-time and casual work is taken into consideration, the total earnings gap between men and women is 35 percent.⁷
- Women have significantly less rates of superannuation savings than men, as well as lower median amounts - \$13,400 for men compared \$6,400 for women.⁸
- 71 percent of primary carers in Australia are women⁹ - with over one in four (26 percent) women carers reporting fair to poor health compared to 12 percent of women generally¹⁰ and over 10 percent of primary carers reporting a stress-related illness.¹¹
- In 2006, 87 percent of one-parent families with children under 15 years were headed by women.¹²

4 A 10 Point Plan for Victorian Women's Health 2010-14

Government commitment to women's health must improve women's health status as well as improving environmental, social and economic outcomes for women. Victorian women's health services advocate the following 10 points for action over the next five years.

1. Embed a **social determinants framework** in the approach and actions of the state women's health policy, based on the accepted premise that social determinants impact on the health of individuals, families and communities through social, environmental, economic, biological and gender factors.
2. Adopt a **gender equity approach** that uses tools such as a gender responsiveness framework, DHS Gender and Diversity Lens and legislating gender equity requirements. Victorian publicly funded services (including health services) should plan for and report on gender and diversity. This includes a commitment to **gender-based analysis of health outcomes**, to enable the development of effective interventions, and evaluation of those interventions.
3. Resource implementation of a **human rights approach** that identifies and prioritises the rights of groups of women at higher risk of poorer health and wellbeing, including those with multiple needs and multiple indicators of disadvantage.
4. Develop a model for **social inclusion** in government policy and service delivery that takes in to account the different ways in which women from diverse sub-cultures create community and relate to the broader community - such as women in metropolitan, regional and rural communities, Aboriginal and Torres Strait Islander women, immigrants and refugee women, women with disabilities and same-sex attracted women.
5. Adopt a **diversity rather than a lifecourse approach to women's health** policy that recognises the diversity and complexity of women's lives and health needs, including life course. This should be aligned with a social determinants approach to health inclusive of factors such as Aboriginality, cultural, religious and linguistic diversity, disability, sexual identity, age, geographic location and socioeconomic status.
6. Retain and increase funding to **women's specific services**.
7. Demonstrate **high level cross-government leadership** by implementing meaningful joined-up action across government departments via coordination and oversight by the Premier's office. This requires a whole-of-government framework and target setting through the Premier's office, with each ministerial portfolio required to develop explicit strategies to meet outcomes that are measurable and reported against on a regular basis.
8. Provide **new funding** to ensure that new initiatives and research can realistically deliver required changes and improvements.
9. Establish and resource mechanisms that ensure an **inclusive approach** to development and delivery, with women's health advocates involved in priority setting, service delivery and evaluation processes. This includes the establishment of Women's Advisory

Committees within each of the critical portfolio areas, and the establishment of diversity units across all government departments.

10. Resource the following key *priority areas and recommendations*:

- Women in a changing society;
- Sexual and reproductive health;
- Prevention of violence against women; and
- Mental wellbeing and social connectedness.

10.1 Women in a changing society

Recommendations for action by the Victorian Government

- 1) Fund a comprehensive gender analysis around the response to, and impact of, climate change and related natural disasters on women – specifically in relation to the allocation of resources, decision making, planning and differential impacts on women.
- 2) Amend the *Victorian Equal Opportunity Act* to include a requirement that all private and public sector agencies report against a gender equity framework.
- 3) Fund research relating to women in a changing society and disseminate findings on topics including:
 - a. the impact of paid and unpaid work and inequitable work/family balance on women's health;
 - b. the impact of economic and environmental change on women (including bushfires), and responses by women;
 - c. women and homelessness arising from increased housing prices, poverty, discrimination, family violence, bush fires and displacement;
 - d. the impact of war on women refugees, implications for resettlement opportunities and gender analysis of settlement process for refugees and new immigrants;
 - e. the impact of the recent global financial crisis on women.

Evidence for action

Rapid and constant change within modern society presents challenges for all members of the community. While emphasis is required in each priority area to attend to the impact of change on women, there are two areas where change has been so rapid and so pervasive that a specific, new priority area is required. These are globalisation (including the 2008/09 financial crisis, population changes driven by high levels of immigration, and women's economic participation) and climate change (including bushfires, drought, global warming, water shortage and water allocation policies). A gendered analysis reveals that these changes present particular challenges for women, with many having a direct impact on their health and wellbeing.

Australian and international research in these fields has shown that:

- Women and men's decisions in times of crisis differ along risk-taking lines, use and type of coping strategies, adaptability, and advice-taking and information-seeking behaviours.¹³ Existing gender roles and inequalities shape responses so that new

challenges and changing conditions can magnify and create new inequities and vulnerabilities.¹⁴

- In relation to the impact of extreme environmental events a significant proportion of women live below the poverty line; rely upon state supported social services; and are subject to male authority in the household regarding use of emergency assistance assets and key decisions about evacuation and relocation.¹⁵
- There is typically a differential impact of fires on health, with women and others of low socio-economic status found to be worse off.¹⁶
- As identified in the national review of drought policy in 2008, there were significant changes in gender roles as a result of drought (such as women seeking more off-farm employment and increasing their contribution to farm work), as well as other gendered impacts including increased isolation and lack of supports provided.¹⁷
- There is little existing analysis about the role that gender plays in bushfire situations, despite evidence that the frequency of very high and extreme fire days will increase by up to 25 percent by 2020 and 70 percent by 2050 across south-eastern Australia.¹⁸
- Long-term exposure to financial hardship has a negative impact on health, and women are especially affected.¹⁹
- Many women experience anxiety about their futures, with the knowledge that financial independence is unlikely in post-retirement or later years resulting from their reduced lifetime earnings.²⁰
- The impact of poverty and financial uncertainty upon women, coupled with gender specific inequities that are greater for marginalised and minority women, increases the likelihood of poorer health outcomes and decreased quality of life.²¹

10.2 Sexual and reproductive health

Recommendations for action by the Victorian Government

- 1) Fund the development and implementation of a statewide sexual and reproductive health strategy, based on current research and consultations already held.
- 2) Fund translation of research into practice in relation to women's sexual and reproductive health and disseminate findings on topics including the link between violence against women and rates of sexually transmitted infections, abortion, cervical cancer and pregnancy.
- 3) Continue with implementation of compliance with the *Abortion Law Reform Act 2008*:
 - a. Expand the existing statewide pregnancy support helpline through additional funding, to enable the provision of information and counseling about women's options including safe and legal abortion and referrals to services providing abortion;

- b. Take action to ensure women accessing abortion services are not targeted and harassed by anti-choice picketers;
 - c. Implement a requirement in funding agreements that all publicly funded sexual and reproductive health services, including those providing termination of pregnancy and contraception, meet catchment needs;
 - d. Ensure education, training and professional development on provisions under the *Abortion Law Reform Act 2008* for all relevant health professionals, including through medical and nursing courses.
- 4) Fund and implement comprehensive sexual and reproductive health education programs in schools that include:
- a. standardised curriculum, teacher training/time and requirement for school commitment to delivery;
 - b. accountability mechanisms to ensure compliance and use of best practice;
 - c. and an emphasis on health promotion/prevention opportunities;
 - d. within a framework of healthy relationships and joint responsibility between young men and women.
- 5) Develop and fund strategies to combat the increasing sexualisation of young women and girls evident in media and product marketing.

Evidence for action

Reforms to abortion law in Victoria were welcomed by Victorian women's health services and the vast majority of Victorian women when enacted in 2007. A wide range of other sexual and reproductive health remains a critical concern for Victorian women. In the absence of a comprehensive sexual and reproductive health strategy, the following issues are likely to remain problematic, and in fact worsen, in future:

- For young women in Years 10 and 12, experience of unwanted sex has increased from 28.1 percent of sexually active female students to 37.8 percent in 2008.²²
- Chlamydia was the most frequently reported infection notified in Australia in 2008, with 58,456 newly diagnosed cases. Among women, the rate of Chlamydia diagnoses doubled from 89.5 per 100,000 in 1999 to 179.7 per 100,000 in 2003, and almost doubled again to 323.5 in 2008.²³
- In 2008, 2.4 percent of sexually active Year 10 female students had been diagnosed with a sexually transmitted infection (STI) and 3.4 percent of Year 12 students (compared with 2.9 percent of Year 10 and 1.9 percent of Year 12 male students).²⁴
- Young same-sex attracted (SSA) people surveyed were five times more likely than their heterosexual peers to report having an STI, with 9 percent of young SSA women reporting having an STI.²⁵
- The current fertility rate in Victoria is 1.87 babies per woman (below the national rate of 1.93). This has increased since a low of 1.61 in 2001, with the greatest proportion of births in Victoria occurring for women in the 30-34 age group.²⁶

- Infertility is a growing concern with approximately one in six Australian couples taking longer than one year to conceive a planned pregnancy during their reproductive life²⁷ and Victorian women increasing their overall number of infertility treatment cycles from 10,118 in 1999 to 17,560 in 2008.²⁸
- Aboriginal and Torres Strait Islander women are generally younger than non-Aboriginal women giving birth, with almost 75 percent aged below 30. This is compared with less than 50 percent of all women giving birth in Australia aged below 30[1].²⁹
- Over half of all women (51 percent) have experienced an unplanned pregnancy, and at the time of their unplanned pregnancy, 60 percent of women were using at least one form of contraception.³⁰
- At the time of their unplanned pregnancy, the largest group of women using contraception were on the pill (43 percent), while 22 percent were using a condom.³¹
- A large representative national survey found that 22.6 percent of women aged 16-59 years in Australia report ever having had an abortion.³²
- Studies in Australia and internationally consistently indicate an emphatic association between partner violence and abortion, indicating that efforts to prevent partner violence could also reduce levels of unwanted pregnancy. For instance a study of 9,683 young Australian women aged 22 to 27 found that those reporting abortions either as teenagers or later in their 20s, were more than three times as likely to have been abused by a partner as those who didn't terminate.³³

10.3 Prevention of violence against women

Recommendations for action by the Victorian Government

- 1) Fully fund the implementation of 'A Right to Respect: Victoria's Plan to Prevent Violence Against Women 2010-2020', including culturally-specific prevention and response strategies for diverse communities.
- 2) Fund women's health services to continue to work in new settings for violence prevention.
- 3) Ensure that the Women's Health and Wellbeing Strategy includes actions from the State Plan to Prevent Violence Against Women that are specific to women's health and wellbeing.
- 4) Fund broader initiatives that reflect an understanding of the United Nations definition of violence against women (including factors such as workplace sexual harassment and violence, female genital mutilation, trafficking in women and forced prostitution, and pornography).
- 5) Fund the development of research, information and community resources (to be delivered through a range of media, including new media) about violence against women reflective of the UN definition (see p. 15).

- 6) Fund women's health services to develop strategies to redress problems arising from multimedia (including the internet and mobile phones) such as cyber bullying and cyber safety.
- 7) Develop strategies to increase service provider, legal sector and general community awareness of the effects and prevalence of partner rape to ensure:
 - a. Increased awareness of criminality;
 - b. Increased number of criminal charges laid;
 - c. Building the capacity of service providers and the judiciary to respond appropriately to women experiencing partner rape;
 - d. Promoting community understanding of women's rights within relationships.

Evidence for action

The data and research findings around the problem of violence against women demonstrate that, despite many years of government attention, significant additional effort and action is required to adequately address the massive social, economic and health impacts of such violence. Newly emerging problems include the increase of violence through activities such as cyber bullying, and increasing homelessness related to family violence resulting from the critical shortage of affordable and accessible housing in many Victorian communities.

- For Victorian women under the age of 45, violence is the leading contributor to death, disability and illness.³⁴
- 1 in 3 Australian women experience physical violence, and 1 in 5 experience sexual violence, in their lifetime³⁵. It is estimated that 1 in 10 experience rape from an intimate partner.³⁶
- Women represent nearly 90 percent of reported rapes and 76 percent of reported sexual assaults.³⁷
- Women with disabilities, regardless of age, race, ethnicity or religion, are twice as likely to experience violence than other women, but less likely to receive an adequate service response.³⁸
- Domestic violence is the leading cause of homelessness in Victoria, with women and children still being forced in the majority of cases to flee the family home.³⁹
- Women who have experienced violence are more likely to suffer mental health problems including depression, anxiety, post-traumatic stress disorder, self-harm tendencies and suicidal thoughts.⁴⁰
- Violence against women is associated with ongoing physical conditions including chronic diseases, disabilities, irritable bowel syndrome, smoking and substance misuse.⁴¹
- In 2005, 114,500 women reported having experienced intimate partner violence in the twelve months prior to the survey.⁴²

- In 2005, for women who experienced violence during the last 12 months, over three-quarters (76 percent) of the violence was perpetrated by someone they knew, with over one-quarter (26 percent) of women reporting that the violence was perpetrated by a partner.⁴³
- Aboriginal and Torres Strait Islander women are more likely than non-Aboriginal women to be a victim of violence. Around 22 percent of Aboriginal and Torres Strait Islander women over the age of 18 reported that they had been a victim of physical or threatened violence in the twelve months prior to being surveyed.⁴⁴
- Forty percent of young same-sex attracted females in one study reported being abused at school. Abuse reported by males and females ranged from having clothes and possessions damaged, to rape and hospitalisation for injuries.⁴⁵
- A 2005 study found that 14 percent of students had been victims of cyber bullying.⁴⁶ While US research shows gender differences in cyber bullying strategies,⁴⁷ Victorian research is required to understand this rapidly growing problem (64 percent of houses in 2007 were with internet, compared with 16 percent in 1998⁴⁸).

10.4 Mental wellbeing and social connectedness

Recommendations for action by the Victorian Government

- 1) Apply a gender-sensitive lens in implementing the recommendations in 'Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019'.
- 2) Fund services to develop programs to work with girls in schools to promote mental health and wellbeing (to include initiatives that address bullying, alcohol use and abuse, body image, self-harm, depression).
- 3) Fund improved access by women to mental health prevention activities and programs, particularly for Aboriginal and Torres Strait Islander women.
- 4) Provide funding for implementation of recommendations on gender sensitivity and safety in adult acute inpatient units (as outlined in the 2008 report by the Mental Health and Drugs Division, Department of Human Services)

Evidence for action

Sex and gender differences are not adequately taken into account in mental health research or service provision in Victoria. This is despite evidence by the World Health Organisation that gender differences are evident in the onset, prevalence, diagnosis, trajectory, co-morbidity, treatment, prognosis and outcomes of mental health and depression. Some of the key statistics for Victoria and Australia include:

- Mental health and wellbeing is directly related to social context, with depression more common in situations of extreme stress combined with inadequate support, such as

that experienced by newly-arrived migrant and refugee women, women with disabilities and new mothers.⁴⁹

- Mental illness is responsible for approximately 15 percent of the total disease burden in Victorian women.⁵⁰
- Depression is known to be more common among people who are economically vulnerable or who live in poverty, and this is predominantly women and children.⁵¹
- Almost one in ten Victorian women seek professional help for a mental health related problem. Mental health is also linked to physical health with chronic depression being one of the leading causes of disability in Victorian women as well as being strongly associated with cardiovascular heart disease and stroke.⁵²
- Women are more likely to suffer with more than one mental illness at a time (co-morbidity), which is linked to increased severity of mental illness and increased disability.⁵³
- Isolation and barriers to women's full participation result from a combination of factors including unmet mental health needs, family violence, and women's greater burden of family responsibilities combined with difficulties accessing resources and services such as childcare and public transport.⁵⁴
- Young women aged 15-19 years are three times more likely to be admitted to hospital for self-harming than their male counterparts.⁵⁵
- Homophobic abuse has a profound impact on wellbeing, leaving those abused feeling less safe at school, at home, on social occasions and playing sport.⁵⁶ Self harm, legal and illegal drug use as a response to abuse is greater among young women than young men.
- In Victoria, women and girls account for 94 percent of the total disease burden related to eating disorders.⁵⁷
- Aboriginal and Torres Strait Islander women are twice as likely to report high or very high levels of psychological distress compared to non-Aboriginal women. When surveyed in 2005, two-thirds (66 percent) of Aboriginal and Torres Strait Islander women reported low/moderate levels of psychological distress and 32 percent reported high/very high levels of psychological distress in the month before the survey.⁵⁸
- Many women in adult acute inpatient units have experienced abuse, trauma and violence, both within mental health services and at other times. However research has shown that negative responses by mental health providers to the reporting of sexual assaults by inpatients can result in low reporting rates with one study finding only 50 percent of assaults being reported.⁵⁹

5 Conclusion and next steps

Victorian women's health services recognise that there is significant capacity to improve the health and wellbeing of Victorian women, and are committed to being part of the proposed solutions as outlined in this document.

Through collaboration and partnership with women's health services, as well as increased resources, the Victorian government could take a leadership role in developing a new approach to women's health. A cross-government approach, coordinated through the Premier's office, is vital to achieving the desired outcomes and improvements.

The lead up to the 2010 state election provides an opportunity to rethink and evaluate past approaches, and develop a new vision that will measurably reduce the inequities and poor health outcomes faced by Victorian women.

6 Definitions

The **social model of health** recognises the effect of social, economic, cultural and political factors and conditions on health and wellbeing. It is a conceptual framework for improving health outcomes, aimed at preventing and reducing illness and addressing inequalities and disadvantage that exist within the community.

The social model of health includes:

- Recognition of the broad social, economic and environmental determinants of health and illness
- The importance of health promotion and disease prevention
- The importance of community participation in decision making
- The importance of working with sectors outside of health
- An understanding that equity is an important outcome of health service intervention.⁶⁰

A **social determinants of health** approach recognises that some groups in society have a much poorer chance of achieving their full health potential as a result of their life circumstances – including political, social, economic and environmental conditions. Basically, the most disadvantaged groups have the poorest health and the highest exposure to health-damaging risk factors. The life circumstances or determinants of health include people's social and economic circumstances, indigenous status and ethnicity, disability, stress, gender, early life development and experiences, social exclusion, work and unemployment, and social supports.⁶¹

The **United Nations defines 'violence against women'** as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Violence against women is understood to encompass, but is not limited to:

- (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.⁶²

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