

10 Point Plan Partners



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Women's Health Matters: From Policy to Practice

**Statewide Summit
Held 13 July 2006**

PROCEEDINGS

Darebin Arts and Entertainment Centre
cnr Bell St & St Georges Rd Preston
Melbourne, Victoria ,Australia

Published by Women's Health Victoria
Level 1, 123 Lonsdale Street
Melbourne Victoria 3000, Australia
(GPO Box 1160, Melbourne, 3001)

Telephone: 03 9662 3755
Facsimilie: 03 9663 7955
Email: whv@whv.org.au
URL: <http://www.whv.org.au>

Published on behalf of the 13 partners to the Women's Health Advocacy Action Plan activities and 10 Point Plan Summit:

Gippsland Women's Health Service
Multicultural Centre for Women's Health
The Royal Women's Hospital
Victorian Women with Disabilities Network
WIRE Women's Information
Women's Health East
Women's Health Goulburn North East
Women's Health Grampians
Women's Health in the North
Women's Health in the South East
Women's Health Loddon Mallee
Women's Health Victoria
Women's Health West

These proceedings were edited by:

Marilyn Beaumont, Women's Health Victoria and
Chris Black, Black Ink Consulting.

First Published 2006

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ISBN: 0 9757540 3 3

For further information contact any of the partners listed above.

**WOMEN'S HEALTH MATTERS: FROM POLICY TO PRACTICE
2006 STATEWIDE SUMMIT
13 JULY, 2006**

**PROCEEDINGS
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INTRODUCTION

In November 2005 a report was made to the Women's Health Services who are the partner organisations behind the holding of the summit, on a project to develop a communications framework and strategy to:

- Increase the profile of women's health services
- Increase the understanding of their roles amongst stakeholders
- Act politically in getting recognition of women's health, and
- Work together to get delivery of a statewide women's health policy with a gendered social analysis of health in broader health and related policies.

This report was the underpinning for the Women's Health Advocacy Action Plan November 2005 to November 2006. This Plan has a number of elements including:

- the development Women's Health Matters: from Policy to Practice A 10 Point Plan for Victorian Women's Health 2006-2010 (attachment 1)
- Advocacy for a range of organisations influential across the social determinants of health to endorse the 10 Point Plan. As at July 2006 these were:

Arthritis Victoria
Australian Institute for Primary Care
Australian Women's Health Network
Carers Victoria
CASA Forum (Centre Against Sexual Assault Forum)
Centre for Culture Ethnicity and Health
Country Women's Association of Victoria Inc
Domestic Violence Victoria
Eastern Domestic Violence Outreach Service Inc
Elizabeth Hoffman House Aboriginal Women's Service
Family Planning Victoria
Gippsland Women's Health Service
Health Issues Centre
Immigrant Women's Domestic Violence Service
Key Centre for Women's Health In Society
Multicultural Centre for Women's Health
Municipal Association of Victoria
Public Health Association of Australia (Victorian Branch)
Queen Victoria Women's Centre
Royal Women's Hospital
Tweddle Child and Family Health Service
Union of Australian Women (Victoria)
Victorian Aboriginal Community Controlled Health Organisations
Victorian Alcohol & Drug Association
Victorian Community Health Association
Victorian Council of Social Services
Victorian Local Governance Association
Victorian Women with Disabilities Network
WIRE Women's Information
Women's Domestic Violence Crisis Service
Women's Health Association Victoria
Women's Health East
Women's Health Goulburn North East
Women's Health Grampians
Women's Health in the North
Women's Health in the South East
Women's Health Loddon Mallee
Women's Health Victoria
Women's Health West
Victorian Women and Mental Health Network

- The holding of a Victorian Statewide Summit focused on the 10 Point Plan.

The Summit was held in Melbourne on 13th July and was attended by 200 people.

Participants represented a wide cross-section of organisations with influence across the social determinants of health, health promotion advocacy capacity and political connection. This included:

- State Government Members of Parliament and departmental officers;
- Local Councils (Mayors and staff);
- women's organisations and women's health organisations;
- ethno specific and health issue specific groups;
- peak organisations; and
- representatives from the 40 organisations that have endorsed the Plan.

The intention of the organisers was to have the proceedings transcribed as the basis for a publication from the Summit. A transcriber was present from the beginning of session 2. This is reflected in this publication.

WHY WOMEN'S HEALTH MATTERS

Women are different from men and experience life differently, both in sickness and in health. Growing up, and as adults, women have different experiences based on both biological factors and gender roles. As well as the obvious anatomical differences, these include genetic, hormonal, psychological and social factors. In responding to women's health issues we must recognise and acknowledge these differences, without overshadowing or dismissing the commonalities they share with men.

There are some conditions that affect more women than men, such as arthritis, major depression, osteoporosis, eating disorders and the health impacts of family violence. There are also gender differences in relation to the presentation of heart disease, patterns of HIV infection and the susceptibility to alcohol related damage. And there are some conditions that only affect women, such as pregnancy, childbirth and menopause.

However women's health is still too often seen by many as being just about women's reproductive health. While this view remains, particularly amongst those in decision making positions in government and in the health care system, women's health will continue to be compromised by policies and programs that simply don't respond to their needs.

Despite the growing international recognition of gender as a determinant of health, this awareness has yet to be incorporated into mainstream health policy, and in the design and delivery of programs and services. Victoria has made some progress in this area over the past 20 years, but not enough.

Better outcomes in women's health have benefits for individuals and their families, and for the broader community. Flow on benefits are extensive and include greater participation and productivity by women in the paid and unpaid workforce, and less demand for high cost health services to be funded by government.

These better health outcomes can only be reached by having health policy that is approached from a gendered and whole of government perspective – one which responds to the broad range of economic, social and cultural factors that impact on health outcomes for women.

SUMMIT AIMS

From a women's health perspective, the aims of the Summit were to:

- Develop shared understandings of the policy and practice potential of gender as a social determinant of health
- Explore the application of gender within health priorities
- Share learnings that health is promoted most successfully when there is support for activity at all health promotion levels and across different sectors
- Provide impetus for development of integrated health promotion plans across Victoria
- Broaden the potential for inter-sectoral collaboration
- Network and share ideas about working in different ways to achieve better health outcomes

OPENING OF SUMMIT

Facilitator: Marilyn Beaumont, Executive Director, Women's Health Victoria

Welcome to the 2006 Statewide Summit - Women's Health Matters: from Policy to Practice, a 10 Point Plan for Victorian Women's Health 2006-2010.

And to the celebration of the 21st birthday of the launch of "*Why Women's Health*".

In Joy Murphy Wandin's absence I want to acknowledge the traditional owners of the land and acknowledge that we are meeting on country for which the Kulin Nation people and their ancestors have been custodians for thousands of years. We acknowledge and pay our respects to the Kulin Nation people and to past and present Elders and give thanks for allowing us to meet here today.

I want to make a few remarks about how this day came into being. Last year four things coincided:

The first of these was the April 2005 Australian Women's Health Network National Women's Health Conference held in Melbourne. This amazing conference finished with Ilona Kickbusch's powerful vision for the future where she called on all Australian States and Territories to continue the development of women's health policy and practice in Australia and, amongst other things, hold state summits over 2006-2007 leading into a national summit.

The second of these was the need to do better in building capacity and broad coalitions which are necessary to take women's health and health promotion beyond where we have been. Some glimmer of what was wanted was emerging from the high level of interest we were seeing in the women's health services forums which began to include primary care, community health and DHS staff more broadly. Along with the opportunities we have to capture this potential as we develop our three year 2006 - 2009 health promotion plans across the state.

The third of these was the November 2005 report to the Women's Health Services who are the partner organisations behind the holding of the summit, on a project to develop a communications framework and strategy to:

- Increase the profile of women's health services
- Increase the understanding of their roles amongst stakeholders
- Act politically in getting recognition of women's health, and
- Work together to get delivery of a statewide women's health policy with a gendered social analysis of health in broader health and related policies.

The fourth of these was a conversation with Kay Setches (former Victorian Minister). Twenty-one years ago the women's health movement was one of a number of broad social change forces. This movement grew out of women wanting something different from health services. Wanting more control about the decisions which impact on their health. Kay reminded me that we create a better future by understanding and building on the past, by translating what we now know into current and future contexts of women's lives. And we are not done with this yet.

These four things have come together today in this Summit, and further work will include what comes out of the Summit.

The 13 partners in the 10 Point Plan and the Summit are:

- Women's Health Victoria,
- Women's Health in the South East,
- Women's Health Goulburn North East,
- Women's Health Loddon Mallee,
- WIRE Women's Information,
- Women's Health East,
- Women's Health Grampians,
- Victorian Women with Disabilities Network,
- Women's Health West,
- Gippsland Women's Health Service,
- Women's Health in the North,
- Multicultural Centre for Women's Health, and
- The Royal Women's Hospital.

We have VicHealth, the women's health services and health promotion services to thank for their financial help in organising the Summit and producing the banners.

There has been incredible work done by women's health service staff and supporting organisations in generating the 10 banners and seeking endorsements resulting in the 40 organisations who have endorsed the 10 Point Plan, many of whom are represented here today.

In welcoming each one of you I would like to make particular mention of some.

- Minister for Women's Affairs, Mary Delahunty MP
- Member of the Victorian Parliament, and Parliamentary Secretary for Justice, Jenny Mikakos MLC
- Advisers to the Premier and Minister for Women's Affairs,
- Eight of the 27 women Mayors in Victoria
 - Mayor Heather Mutimer of Hepburn Shire,
 - Mayor Lisa Price of LaTrobe ,
 - Mayor Libby Mears of Surf Coast Shire,
 - Mayor Janet Bolitho of Port Phillip,
 - Mayor Jan Vonarx of Alpine Shire,
 - Mayor Mary Fraser of Towong Shire,
 - Mayor Lynette Gunter of Murrindindi Shire and
 - Councillor Kathleen Maltzahn representing Mayor Jackie Fristacky of Yarra City.

And in acknowledging people let me say that without people's energy and hard work to make good ideas become reality this day would not be happening. In particular for this I would like to thank members of the Committee which it has been my privilege to chair:

- Kathleen Walsh, from Women's Health in the North;
- Diane Wilkinson, from Gippsland Women's Health Service;
- Liz Chatham, from Royal Women's Hospital; and
- from Women's Health Victoria - Chris Hazell, Petra Begnell, Kerrilie Rice.

This day is about you coming together with us to have a conversation, to develop a shared understanding about "Why Women's Health", to move on from that to explore new frontiers, and generate a shared understanding to implement a new way forward.

To help us get underway it is my pleasure to introduce Kay Setches to give the opening address.

OPENING ADDRESS

The Hon. Kay Setches - 21 years ago - the development of 'Why Women's Health?' 2006 - Why Indeed?

Kay was elected as a Member of the Victorian Parliament in 1982. Between 1986 and 1988, she chaired the Victorian Women's Health Policy consultation with 6000 Victorian women which culminated in the establishment of the now multi-million dollar Victorian Women's Health Program.

Between 1988 and 1992 Kay was Minister of Conservation Forests & Lands and Minister of Community Services & Minister for Child Care. Kay has undertaken consultancies for the Federal Government's Office for the Status of Women, Australian Council for Overseas Aid Agencies and the Kathleen Cunningham Foundation.

In 2001 Kay received the Centenary of Federation Medal and was added to the Victorian Honour Roll of Women – 'Women Shaping The Nation', for significant contributions to Victoria. She is currently a member of the Queen Victoria Women's Centre Trust Board; and a foundation Member and past Victorian Co-convenor of EMILY's List Australia.

Distinguished guests.

Thank you for inviting me to participate in this important and historic gathering. In 1985 when asked by the then Minister for Health David White to convene a working party, with a view to develop a Victorian Women's Health Policy, I and the other members of the working party were determined to bring to the development of that policy the broadest possible view of women's health.

All of the Working Party, including those excellent women, Terry Jackson, Rose Sorger and Bernadette O'Connell resolved to take into account women's social, economic, and working environment, as well as the necessary medical and physiological aspects of women's lives.

That broad view, a social model of women's health which was quite radical at the time, was adopted in the contents of the Working Party's discussion paper "Why Women's Health" which was released in December 1985, for community consultation.

- 4000 copies were distributed
- 344 questionnaires and 77 submissions were completed, representing a response from 7,000 women
- 45 face to face consultations were held by the Working Party

The Discussion paper and consultation acted as a catalyst to raise the debate among women on the issue of Women's Health Services.

The discussion paper found that,

"WOMEN WERE THE MAJOR USER OF HEALTH SERVICES, AND THE MAJOR PROVIDERS OF PAID AND UNPAID HEALTH CARE, AND THAT WOMEN'S HEALTH ISSUES WERE RARELY GIVEN PRIORITY IN TRAINING OR RESEARCH, AND WERE MAINLY DIRECTED BY MEN."

The discussion paper also showed that the causes, patterns and treatment of health and illness, frequently differ between men and women.

The Working Party canvassed the need for new policies and special new health initiatives, which were women centred and women operated.

It raised the questions:

- Are women getting what they need and want from the \$2.25 billion spent in Victoria each year on health services?
- Were Victorian women having their health needs and requirements met by existing generalist health services as they were then directed and operated?

The Working Party, in examining the range of comments and responses from women during the consultations showed the need for the adoption of a “dual strategy” to provide separate women’s health services run for and by women, and accountable to women.

Because the majority of women were always expected to use generalist health services this “dual strategy” would, over time, influence existing health services to meet the needs of women which are in most cases their major users!!

Because of the staggering size of the job that the Working Party encountered in addressing this dual strategy, and my understanding of the cyclical nature of Government budgets, we produced an urgent Interim Report to the Minister of Health in time for the 1986/87 State Budget.

This report did not, could not, document the full picture of women’s health needs.

This report was never publicly released.

As history now shows, as a result of the interim report, the Minister allocated \$400,000 in a full year to a women’s health information service, plus \$400,000 for the first women’s health service. Other outcomes of this report included:

- The appointment of Victoria’s first Women’s Health Adviser
- Establishment of a Women’s Health Unit with 5 permanent positions in the Health Department
- Most importantly the Adviser reported to the Chief General Manager AND the Minister.
- In addition, significant resources were directed to sexual assault services.

The Working Party recommended the establishment of 10 new health services run for and by women. The establishment of these services was to be completed by financial year 1991/1992.

The Working Party’s final report contained the following principles designed to provide the framework for the future development of women’s health policy and health services

- Women should have equal access to all health services
- Policy and programs should give recognition to the different health needs of women
- Women should be represented and able to participate equally in decision making processes.

Most of the recommendations were accepted for implementation by the Government.

In my view there is no separating the political from what occurs around us. It is my way to approach issues in a political manner.

I was not appointed the Chair of “Why Women’s Health” consultations because of my medical knowledge (which is minuscule compared to any person here today).

At the time I was the Chair of the State ALP Parliamentary Women’s Caucus and Chair of the State ALP Parliamentary Health Caucus

One of the main reasons I was made Chair was to find a political solution to ensure that women’s health was placed front and centre on the Cain Government’s political and health agenda in the lead up to the 1988 State election.

The Women’s Caucus at the time included great women like Joan Kirner, Margaret Ray and Caroline Hogg who saw the development of a women’s health policy as one of the major planks of the Government’s Social Justice Strategy.

I saw this was a great opportunity to work with women to bring about a positive reform for women users of the Victorian health system. It was also attractive to ensure that the Government in which I served made a lasting and positive initiative for women’s health.

I am a committed feminist Labor woman who had my own health experiences that had informed my opinions about a social model of women’s health.

The Minister, David White, knew from our Interim Report that any funding of women’s health was going to require major new funding. The Premier, John Cain, wasn’t convinced of the need for a dedicated women’s health program.

The funds for the Women’s Health Program (WHP) were urgently included in the forward estimates for the state budget by David White. New funding initiatives have to clear a number of hurdles.

One of the hurdles was John Cain’s red pen! John used his red pen and removed the WHP allocation. David White reinserted the allocation. John removed it again. They were at loggerheads!

I went to John Cain and appraised him of the urgent need for a WHP and for the funding to be in the coming budget. He was not convinced or moved. He said that the \$2.25 billion general health budget was enough – nothing further was needed.

This was two days from the delivery of the Government’s State Budget by the Treasurer to the Parliament. With dismay I advised David White that as there was no funding in the Budget for the WHP, I would resign the Chair of the Working Party (but not my seat!)

I also told him I would issue a press release immediately the Budget was delivered stating that I had resigned because I had let the women of Victoria down and so had the Government.

I knew this action would destroy my political career, however I was deadly earnest. I was also terrified of the furore and dissension this would cause.

David White acted quickly and decisively.

The health budget papers were pulled from the printing press and re-printed with the WHP allocation included and the budget was delivered with the first funding of a Victorian Women’s Health Program

This removed any reason for me to resign as Chair and I was extremely happy that the program had been funded. David White re-distributed money from the Health budget, and new money was provided in the following year’s budget.

Who controls the money is always a hugely important issue!

Twenty one years is both a long time and a short time. It is a short time to effectively change the whole medical scene in Victoria to improve health services to better respond to women's needs.

However it is long enough for an assessment of positive changes that have occurred and to organise to accelerate change.

The concentrated attack and cutbacks in the years 1992-1998 on public services was particularly brutal on health services. However we fought on! We held on and in many cases the services grew and prospered - where they kept their funding!!

In 1986 I could only dream about having a well funded women's health program as there is now in Victoria. I'm advised that \$8 million annually is spent on women's health services across Victoria.

- This is an increase of 46% since 1999
- This is out of a health budget of \$8.25 billion

In addition, Victorian women benefit from:

- The building and fitting out of a brand new Women's Hospital currently underway
- National prevention programs such as Breastscreen
- Training of women doctors and specialists, who were rare as hen's teeth 20 years ago.
- Improvements to understanding of women's health in training of medical professionals.

So many improvements and gains have been won. Wonderfully, the women's health services in Victoria have acted in the way I had hoped they would, acting as catalysts to address many other social and health related issues facing women such as housing and counselling.

Even though I'm impressed with the gains that have been made by women in ensuring that Government is providing better and more services that suit women, I want to now make a case for revitalising the continuation of a social model of women's health.

I see things through a prism: the gender prism (as well as the political prism). Gender analysis is my primary examination of many issues and matters facing women and our community.

Where are women placed today in the Australian and global Community?

I am very pleased to say there have been some changes in women making gains in decision making roles – for instance:

- All Political parties have more women MPs
- In particular, ALP Governments in Australia have significant percentages of women MPs
- Victoria has 40% women MPs.
- There are 8 women Ministers in Victoria.

However more progress in other areas is urgently required. Men or men's influence control almost all aspects of how we live our lives here in Australia and indeed the world! Women's power is still severely limited.

Men are over represented in the judiciary. Men control the worldwide entertainment industry, and the portrayal of women's bodies is a major product and women and girls are a primary target of this industry. They own and control the worldwide media, which is geared to support the entertainment industry and is often indistinguishable with cross promotion.

Men control and are over represented in recreation and sport. As an example, international level Netball players recently organised to get \$20,000 each per annum, whereas previously they were paid as low as \$5,000.

Can you see elite sportsmen standing for this?

Men control much of the worldwide research and development in medical, pharmaceutical and other disciplines that have enormous impact on women's health and their ability to live happy healthy lives. They control Trade and International Trade Organisations. They control the military across the globe!

And men ensure that arms manufacturing is one of the major global trading commodities.

Men head the established religions and belief systems that we are most familiar with. They control financial institutions (except for Ann Sherry), and women are still a rarity on Private Industry Boards.

Mary Delahunty as Minister for Women's Affairs, has led the way by ensuring the 40% target of women on Government Boards and bodies has been exceeded before allocated time.

Women make up very few of the CEOs of the top firms. When we think Stock Exchange do we think of women? Industry Superannuation has been the exception, with super funds like HESTA, UniSuper and Cbus.

Work and family research has shown that women do the caring and most of the work in the home. Men share very little of the daily household chores. I read that redistribution of time worked from women to men is at the rate of 1 min per year.

Who cleans the toilet is a good test. Who does the family remembering and scheduling of everything is another! And women farmers do a triple shift: work, home and farm.

Don't misunderstand me. I am not a man hater – far from it!

I am describing the wider situation women face. In my experience, women don't often seek power to tell others what to do!

Women generally wish to work with others in a cooperative positive environment and see clear gains and outcomes.

Women know that a community worth living in has to include women's participation and value their unique experiences and talents. Power to act as a group is political power! Today's gathering is a case in point!

Who will make differences on our behalf if we don't force change? Who will fight if we don't?

Many men can't see that there is a problem or that anything needs to be changed. You will have your own cache of incredible responses from men to women's (your) efforts to

make real and structural change in the power relationships affecting your and your family's lives.

And there is so much still to be done:

- Equal Pay for work of equal value
- Sole parents living in poverty
- Meaningful and permanent jobs
- Abolition of violence and sexual assault of women, children
- Paid Maternity Leave
- Removal of abortion from the Crimes Act

Affordable quality, convenient Childcare

- Life long affordable learning and training
- Support for women to choose to have or not have children!

There are the new fights:

- Federal Government Industrial relations and welfare hooliganism
- Environment – greenhouse and water
- The nuclear energy threat - all over again! (with a woman fronting this debate)
- Genetically modified and additives in foods.
- Human rights – support for human rights for asylum seekers and refugees
- Understanding and international support for women's economic and social positions through out the world.
- Religion and belief systems being used to subdue, repress, violate and humiliate women.
- Globalisation and concentration of power in fewer men's hands
- Trafficking of millions of people especially women and girls in slavery for men's gratification and profit.

No wonder we feel under threat and a bit drained at times.

The organisations that have endorsed the 10 Point Plan show that women's health organisations are correct to take up this fight at this time. Though they are appreciative of the women's health services programs now provided, we women are not satisfied!

The State Government is currently working on the second 'Women's Health and Wellbeing Strategy' – so it is important that you move now to have your requests included. The Minister is supportive of this strategy and will value your support to get it up and funded.

Deliberate carefully:

- Is the 10 Point Plan an ambit claim?

What is the most important of the 10 points?

My belief is that each point is equally important. Some of my suggestions would be:

- Ensure consumer input to health decision making
- Make sure sexual health policy is high on the agenda because of the need to decriminalise abortion
- Also address the sexualisation of young girls – and the silent frightening Chlamydia rates, with loss of fertility which will put pressure on other areas of health spending as well as destroy so many young women's lives.
- Prioritise domestic violence as a health issue using the economic arguments that have proved so persuasive.

Prioritise and use political nous.

Now is a crucially politically important time. We are only four months from a State election. 40% of the State Government members are women. These MPs will want to hear about a social model of women's health –but you have to be very clear what you want them to support.

Currently the Liberal Party has four women MPs and the National Party has only one woman MP in Victoria. Speak to these women about the need. Speak to the candidates that hope to be MPs. Both Houses of Parliament will be facing election.

Research on how to influence politicians was undertaken in 2005 by a national public affairs company Parker and Partners

- 60 interviews were conducted with State and Federal politicians.
- Pollies reported there was nothing more frustrating than listening to a negative story with no solution being put on the table.
- 60% found the offering for a solution by an organisation or an individual to be highly positive.
- 36% found data to be a highly effective influencing tool.
- 61% said that non-Government organisations or community-based organisations are influential on their decision making.

Here are some thoughts I would like to leave you with in your quest to get women's health programs and funding up higher on the political agenda:

- Marshall your arguments and data - and 'Go get 'em'!
- Build coalitions with like-minded men. They do exist and are increasing in number.
- Have courage! Old fashioned Guts! Be Unstoppable! We are doing this for so many other women as well as ourselves.
- It is OK to be living on the edge and be an activist.
- It is OK to drop in and out of activism. There are many campaigns that have been fought and won and so many more still to win!
- Be generous to your women friends, colleagues and co workers
- Take sustenance and inspiration from each other.
- Savour each victory small and large – make a meal of every gain!

Most of all, try to have some fun!

Good luck in addressing some of these matters today.

PANEL SESSION 1 - MOVING FORWARD FROM 'WHY WOMEN'S HEALTH' – GENDER AS A DETERMINANT OF HEALTH

Chair: Liz Chatham

Speakers: Dr Dorothy Broom, Dr Robert Hall

Facilitator: Marilyn Beaumont

Session 1: Priority Issues

- Clarify our understanding of the evidence of the relationship between gender and health.
- Gender is currently absent from most broad understandings of health determinants. What impact does this have on health across the population?
- Where do we see gender as a determinant of health incorporated into current policies and programs? What are the benefits of this approach?
- How would including gender as a determinant of health enrich the work already being done?
- What tools can be employed to achieve this? Eg. gender based analysis

Our Chair for this session is Liz Chatham who is currently the Director of Women's Services at the Royal Women's Hospital. In this role she is responsible for maternity, cancer, abortion, gynaecological services, health promotion and allied health programs for the Women's.

Liz has been a member of the WHV Council for 19 months and has a long commitment to women's health. In particular, her interest is in integrating and promoting the social model of health and health promotion into service models with the goal of improving women's experience of care.

Liz will introduce each of the speakers in this panel session.

Dr Dorothy Broom - Senior Fellow at the National Centre for Epidemiology & Population Health at the Australian National University. - “Complicating Gender”

Dr Dorothy Broom has spent more than 30 years teaching and studying gender and other aspects of the sociology of health and illness. In 1991, she published “Damned If We Do: Contradictions in Women’s Health Care”, a political history of Australia’s feminist community health centres. She also played a pivotal role in the successful defence of a sex discrimination complaint brought against the Commonwealth, the National Women’s Health Program and ACT women’s health services. The decision on this test-case for Commonwealth and State targeted services stands as a landmark for its recognition of a social view of health. Dr Broom is currently a Senior Fellow at the National Centre for Epidemiology & Population Health at the Australian National University.

Thank you for the invitation to be here on this important occasion. Part of my presentation today draws on work I have been doing with Dr Sharon Friel (Sharon Friel and Dorothy H. Broom, in press ‘Unequal society, unhealthy weight: the social distribution of obesity’. Chapter in Jane Dixon and Dorothy H. Broom (eds), *The Seven Deadly Sins of Obesity: How the modern world is making us fat*. (UNSW Press). However, Sharon has not had the opportunity to design any of my errors that may follow.

The ambiguity of the title for my presentation today is intended. Gender complicates:

- Collecting health statistics
- Designing policy and programs
- Delivering services

In addition, I want to complicate how we think about gender. In doing so, I will be raising questions about how we currently represent and advocate for women’s health. My intention is to encourage a more effective and nuanced approach.

Instead of nailing down fixed definitions and presenting a compelling linear argument about gender as a determinant of health, I explore two particular instances of population health patterns in an effort to unpack what might be at stake in thinking critically about gendering health.

The examples I consider here are obesity and smoking, by many accounts two of the most consequential health risk factors for contemporary populations in rich and poor nations alike. Like most other risk factors for ill health, excess weight tends to be more prevalent among people further down the social and economic scale, so that sectors of the population who are most disadvantaged in other respects are also more likely to be too heavy.

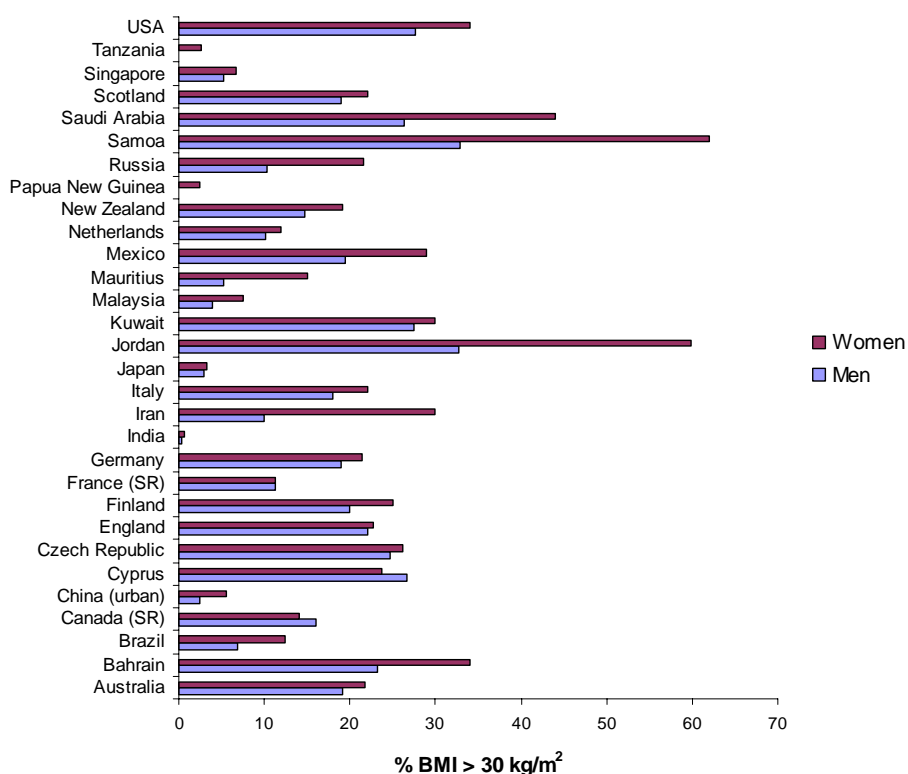
There is an inverse association between obesity and socio-economic position (SEP). There is also a high prevalence of obesity among ethnic minorities.

Internationally, this description applies mainly to rich societies, and it is very different from how one would have described the situation a century ago when thinness tended to be associated with malnutrition and disease, so that heaviness was more prevalent among the wealthy, especially wealthy men.

Overall, people with higher income or better education are less liable to be obese than their poorer, less educated counterparts.

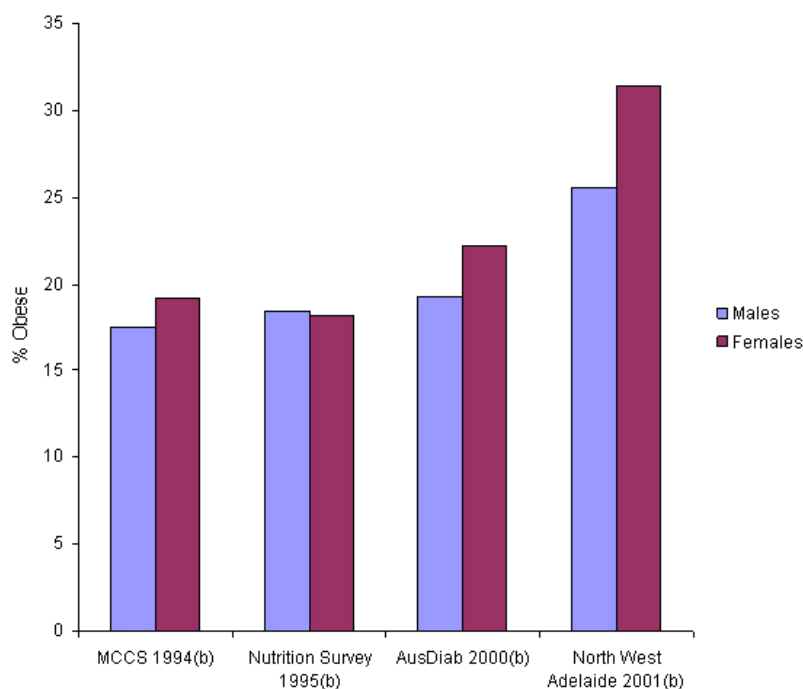
Internationally, obesity is also systematically distributed by gender, with higher prevalence of obesity among women (shown in red bars in Diagram 1) although overweight (not shown) is more prevalent among men.

Diagram 1: Percentage adults obese (BMI>30) by country:



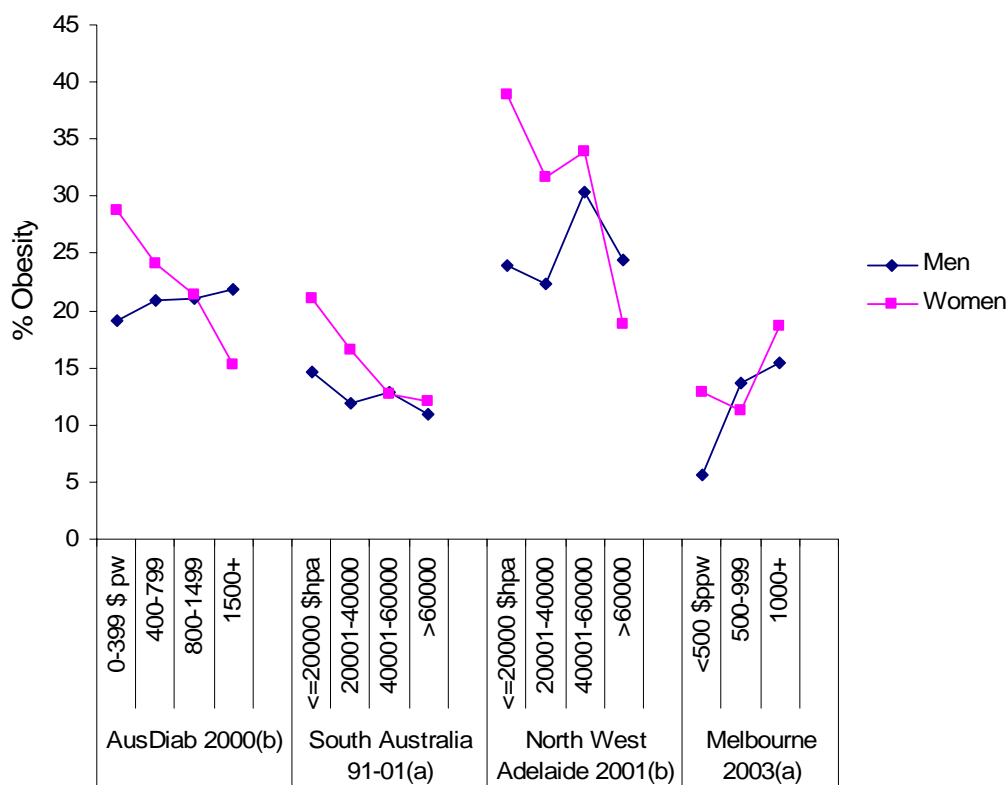
<http://www.asso.org.au/home/obesityinfo/stats/worldwide/links>, accessed March 2006.

Diagram 2: Prevalence of obesity in Australian adults by gender (1994-2001) – measured height and weight.



Australia conforms to the international pattern. Here you also see the rapidly rising prevalence (see Diagram 2). However, looking at SEP and gender together, complications emerge.

Diagram 3: Prevalence of obesity among Australian males and females by income (Australia 1999-2000; South Australia 1991-2001, 2001; Melbourne 2003)



(a) Self report height and weight (b) Measured height and weight

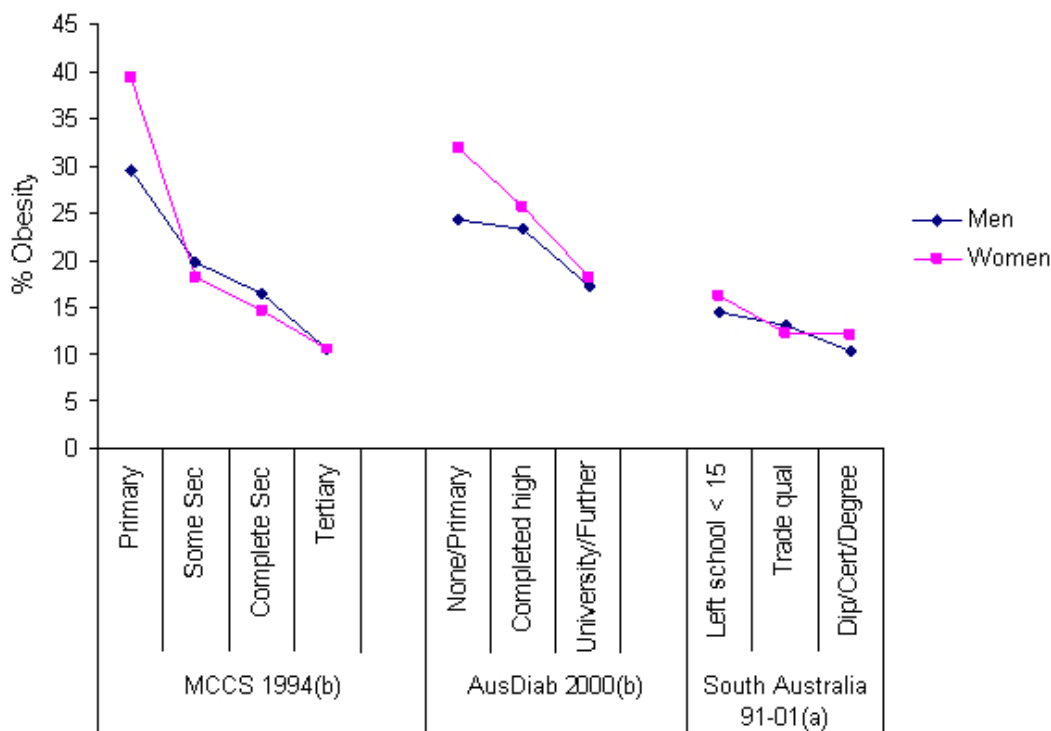
Diagram 3 the prevalence of obesity by levels of *income* for men and women in 4 surveys. The figure suggests that the expected negative association is fairly consistent among women, but is less distinct or even absent for men. Indeed, there is a suggestion of a positive relationship between obesity and income (men on higher incomes more likely to be obese) in three of the studies which is contrary to both the typically inverse association between SEP and health risk, and also to the pattern observed for women.

This finding is echoed by studies from several developed nations reporting that the inverse relationship between SEP and obesity is relatively consistent among women but less clear or absent among men.

Education presents a more regular picture of declining obesity prevalence with increasing amounts of education for both sexes (See Diagram 4).

Thus, while obesity has been unequally distributed in the Australian population for at least 15 years, the nature of the relationship between SEP and obesity appears to differ for men and women, depending on the specific indicator of socio-economic position.

Diagram 4: Prevalence of obesity in Australian male and female adults by level of education (Australia 1999-2000; South Australia 1991-2001; Melbourne 1994)



(a) Self report height and weight (b) Measured height and weight

Compared to education, income may be more ambiguously related to obesity, as it permits high level consumption, including consumption of food and leisure activity that may encourage or discourage healthy weight. In the Australian surveys, high income was associated with healthy weight among women, but not among men. Perhaps the sexes are buying different goods and services with their incomes.

Why might this be?

Internationally, longitudinal studies suggest that obese women incur much more significant economic penalties for their weight than obese men do, whether the penalty is measured in terms of income or wealth. In the US, obese white women are most disadvantaged financially by their weight, whereas white men and black women who are obese suffer little economic disadvantage, while obese black men pay no penalty at all, perhaps because they are already so disadvantaged.

The chances of being married are more compromised for women than men who are obese. These findings show how race and gender complicate the interplay between weight and class, and they indicate that violating the norm of slenderness is particularly salient for women, and most salient for those women who might compete for relatively high-paying jobs, or who might marry men with such jobs.

I now turn to my second example – smoking.

Like obesity, smoking follows the socioeconomic gradient in developed societies. People lower down the socioeconomic scale are more likely to smoke than wealthier, higher status people. And like obesity, the gradient shifted during the 20th century, particularly if we define 'smoking' as the regular use of commercially manufactured cigarettes. Initially

a signifier of discretionary income, smoking was democratised, particularly by war. As its health hazards became more extensively documented and publicised, its popularity among the well-to-do declined, but not so much among working-class and poor sectors of the population.

Diagram 5 shows the gradient among women. The present SEP pattern is much the same among males.

Diagram 5: Percent females aged 25-64 regular smokers, by IRSD quintile*

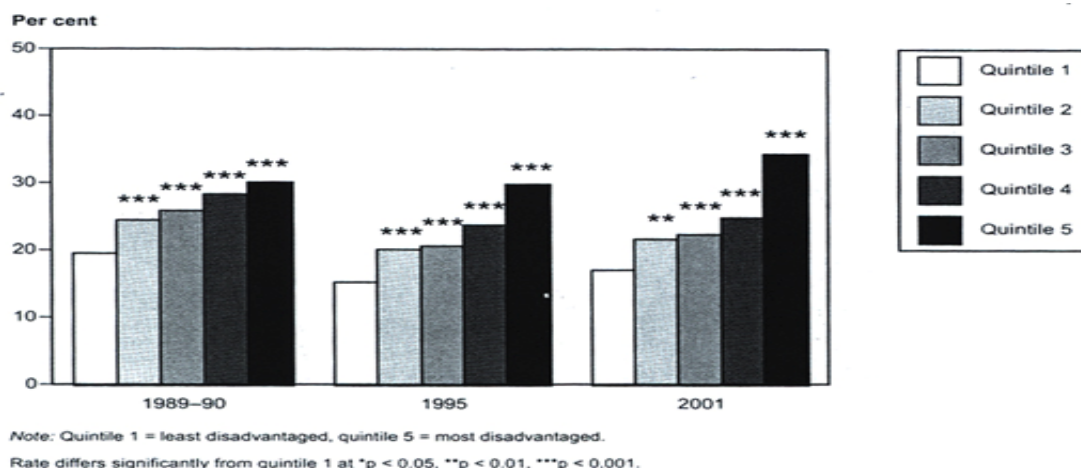


Figure 3.16: Percentage of females aged 25-64 years who were classified as regular smokers, by IRSD quintile, 1989-90, 1995 and 2001

Source: Turrell, G., Stanley, L., deLooper, M., & Oldenburg, B. (2006). *Health Inequalities in Australia: Morbidity, Health Behaviours, Risk Factors and Health Service Use (AIHW Cat. No. PHE 72)*. Canberra: Queensland University of Technology and the Australian Institute of Health and Welfare: p. 43.

In another striking shift, cigarette smoking was a masculine preserve at the beginning of the 20th century, but became a rare case of gender equality by the end, at least in the Anglo-American democracies. That is, while globally many more men than women smoke, the differential is shrinking in many nations; and in North America, the UK and Australia, there is no longer any marked or consistent sex difference.

Unlike obesity, however, as far as I am aware, when gender and class are considered together, there are few anomalies in their relationship with smoking, although this is a topic worth investigating. The dramatic transformation in the sex ratio is – for our purposes – the standout feature.

The changing relationship between gender and smoking is a remarkable story in which the tobacco industry has consistently outpaced the public health sector.

Recruiting women to smoke was not simply a matter of their increasing exposure to previously male environments during the world wars and subsequently, although those experiences played a part. Most people are now familiar with the Lucky Strike campaign ‘Reach for a Lucky instead of a sweet’ (1925) which clearly targeted women and drew an explicit link between smoking and weight control.

During the first half of the 20th century, the image of the cigarette as dirty and masculine (signifying disreputable femininity for the few women who smoked) was supplemented with the idea that smoking could be ‘not only respectable but sociable, fashionable, stylish, feminine’ and modern.

Previously secret documents from the international tobacco industry reveal a highly sophisticated appreciation of how class and age inflect gender to create an elaborately segmented cigarette market. For example, RJ Reynolds identified and developed advertising pitched toward what it labelled the 'virile female': a young working-class woman with limited education, a blue- or pink-collar job, and a fun-loving adventurous outlook

We seem to have come a long way since Virginia Slims. The 'virile female' won't smoke a brand of which her boyfriend disapproves. 'Real women' no longer need to smoke girlie cigarettes to enact femininity.

UK and Canadian research has shown that for working-class mothers isolated with young children 'cigarettes may provide the only moment when the struggle for financial survival can be suspended and they can join a world of personal consumption that most adults take for granted' (quote from Hilary Graham).

The issuing of free tobacco to Australian soldiers in both world wars consolidated smoking as a portable pleasure, accessible in the absence of all others. It reconfirmed smoking as an activity of men and linked smoking to patriotism for everyone. The traditional Australian 'smoke-o' is both classed and gendered, the working man's entitlement to a break from the toil of the job.

These histories are destabilised by various forms of resistance, including the activities of health education striving to introduce other meanings. But the effects of anti-smoking activities are not entirely straightforward, since they configure smoking as a form of resistance to 'wowsers', expert authority, condescending adults, and to the good girl image (as Cathy Banwell has shown).

Conclusion

The two cases show that 'gender' means more than 'women'. In fact, it means more than women and men as demographic categories. It must also incorporate dimensions of culture and social structure. Gender is a fundamentally relational concept whose elements constantly refer to and interact with one another, and in so doing, mutually constitute one another. It is simultaneously productive and constraining.

The cases also show the multiplicity lurking just beneath the surface of the deceptively simple dichotomy: masculine/feminine. Consequently, we should not be surprised by the fact that gender is so fraught with contradictions, confusions, incoherence and misunderstanding.

Furthermore, the case studies show clearly that public health will have limited success if it fails to incorporate gender. In so doing, the understanding of gender must be theoretically informed and empirically detailed. It must also appreciate that similar prevalence rates can be generated by highly gendered processes, so it is unwise to assume that gender is irrelevant simply because there is no sex difference in the rate of a risk or illness. Gender can only be a resource for improving health if it reflects a level of analysis at least as sophisticated as that of transnational tobacco. And that will require a theoretically nuanced understanding of how gender operates. Again, the tobacco case is illustrative.

Commentators often suggest that the gendered meanings of smoking have changed, and that the old connotations have been replaced. I propose that the case of smoking illustrates a more subtle and intricate process than simple substitution. Instead, it seems to me that the previous connotations persist as new ones are brought into play.

Indeed, I believe that efforts to offer new significations (whether to enlarge the market or improve population health) are layered on the traces of the previous meanings. That is, gender is more like the child's 'magic slate' toy than it is like a stencil. Earlier connotations are not erased completely, but continue to permeate the way people interpret and embody current meanings. It is through such layering that smoking can be simultaneously a symbol of rugged masculinity and feminine attractiveness.

Furthermore, gender is both classed and dynamic, continually creating new forms of femininity and masculinity, layered upon older ones. (And we could say the same about class).

The Indigo Girls have a useful cautionary message in their song "Be careful what you pray for". Some of the problems we have now may be results of previous success. Here are three examples:

- **Clear sex/gender distinction.** Feminists, including women's health activists, have worked hard to advance this distinction to overcome biological determinism and call attention to the social and economic dimensions of gender. But relying on the distinction creates problems at the same time as solving others. A few moments ago, I suggested that the masculine/feminine dichotomy was deceptively simple. So is the sex/gender distinction. It is often misinterpreted to mean that anything not physiologically based (eg menstruation) can be unproblematically modified at will (so any persisting inequalities are consequences of conscious, free choice.) If gender is like a magic slate, so perhaps is the sex/gender distinction, and hence our efforts to use it one way are partly subverted by the persistence of other meanings. Consequently, we have to be vigilant about the unexpected implications.
- **Mainstreaming.** Similarly, many women's health activists have sought to get gender out of a policy ghetto and on to the menu for all policy areas. However, such mainstreaming may also have unexpected consequences. In his Massey Lecture, Steven Lewis argued passionately that when something becomes everyone's concern, it becomes no one's responsibility. (Thus, mainstreaming is useful when the objective is to maintain equality, but not as a strategy to overcome inequality.) Thus, we must be strategic and specific in what we mean by mainstreaming.
- **Success.** Australia was the first country in the world to have a National Women's Health Policy (1989). With such a proud history, how can it have fallen into disuse? The National Women's Health Program has never been officially disowned, and the story is probably similar for gaps and omissions in state-based strategies and action plans. I take that to indicate that we have to devise fresh, more nuanced approaches to avoid seeming like recycling an old agenda, even though the core issues from 20 years ago remain as core issues today.

I hope today helps move the thinking and planning in that direction.

Dr Robert Hall – Director Public Health & Chief Health Officer, Victoria - “Gender as a determinant of health”

Dr. Robert Hall has worked in public health at local and international levels for the last 25 years in a wide range of fascinating roles from Aboriginal health in remote parts of the Northern Territory to polio eradication in the Western Pacific Region. He has been an adviser in communicable diseases and Acting Director of the Health Surveillance and Evaluation Unit for the Commonwealth Government and Director of Communicable Diseases in South Australia.

Dr Hall is currently the Director of the Public Health Division for the Victorian Department of Human Services and Victoria’s Chief Health Officer.

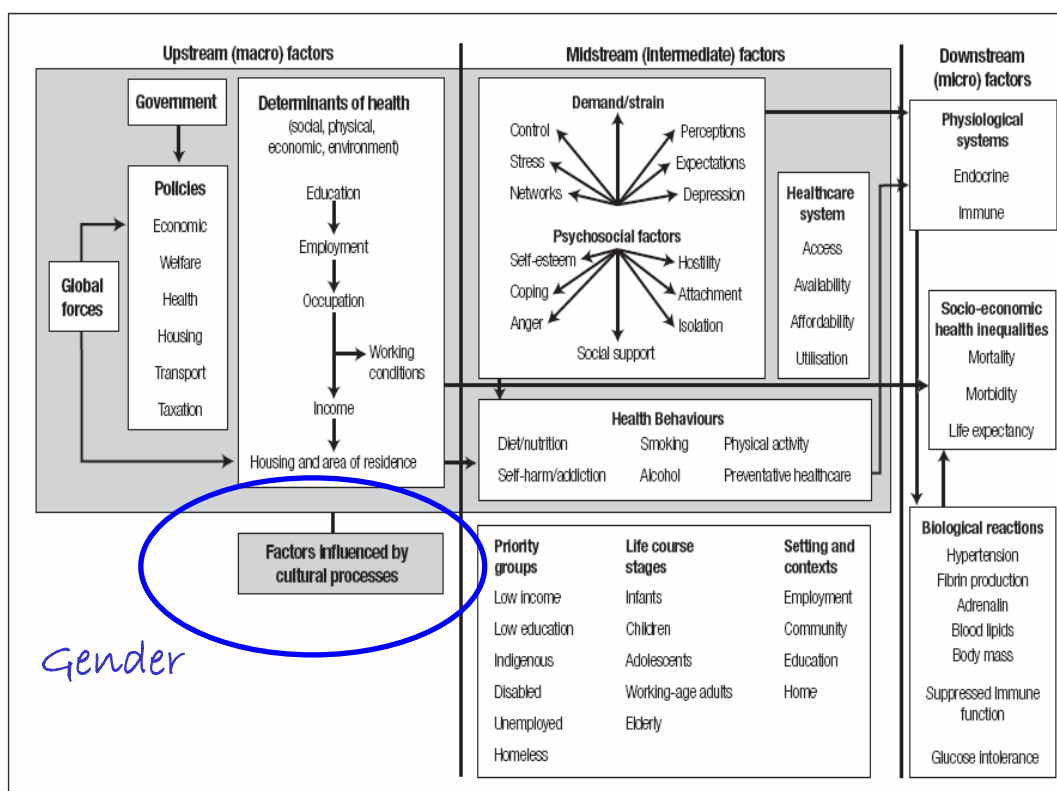
I’m conscious today that I am talking to a highly knowledgeable audience, so I want to get to the discussion part of this session without too much fuss.

Today, I am going to talk about gender as a determinant of health, and present some of the broad information that we know about women’s health in Victoria. Then I want to introduce a few discussion points for the session that I see as areas of tension in using the social determinants model of health.

A. Gender is a determinant of health

Unquestionably, what we know about what creates health and causes illness points us to recognising that gender is a very important determinant of health.

Diagram 1: The Social Determinants of Health



Source: Turrell G, Mathers CD 2000, Socio-economic status and health in Australia. *Medical Journal of Australia* 2000; 172: 434-438.

There are different ways to represent the determinants of health. No one simple representation is perfect, but you can see from this diagram representing Turrell's work in Queensland that gender is a key feature of our macro structure and this context factor shapes everything that then proceeds.

And, obviously, the influence of gender and gender relations as a determinant of health is felt at every point in the life course. And these life course impacts are cumulative.

Also, gender relations are present at every part of the health and disease pathway, and so gender needs to be considered at every stage of health promotion, disease prevention, health care and palliative care.

In understanding the connection between health and gender, we must also be careful not see everything connected to gender as fixed. Gender is a social relation. There are biological differences between men and women that impact on health and well being, but it is primarily our understanding of what it means to be men, women or others in particular contexts that is perhaps more profound.

Gender as a social relation

For example: changes in **work** and the different impact on women and men

Changing labour force participation

Figure 2.1 Married Women's Labor Force Participation Rates

| Year | Participation rate (%) |
|------|------------------------|
| 1940 | 20 |
| 1950 | 25 |
| 1960 | 32 |
| 1970 | 40 |
| 1980 | 50 |
| 1990 | 58 |

SOURCE: Bureau of Labor Statistics, Special Labor Force Data.

Norepinephrine Excretion in Male and Female Managers During and After a Day at Work (from Frankenhaeuser *et al.* 1989).

MANAGERS AT WORK

| Time of day | Female (pmol/min/kg) | Male (pmol/min/kg) |
|-------------|----------------------|--------------------|
| 10 | 2.1 | 1.8 |
| 12 | 2.3 | 1.8 |
| 14 | 2.1 | 2.0 |
| 16 | 2.0 | 1.7 |
| 18 | 2.2 | 1.9 |
| 20 | 2.4 | 1.4 |

With thanks to Ichiro Kawachi for the slides

As an example, you can see with the graph on your right for male managers coming home from work is a stress releasing event, but for female managers coming home actually adds to stress.

Richard Wilkinson has reflected this understanding by showing that women, or the status of women, is in fact a determinant of the health of others. If you increase women's status in society, you improve men's health.

This points also to inequalities between women and so also differences in women's health outcomes, a point I will return to later.

That gender is relational offers us our biggest challenge in explaining health differences, but also our greatest hope for change. There is not a lot fixed and immutable in the picture of health that I am painting.

B. The health of Victorian women

You will all be very familiar with the data that we produce and that others produce on the health of women in Victoria. So I don't want to retell what you know.

I encourage you to look at our reports on the health status website and I encourage you to provide feedback to our Chronic Disease Surveillance Unit on this material.

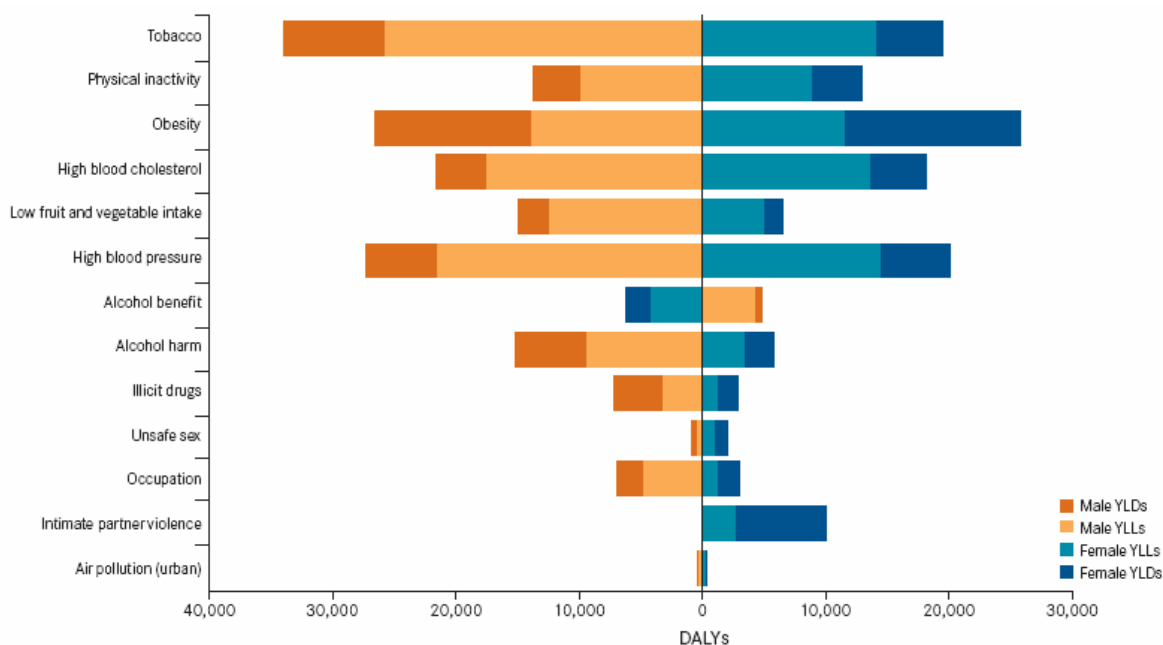
(See www.health.vic.gov.au/healthstatus for a range of health data, including information about gains in avoidable mortality by sex (1979-2001) and YLL rates for major disease groups by sex, 1996 and 2001.)

Our published data over the last 10 –15 years documents increasing life expectancies and falling death rates from key diseases, such as cardiovascular disease, breast cancer and cervical cancer.

Importantly, the large majority of Victorian women rate their own health as good to excellent. Despite these positives, a significant number of challenges continue to confront policy makers, service providers and others concerned to improve women's health and wellbeing.

Some of these areas of concern include: High rates of obesity, disability (especially among older women), smoking (associated with increased deaths from lung cancer), intimate partner violence, racist violence, depression and anxiety. These factors all feature in ongoing discussions on women's health in the State.

Diagram 4: Disease burden attributed to selected risk factors, Victoria 2001



And we also must contend with ongoing health inequalities among different groups of women. This must be a major area of concern and I hope is something that is discussed throughout today's conference. It is most definitely something that the Department is focusing its attention on. The following data clearly poses some key challenges to how we might want to work together to improve the health and well-being of all Victorian women.

Diagram 5: Avoidable mortality by Quintiles of disadvantage, 1997-2001

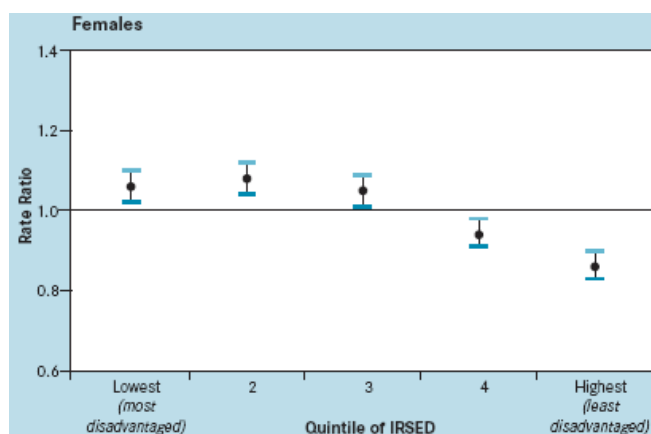


Diagram 6: Life expectancy at birth, by socio-economic status, 1996-2003

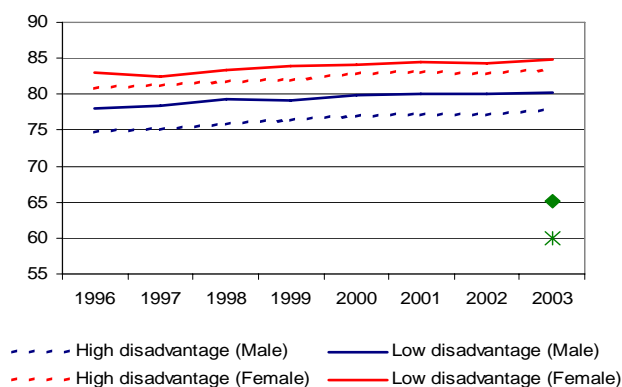


Diagram 7: Significant differences in rates of health-related factors between less and more disadvantaged areas, Australia, 1995-2001

| <i>Young women</i> | | |
|--------------------------------------|------|------|
| | 1995 | 2001 |
| Self Assessed Health as Fair or Poor | ✓ | |
| Bronchitis/ emphysema | | ✓ |
| Smoking | ✓ | ✓ |
| Obesity | ✓ | |
| Alcohol Risk | ✓ | |
| Food Insecurity | ✓ | ✓ |
| <i>Mid age women</i> | | |
| Self Assessed Health as Fair or Poor | ✓ | |
| Bronchitis/ emphysema | | ✓ |
| Smoking | ✓ | ✓ |
| Obesity | ✓ | |
| Alcohol Risk | ✓ | |
| Food Insecurity | ✓ | ✓ |
| <i>Older women</i> | | |
| Self Assessed Health as Fair or Poor | ✓ | |
| Bronchitis/ emphysema | | ✓ |
| Smoking | ✓ | ✓ |
| Obesity | ✓ | |
| Alcohol Risk | ✓ | |
| Food Insecurity | ✓ | ✓ |

C. Points of tension in using the determinants of health...

1. The whole v the parts

Firstly, the determinants of health offers an explanatory model that seeks to balance all of the factors influencing health. In giving emphasis to gender we have to be careful not to segregate gender from other influential factors. The model works as a whole rather than as a conglomeration of separate parts.

That is not an argument about not considering gender, but it is a note of caution about always representing the entire context, particularly when we discuss health inequalities.

2. Pros v Cons of lifestyle responses

Secondly, the determinant that the general public, the media and others tend to see exclusively is the lifestyle or behavioural factors. But we have to be very wary about the limited probability of behaviour causing health. Recent studies indicate that lifestyle or health behaviour differences (such as smoking, diet and risk taking) account for only 30% of health differences between social groups.

Understanding how the behaviour and the choices of individuals influence social position or health has always been a contentious area of research and social policy. Consider these three points:

- We know that there is a correlation between unhealthy behaviours and low socio-economic status. However, the impact of actions to change the former without attention to the latter has been limited.
- We know that it is the upstream, material determinants that have greatest impact and are supported by the greatest weight of evidence.
- We also know that strategies to change individual health behaviour must account for the unique influences of diverse social environments – one strategy will not fit all.

In light of this, we have to be very careful about how women are particularly targeted by lifestyle interventions.

For example, one piece of research in the US on parental time and nutritional intake of children showed that the more time mothers spend with their children the lower the children's Body Mass Index (BMI). Conversely the more time fathers spend with their children the higher the children's BMI.

You can imagine how, in seeking to halt the increase in children's BMI, the focus could shift exclusively to women. The danger is that in seeking to address the obesity epidemic we may reinforce gender role stereotypes, targeting change initiatives only to women such that while some children's health may improve, women's health will suffer.

So I think, with our understanding of gender and the determinants of health, we need to exercise a lot of caution about lifestyle interventions – despite their attractiveness.

3. Deficits v Assets

A third tension to consider is that by identifying the primacy of the social determinants of health and health inequalities we need also to continue to identify the assets in women's health.

As an example, Sally MacIntyre, a leader in inequalities research from the UK, has identified the different social and biological vulnerability of men and women to the physical and social environment. She correctly identifies that not only do women live much longer than men, but that the socio-economic gradient in health among women is much flatter than that among men. And this is true in numerous developed countries including Australia.

This is not artefactual and it shouldn't be dismissed. Rather it should propel us to consider any clues this may provide about the pathways between the social determinants of health and protective factors that could better assist people (women and men).

In addition, another asset that needs to be acknowledged is the effective mobilisation of the women's movement to advance women's health – as is witnessed in today's conference.

4. Health Care v Health Promotion

Finally, one last balancing act to consider is the interrelated roles of health care and health prevention. The social determinants model does not mean that health care exerts no influence on health. Primary and Tertiary health can and are being oriented towards prevention and towards the social determinants. In fact, the UK Health Inequalities program, which is often cited as a standard for us to work towards, provides a strong leadership role to health services. Creating opportunities for health services to take action on equity is of fundamental importance.

Conclusion

Patterns of health and disease are largely a consequence of how we learn, live and work.

In conclusion, I reiterate that gender is a crucial element to the determinants of health framework and it certainly provides an analysis that we bring to health promotion and Public Health in Victoria.

In talking through some points of tension in the determinants of health model I don't want to downplay its great value, but I do want to promote engagement and further development of the model. So I look forward to our discussion...

Session 1 – Questions And Answers

Chair: Liz Chatham.

(Note: for Session 1 there was no transcriber in attendance. The following is a record of questions asked of the speakers following their addresses.)

Q. Liz Chatham (Royal Women's Hospital) Will the Department of Human Services include gender as a social determinant of health?

DR HALL: DHS is reviewing its public health promotion strategy and picking a range of determinants to include. Gender will be one of them.

Q. Melissa Afentoulis (Women's Health West): In reviewing health promotion priorities, will intimate partner violence be considered a priority?

DR HALL: Priorities are evidence based. Intimate partner violence will be an issue.

Q. Ingrid Hindell (Growthability Consultants): Access to complementary services for women should be considered, does anyone collect data on use of complementary services?

DR HALL: Complementary services are an important part of health and access to these services should be included in the range of health services available to women.

Q. Perla Luetic (Filipino Women in Australia): How can we address the rise in smoking rates particularly among young women?

DR BROOM: The issues must be thought through carefully. Campaigns can have paradoxical effects. For example, to discourage women from smoking while pregnant is a focus on the implications for someone else. Women should value themselves. Effective health promotion needs thought. Issues of different ages of women are important and issues of different ethnicity and class.

CELEBRATION OF 21 YEARS OF ‘WHY WOMEN’S HEALTH’

Launch of ‘Why Women’s Health’ banners by Minister Mary Delahunty MP Victorian Minister for Women’s Affairs and Minister for the Arts, Member for Northcote

The Minister helped celebrate the 21st birthday of the launch of “Why Women’s Health” by cutting a birthday cake and speaking about 2006 marking 21 years since the establishment of the then Labor Government’s Ministerial Women’s Health Committee in Victoria, which led to the report ‘Why Women’s Health’.

This process was the first comprehensive examination of women’s health and services in Victoria and led to the establishment of the Victorian Women’s Health Program services.

The Minister launched a series of 10 banners produced by women’s health services across Victoria in conjunction with a range of health promotion agencies.



Caption: Minister Mary Delahunty launching the banners

Reflecting on ‘Why Women’s Health’ as a collection, the banners take up the title of the original report 21 years ago. The first banner provides an overview of why women’s health is important. The nine remaining banners are topic-based. The nine topics have been selected as a sample across the range of topics within health determinants, health issues and health priorities.

Content for the banners was developed by a range of representatives from the women's health services and health promotion agencies. Each of the banner titles are listed along with the organisations who were involved in their development.

1. Why women's health: an overview (Women's Health Victoria)
2. Women and alcohol (Gippsland Women's Health and Turning Point Alcohol and Drug Centre)
3. Women and economic participation and financial security (Women's Health in the North)
4. Women and heart disease (Women's Health Grampians)
5. Women and mental health (Women's Health Loddon Mallee)
6. Women and sexual and reproductive health (Royal Women's Hospital and Family Planning Victoria)
7. Women and cancer (Women's Health Grampians)
8. Women and social connectedness (Women's Health Goulburn North East)
9. Women and tobacco (Women's Health Victoria and QUIT Victoria)
10. Women and violence (Barwon South Western Regional Women's Health)

The banners provide a permanent exhibition on what is current knowledge of gender/women's health and the particular topic. Post-conference all the banners are available for borrowing and continued discussion by a wide range of organisations undertaking health promotion activities across Victoria. They are a learning tool for services and communities across Victoria to understand why women's health matters both now and into the future.

Following their use at the Summit, each banner will be available for loan from the Women's Health Victoria Clearinghouse.

PANEL SESSION 2 - HEALTH PRIORITY SETTING, EVIDENCE AND GENDER

Chair: Susan Reid

Speakers: Professor Helen Keleher and Kerrilie Rice

Facilitator: Marilyn Beaumont

Session 2: Priority Issues

- *How do we take advantage of the opportunities within the current health promotion priorities to effect the best outcomes for women?*
- *How could the evidence about gender in health be translated in health promotion priority setting?*
- *How would the health promotion priorities look if a gender lens was applied?*
- *Why were the 10-Point Plan priorities chosen? What is the evidence for their inclusion? How are they interconnected?*
- *How might the 10-Point Plan priorities connect with existing government health promotion priorities?*

It is my great pleasure to introduce Susie Reid as Chair of this session. She is manager of Women's Health Goulbourn North-East for the Hume region, which covers one-fifth of the State. Susie has 15 years' experience in the health sector, plus a diverse career in business and education.

Susie will introduce each of the speakers in this panel session.

Professor Helen Keleher - Head of the School of Primary Health Care, Monash University - “Health priority setting, evidence and gender”

Professor Keleher is the head of primary health care at Monash University’s Peninsula Campus. She has a special interest in women’s equity issues and women’s health, in health promotion, health policy and the determinants of health. Helen is immediate past National Convenor of the Australian Women’s Health Network and was Co-Convenor of the fifth Australian Women’s Conference in 2005.

Currently, Helen holds an appointment to the Women and Gender Equity Knowledge Network of the World Health Organisation Commission on the social determinants of health.

Thank you to the organisers for asking me to speak on health priority setting and gender, because these are issues that I have a great deal of interest in. I will background briefly by explaining that I was part of the Department of Human Services health promotion priority setting processes earlier this year. Through workshops that were held around the State with my colleagues, we heard what the field were saying around health priorities for the next five years.

So with that background, I just want to remind us all that we may talk about gender as if it is something else, something we need to come to terms with, but we live with it every day. It permeates our everyday lives, every corner of our lives, in some ways the socialisation that we all experience - men or women.

There is no escape for any mere mortal from gender. It is a universal and lived experience, and whilst that lived experience is different, obviously, for different people, it is with us. It is part of us. We have to understand that and the health system will do better if we understand that. It is a well established construct theoretically, and there is an enormous amount of evidence that has been mounting for decades on the effects of gender on mental health and wellbeing, physical health, work, education and so on.

The evidence comes from a whole range of disciplines - from sociology, political science, psychology, public policy, medicine, health sciences, human rights, education. There is a very wide list of disciplines engaged with studying the importance of gender.

It is not as if we don’t know what should be done about gender. This is not news. But sometimes it feels like it is. At all levels of governments and of policy development, across countries, within countries, there has been global interest in gender. Even the World Bank talks about gender. The United Nations, through the various commissions on human population, and now the World Health Organisation through social determinants of health - the commission has seen fit to include gender as one of its main foci.

While there is debate about it permeating through every other network, or whether it should stand alone, isn’t the point. The point is that gender has to be there. We can’t ignore it. It needs to be visible and there are decades of interest in that ability.

I want to revisit the language around the determinants of health and understand why gender sits in there. If you are familiar with the determinants of health, work that has been coming out of various governments and published literature, there are lists about what those determinants are, and what they are saying is the evidence is around these kinds of things.

In some of those lists, the World Health Organisation has a list called “Solid Facts”. Gender is not included, and nor is culture. I find it hard to see how culture cannot be on the list. Health Canada includes gender and culture in their list. So there is debate around where it sits, whether it is really a cross-cutting theme for all other determinants,

or a determinant in its own right. I'm not sure if we should get caught up with that, because it is a lived experience, and we all have to take account of it.

The determinants of health in those social conditions in which people live and work reflect social hierarchies. They reflect the level of resources in any country and in any community or family, the degree of control and influence that people have over those conditions.

I'm not going to dwell on determinants particularly, but what this thinking has given us is an understanding of the idea of working from the downstream to the upstream. We have had development in western culture health systems, particularly in what is called downstream. Downstream is providing illness services. The investment primarily in departments of health is in the downstream. Governments are very concerned with the downstream. Because of the cost and because of the interests to consumers who want services at the tertiary end, this is how health is depicted.

You notice in health issues it is not upstream health that is the concern of the media, it is always the downstream. That is what pushes people's buttons, and if it pushes the buttons of the electorates, it pushes the buttons of the governments.

They know - and we know - the investment has to be more particularly in the upstream, what we call socio-environmental issues, sometimes called the structural level, or social-structural level.

Through the '70s, '80s, '90s and today, there are people who think we need to act through changing individuals' behaviour to achieve better health, but indeed, our argument is that we don't. We can move straight into upstream thinking and the social and structural issues without getting filtered through behaviours. If we were having this discussion today in the United States, you would be throwing eggs at me, but there is now good evidence that says we don't need to think behaviours first, we need to think behaviours after we have done the structures. We can work on them together, but in working on behaviours only, we are throwing good money away.

The evidence around the work on behaviours, as an approach by itself, is not strong. There is a lot of evidence and it shows there is not much change by just focusing on that.

We need to work on structures and systems which create health - and they are economic, environmental and so on. Gender is deeply in the heart of that. It is critical and there is evidence, but I am astounded that health promotion and public health movements and practitioners do not integrate gender particularly well. Health promotion and public health worlds are the worlds in which I play most of my life, and it is incredible to me that gender is not taken account of in so much work. The effort then - the money that is spent - lacks effectiveness because it is not taking into account the key aspects of all our lives.

So whilst we know that gender is important, and the evidence has been mounting for decades, we still have health promotion, public health systems, funding and policy that take no account of them at all.

It is one of those things which really has not been able to maintain momentum in the United Nations. But I did get this press release recently that I thought I would share with you: just a piece of it that talks about the call from the International Council of Nurses, which I found very interesting (I was a nurse myself). The press release says that even nursing - which has a lot of literature around gender but has not acted particularly well on gender approaches in health systems - is calling for a much stronger degree of action from the U.N. on addressing issues for women. I thought that was really interesting, this call for a reactivation of a body around gender and gender equity.

How is it that health promotion and public health get away with it? It is a Houdini act. How is it? It is astounding. Gender blindness that permeates health care is really not acceptable in 2006. We have the evidence in front of us - it flies in the face of evidence that does not take account, conspicuously, of gender.

What are the problems? Why is it so?

We could write papers about this, but fundamentally the health system is inherently conservative. I think the health system is realising that health is not created by them, but I think we need to keep reminding them that health is not created in the health sector. Health needs to drive many of the programs, but health is not owned by the health sector. It is created out there in every other sector - education, access to services, discrimination legislation and so on. Help these people up when something has gone wrong and restore people to good health.

Health-systems thinking is dominated by those very acute demands that are placed on what generally is understood as a very under-funded public healthcare system. Pressure on pharmaceuticals, work forces and those things are very real, and we want them to work when we need them to be working, but we need to invest much further with that. To fund them without a gender perspective is to lose a great deal of effectiveness.

I wanted to talk to you quickly about health promotion priority setting. In Victoria the consultation process to set these happened over late February to May. It was a process that required Ministerial sign-off. They ran workshops round the State, to which a very wide range of organisations were invited. Health and many other sectors were there, local government, for example, education, transport - VicRoads were at a couple.

The idea was priorities were put forward by the department for discussion – they were all up for debate or change. The views of the field were very well documented. We were involved in the analysis of the themes that arose from the workshops and I think it has worked. It is worth noting that women's health were very well represented, they were very well organised and made sure the voice of women's health was there. The priorities that were put forward by the department were, and the department has acknowledged they are, dominated by midstream thinking.

These are the priorities that were put forward:

- physical activity and an active community;
- accessible nutritious food;
- promoting health and wellbeing
- reducing and minimising the harm from tobacco and alcohol.

What the field was saying, was that to a degree they supported these priorities - there was some debate around the edges - but that the real issues are around disadvantage, poverty.

Women's health talked about violence a good deal, how violence underpinned injury and mental health, and therefore the focus should be on the causes of those midstream health priorities, the causes of the issues that create those kinds of priorities. They wanted much more upstream thinking.

That is very challenging for a department. It has to sell the message through the hierarchy to Ministers, and it is a difficult message. The priorities are always going to be prepared in light of what is going to be acceptable to the Minister and senior advisors. I don't think the message around gender has permeated that yet. Even though it is a strong message and we have significant benefits around violence against women, it has not permeated the process.

Clear and consistent messages are coming through, from women's health and many other organisations of good reputation, about the need to focus on disadvantage and the principles around the priorities. I think that is really challenging and we wait to see what comes out from the department as the priorities for the next three years. There is no doubt it will be mediated.

What I find so challenging is that despite the evidence about gender, despite the fact that the department understands the determinants, and there are many people talking about determinants across government, it is still a very difficult message to sell. We have to ask: why is it so?

What we need to advocate for much more strongly is the need for joining up the policy areas and making sure one is influenced by the other. That they are not sitting in compartments or divisions without crossing others. Whilst there are, no doubt, good attempts by people working in women's health to make it happen, it needs to happen at a higher level. We need to build, to be trying to influence that more and more strongly.

Here we are 21 years since "Why Women's Health Victoria" was launched. Since that time the women's health sector in Victoria - and many of you have lived through the history of that with us - has been challenged, there have been attempts to integrate the women's health sector into wider community health.

We had a great campaign, which involved Jo Wainer. She organised friends of women's health, one in every region. I was the friend in Loddon Mallee, where I was living at the time. She had a media kit, so we were all saying the same things on a given day. It took 48 hours. We blasted the media. We had talk-back, press releases going out, stories for local newspapers, it got picked up by the media and in 48 hours the then Minister of Health changes her mind about integrating the services. It has always been an under-funded sector with region-wide expectations of tiny little services. It is unrealistic to expect that women's health services can do all this on the part of public health and health promotion.

So the leadership is within women's health services and its supporters and it always has been. But we need additional force: leadership has to be mandated into priority setting, incorporation of gender considerations needs to be mandated. The 10-point plan clearly sets out - as do many other documents - where women's health needs are and how they should be met. It is not that we don't know. We need a policy and practice framework.

It has been a problem with the way women's health services were established - that is, not with women's health services themselves, but with the way every other DHS funded health service was NOT mandated to work with women's health services. So there has never been anything mandated through funding - and funding and service agreements are the place it should be done.

Hospitals, health networks, community health - whoever it is that is funded by the department - should be mandated, through their funding and service agreements, to work with women's health and through a gender perspectives. It is wrong that that has never been done. It is time it was.

So the key question is: how will the Department of Human Services actively support the sector that is funded? There is the need to work much more closely with women's health services on all processes. It should not be challenging to work with gender perspectives. They work as well as for men as women. It should be regarded as necessary for effectiveness.

It is not just about doing the thing right, it is about doing the right thing by women and, as I said before, it's about time.

Thanks very much.

Kerrilie Rice - Policy and Research Officer, Women's Health Victoria - "Health Priorities, Evidence and Gender"

Kerrilie Rice has a Bachelor of Applied Science with first class honors in Psychology/ Psychophysiology and studied for a PhD on the role of oestrogen in the memory in women after menopause. In addition to her studies, Kerrilie has co-coordinated a state-wide women's health teaching program, taught woman-sensitive examination and communication skills to doctors, nurses and medical students, spent time as an academic researcher and enjoyed several years with a national education union.

Over the last 3 years, Kerrilie has further developed her strong networks and diverse experience in the position of Policy and Research Officer at Women's Health Victoria.

There are a number of ways of considering gender within the context of health, which Helen picked up on. Following on from both Robert and Dorothy's discussion this morning, Helen spoke about the dominant thinking in the health system. Particularly with regard to health priority setting and how priorities are thought of, how priorities are developed and what type of things we can do to influence that.

What I would like to do is turn our attention now to explore specific health priorities – namely, those that are identified in the 10-point plan for women's health.

In the 10-Point Plan the priority areas identified for across government action are:

- Violence against women
- Mental health and
- Sexual and reproductive health.

The 10-Point Plan seeks to have funded programs and initiatives within these priority areas developed as well as a commitment to fund research to continue to develop the evidence base around them. Helen made mention of the need to apply a *gender analysis framework* to policy and practice. I will talk about the connection between the priorities and a gender analysis framework.

Gender analysis framework is a tool that enables the development of policy, programs and services to take account of and be responsive to gender. It is predicated on the following points:

- that all policies, programs and services have an impact on women and men;
- that these affect women and men in different ways; and
- that women and men are heterogeneous groups of and within themselves.

When we think about a gender analysis framework, there are three primary components we keep in mind:

- Gendered data,
- Gender-impact assessment, and
- Gender awareness training.

Gendered data includes the collection of sex-differentiated data that is analysed from a gender perspective, such as the obesity data Dorothy was talking about. It needs to be cross-referenced to develop clear meaning and it needs to be nuanced.

Gender-impact assessment includes the assessing of existing programs to analyse the differences. It asks: is it responsive to gender? If it is, is it appropriate? Does it reflect our knowledge in the area? Does it highlight gaps in our knowledge? Gender-impact

assessment is undertaken to neutralise discriminatory effects and to enhance the aspects of that.

Gender awareness training, which is the third component of the framework, is about sharing this information with other people, part of what we are doing today. It is about building capacity in including a gendered understanding into everyone's work and promoting the aims of gender equality generally. It is not necessarily about health. A gender-policy framework can be applied at a macro and micro level across a whole lot of levels.

With this in mind, let's have a look at the three 10-Point Plan priority health promotion issues.

Why were these particular priorities included in the 10-Point Plan

As Helen pointed out, the issues are not new, the evidence is well known. They are issues that have been identified by the women's health services and women themselves. They demonstrate how women's voices inform practice.

Karen Wills (2003) reflected that the whole-of-community consultation is a well-established public health strategy for improving health outcomes for particular groups. She noted the importance of women's voices being heard in the development of priorities that impacted on women's health. Historically, that has been important, and it continues to be important. These priorities reflect that.

The priorities in the 10-Point Plan also make up three of the seven priorities that were nominated back in 1989 in the National Women's Health Policy. They are not new. Although it was 17 years ago, it resulted in a nationwide process that took in the views of over a million women across Australia. The 10-Point Plan reflects women's voices now and then.

What is the evidence for the inclusion of these priorities?

There are many important health issues that impact on women's lives. The three priorities in the 10-point plan have a strong gender-evidence base. There are significant interactions between them and there are clear opportunities for change.

Violence Against Women

Violence is significantly gendered.

- Exposure to violence as children or adults places women at higher risk of poor physical and psychological health outcomes throughout their life.
- You will all know about the VicHealth study measuring burden of disease from intimate partner violence, which measured it as the leading health problem.
- One in five Victorian women will experience intimate partner violence some time in their lifetime.
- In Victoria it is estimated that violence against women will cost \$2 billion a year. We know this. There are opportunities to change this.

Mental Health

Gender differences exist in the diagnosis, onset and course of illness, the social experience of mental health. These include:

- The fact that women are twice as likely as men to be diagnosed with depression or anxiety disorders, and twice as likely to be diagnosed with major or long-standing depressive disorders.
- Women with depression are significantly more likely to be prescribed antidepressant treatment than men with the same diagnosis (Williams, 1995).
- There are gendered divisions of labour in the economy, the home and the community and gender-based expectations about roles, responsibilities, and power relations that have been identified as likely contributors to women's greater risks and vulnerabilities to depression. Socio-economic factors, such as low rates

of pay, part-time employment, casual employment, poverty and unemployment, caring for a person with a chronic physical or mental disorder have also been identified as increasing vulnerability to mental health issues such as depression.

- The greater number of women diagnosed with depression may be related to the conflicting interplay of gender biases and treatment by medical practitioners and other professionals. It also might be part of different help-seeking behaviour between the sexes and the different ways in which women and men deal with and acknowledge their stress (Rice, 2005). Research has suggested that women and men respond to distress differently as a result of gender expectations and socialisation.
- During times of difficulty, women are more likely to turn to members of their social network for emotional support than men (Edwards, Narzoo & Brown, 1998). However, men may be more vulnerable than women to the effects of social isolation (House, Landis and Unverson, 1988). Therefore, we need to better understand and be responsive to the social connectedness of mental health between women and men. It's not new, we know it - there is an opportunity to change.

Sexual and Reproductive Health

Recent public debate has demonstrated that many issues we thought were settled, issues with access to safe and legal reproductive health services are being challenged.

Issues include access to pre- and post-intercourse contraception, termination of pregnancy services, confidential treatment for young people, invitro fertilisation for certain groups, the rise in sexually transmitted diseases including Chlamydia and, a variety of birthing options.

These issues don't fit within one section of a government department nor, due to the social convention of some of them, within one single department. Addressing them in a coordinated way requires a policy that works across and within government departments. It is not new. There is an opportunity for change.

What is the interconnection between these issues?

Violence against women impacts on women's physical, mental, sexual and reproductive health. This includes greater use of health care services, increased symptoms and medical conditions such as sexually transmitted infections and depression (ALSWH, 2005).

The experience of violence has been identified as an obstacle to achieving good sexual and reproductive health through an inability to negotiate safe sex and make appropriate sexual choices (Butler 2004). The Australian Longitudinal Study of Women's Health found younger women who experienced violence are three times more likely to report having herpes, hepatitis C and three times more likely to have a miscarriage. This doesn't include chronic gynaecological issues.

Women who have experienced abuse are also more likely to experience anxiety, use psychoactive medication, have an increased incidence of suicide reports, cause harm to themselves (Taft, 2003), and increase a woman's vulnerability to violence - so it goes both ways.

People who are most disadvantaged are likely to experience the effects of violence, poor mental health and poor sexual and reproductive health. The context means they often face multiple disadvantages and in these places, the impact may be experienced more severely by women.

There are clear interactions between violence against women, women's mental health and women's sexual and reproductive health.

So what is the 10-Point Plan asking in terms of priorities? What are the opportunities that exist?

Much of the current focus on responses to violence against women is directed toward police and offender management. Some of the women's services are funded for violence prevention work. A recent public survey by the Australian Study of Sexual Assault noted inter-sectoral responses are important in prevention of gender violence. Justice, law enforcement, corrections, education, employment, community services and health all operate in prevention and treatment.

Action on prevention of violence against women needs to be further developed across government to bring together and capitalise on the work that has been done across the range of sectors. The 10-Point Plan asks:

- that violence against women is acknowledged as the greatest disease burden of disease for Victorian women, and that adequate funding be made available within the State's health policy framework and service delivery models;
- That in the area of sexual and reproductive health, a State-wide policy is developed and supported by funded programs; and
- that women's emotional and health needs are met by reviewing all existing policies and programs from a gender perspective and promoting this, not only at State, but also at Commonwealth level.

As we have seen, there are significant interactions between these priorities and coordinated policies, programs and services that will benefit greatly by addressing interconnections. Good sexual and reproductive health does not occur in a vacuum. It cannot be achieved by considering only violence against women.

Jenny Lewis has commented on the expertise and authority that come into play which influences health policy. She notes that when health issues are raised by women, they can sometimes be seen as bringing their own issues to the table. However, all health is gendered and the priority areas identified in the 10-Point Plan are no exception. While the focus here today has been on women's experiences, developing appropriate gendered research, policy and practice responses will have positive benefits for everyone in our society, not just for women.

Palmer and Short (2000) have identified three strategies that have been used by the women's health movement to effect change. I was thinking about this speech when I was reading this the other day. The things they identified were:

- the recognition of women's special health needs, which influences more than reproductive health;
- the establishment of women's health services; and
- a shift in the focus of the health system towards prevention and health promotion.

These are strategies that the women's health movement have used. I think we are still working on the last one. Let's keep taking it forward and find ways to develop a gendered framework in all State and Commonwealth health priorities.

I was reminded this week of a saying that the most powerful thing is an idea whose time has come. Well, Helen said it – it's time.

Session 2 – Questions And Answers

Chair: Susan Reid

Q. Tricia Malowney (Victorian Women with Disabilities Network). A quick statement, if you like, around acknowledging the work already done by many women here and including women with disabilities in their work. A question around how can we ensure that the relationship between gender and having a disability can be worked into the 10-point plan. How we can ensure that when the word “disability” is mentioned, the woman isn’t referred to disability services when the issue is domestic violence? So it’s a question for everybody here.

KERRILIE RICE: Thanks, Trish, I was actually going to put something about that in my speech and I thought I might have trouble, time wise, so I cut it out. I apologise. What I did have in there was that gender is only one way of looking at this and there are a variety of lenses that we can apply in looking at issues to consider: Is this responsive to my needs? Does it take up knowledge that we have? Does it identify gaps in our knowledge? Does it take us forward? Disability is one lens that we could place over it. Culture is another lens, adversity is another, sexuality is another. We have multiple lenses or diversities, gender and disability and sexuality in mental health. So I think while today I was talking primarily about gender analysis framework, I don’t think about it just as gender, but I think about it as an opportunity to apply the lenses that are appropriate within the work that is being done at the time.

HELEN KELEHER: I think there is lot of scope for the priority-setting processes, even outside the 10-point plan, to have a framework of principles around them. So that those different lenses or diversity is thought through and applied, depending on what the issues are.

Q. Linda Bennett (Women’s Policy Officer, Victorian Local Governance Association): The VLGA is one of the supporters of the 10-point plan. The reason we are here today, and the reason that women Mayors are here also, is we want to start some conversations about the relationship between local government and women’s health. Working at the upstream end, that is where local government is, there seems to be a potential partnership. There are many fantastic examples around the state of local councils working in the area of women’s health and prevention, and some great partnerships happening. So I was hoping that in the intervening time between sessions there might be some conversations happening around that. I would like a comment about what I have just said.

HELEN KELEHER: That’s fantastic, Linda, and it’s a good question. I put this to a couple of local governments that I have been working with - is there anything they do in local government that is not ultimately about health? Actually, the one that comes back is parking tickets. If local government is ultimately about health and wellbeing in its communities, which it is, then clearly there needs to be a strong gender framework, but also for all those other lenses. It is around the framework of principles, around what creates health and helping councils to work through how they actually measure their outcomes. There seems to be a great need to develop evaluation frameworks that also measure, not just in terms of “we did a good job”, but the process of evaluation, but outcome frameworks. The VicHealth framework is good for that because it talks about long-term benefits across a number of levels. There is loads of scope and I’m sure the Women’s Health Services welcomed your question.

KERRILIE RICE: It is a terrific question. I have been thinking about it, too. I think that the next two sessions today are really where that is leading. The session after lunch is about collaborative work and the last session this afternoon is about looking forward to the

future, and one of the speakers is one of the women Mayors. That should be a good way to have those types of discussions.

Q. Marg D'Arcy (Royal Women's Hospital). Mine is more a statement rather than a question. It is a statement about violence against women and our terminology. Sometimes what happens in a discussion about violence against women, it gets down to domestic violence, or intimate-partner violence, and it is important to continue to remind ourselves that violence against women, in all its forms, has an impact on women's mental health and all sorts of health and wellbeing and that we need to be very conscious and keep reminding ourselves that we are talking about all forms of violence against women: trafficking, child sexual abuse and so on. There's lots of research now to suggest that there's increased rates of HPV and these have a huge impact on women's sexual and reproductive health. So just a plea to keep thinking about violence against women broadly and not condense it down to domestic violence, which is not to trivialise the impact of domestic violence, of course.

Q. Wendy Bennett (Australian Polish Community Services). I want to talk about evidence: I think there is one piece of evidence that I think is difficult to find. It identifies the culture and language of people who are using services. We want to develop programs, and without that information it just doesn't work as effectively. As a community organisation we can't go and collect data that identifies what the health issues are within the Polish community because it is not collected. We can't then look at how we need to focus our response to those issues. Basic development of policy and direction needs to really improve in that collection of data around those areas.

KERRILIE RICE: Absolutely. We hear you, absolutely. About 18 months ago, we developed a gender data directory. This is a gateway to how to find data on over 70 key indicators of health and wellbeing. It was just about sex-designated data when we developed it. As we were developing it we became aware of all these other ways we wanted to be able to look at the data, sometimes it was incredibly difficult just to find sex-designated data on Victoria, let alone a particular region of Victoria or with a particular cultural group. It was a significant problem and something we have spoken with DHS about. I know Women's Health in the North did some terrific work early this year, or late last year, about developing a data book on women in the northern metropolitan region of Melbourne. It was an enormous investment for them and it is a terrific resource. It is unfortunate that it takes that to get that kind of data out, so we hear you.

Q. Ingrid Hindell (Growthability Consultants). Women with disabilities are not included in data for all women.

KERRILIE RICE: We still rely on specialist services to produce that data and to publish that data. We shouldn't have to.

HELEN KELEHER: It does seem like there are opportunities to try and get Victorian health surveys (because they do have the resources), to develop a set of questions that are targeted around women with disabilities.

Q. Heather Bickley (Community psychologist, Melbourne University) I haven't had direct input, I just wanted to raise a couple of areas of discomfort I'm feeling. I'm wondering, if someone who has been closer to it, one is the use of the term "10-point plan". For me it conjures up Wik and the way Aboriginal people were dispossessed. So I was wondering about the use of the term, that was one area. The other is in terms of the mental health question, in particular, which I know a bit about: what is the trade off between having to use medical terms like "depression", while we are using a social model of health? - it raises huge contradictions. You might find yourself having to direct services around women having to get a diagnosis first, when we know that is not how women's health and holistic health operates. I was just wondering if anyone can comment?

MARILYN BEAUMONT: I will comment on the first part of the question which is: why was it called a 10-Point Plan? Part of it is, it needed to have a catchy title. When we looked at the range of issues, we gathered them into 10 major areas. It is a political process we are engaged in - that of trying to get people focussed in talking about common themes. So how it translates into practice, where it connects into, and merging into the women's health and wellbeing strategy across government, all of those things will play out over the next few months or so. So it is part of getting people engaged and being able to speak about one thing, and we called it a "10-point plan". It came out of the communications strategy framework that the Women's Health Services invested their time and money in. I think that it is a useful tool for those purposes.

HELEN KELEHER: I might comment on your question about women's mental health. It doesn't matter if it's women or men, it is embedded in the social experience. But the emphasis currently is the medical model and, of course, many, many people do need to have medical treatment and do want to have medical treatment for their depression. However, we are seeing the primary-care sector being put up as people's primary point of contact and often it is put up as the only point of contact. The referrals pathways are very ordinary. Women, in particular, who are really seeking to develop their own care pathways are not being given good referral pathways. Often they can't afford the kind of treatments that are in the private sector - the public sector is critically under funded, for services for depression and the violence and so on. I think we need to challenge the model. Having a General Medical Practitioner as case manager is good for medical treatment, but it doesn't work for the social aspects, which are probably bigger than the medical treatment itself. The risk is if people aren't picked up early enough with a variety of options to explore, they fall into chronic illness. What we are seeing in the health system now is just that - people are really ill because we are not doing enough earlier in the right kinds of models.

Q. Moira Callan (Australian Research Centre in Sex Health and Society). Gay and lesbian health and gender blindness. Talking about women's health leaves out thinking about lesbians. We know that the levels of domestic violence are very high and physical and mental health are also pretty high up there, how do they figure in the 10-point plan?

HELEN KELEHER: I think it is a lens, that sexual orientation is another lens. Because it fits into the questions about: are we collecting the right data? Asking the right questions to get the data? When we look at the existing policies and programs and service-delivery models, do they meet our needs? Are they responsive? How do we raise awareness and bring it into the work? It is another lens we would be applying, and there are multiple lenses. It is a problem that the development of thinking around better policy and development of 10-point plans is coming from very small women's health services who are trying to pull this together, doing their very best with the resources they have whilst trying to meet needs out there. The point about transgender, gay and lesbian health, women with disability, new-arrival women, we need a comprehensive women's health policy at the Commonwealth level that picks up all the issues, that has an agreed framework of principles, and we need it at the State level as well.

Q. Sue Clarke (Bendigo Community Health). My question is related to something Helen said about the upstream, downstream. A few weeks ago I attended an alcohol and drug forum conference and there was an international speaker. He said, "It's a waste of time throwing all this money at health promotion and illness prevention. After all, how people's behaviour is impacted on is actually what is going to make the difference, and behaviours need to have consequences." So my concern is how does this sort of thinking permeate when it was a State-government forum who had brought this international American speaker over to have his say? I do wonder about that notion of that shift between what you can count and make a difference on and whether you can say people

have done the right thing and wrong thing and keeping a strong focus on prevention and intervention.

HELEN KELEHER: I understand there was a story in The Age a couple of weeks ago about Ted Shrieker delivering a message to Cabinet about early childhood similar to this. The trouble with the behaviour thing is that it is enormously popular, it is a populist model. People buy into it and throw money at it without considering social and structural issues as well. In my own university, money has arrived and we tackle alcohol on campus - we don't start with little things. People smile and say, "It is every student's right." They used to call it "green week" - it's not about the environment. It's now a rite of passage. Things happen and they happen to girls and happen to young men and there is violence and alcohol-fuelled behaviour, and it is appalling. To their credit, our university started taking action. There is a workshop today on university alcohol policy. I think we need to document good practice here and we need to challenge a behaviourist approach. I don't doubt there is a need for behavioural changes in relation to a number of issues, especially around alcohol and violence, of all types. They are not strong and they do have some impact in the long term, but they need to have the upstream thinking as well or they are a waste of time and money. We just need to keep getting, gathering the evidence.

Q. Jane Patrick (Women's Health Victoria Council). I just wanted to mention one more idea. Don't let the idea of a gendered analysis of health for children and young people drop out of the discussion because there hasn't been much mention of this, there is an assumption of a focus on adult women's issues. The second thing is, women shouldn't be healthy for the sake of their children, they should be healthy for their own sake - children desperately need healthy mothers.

HELEN KELEHER: There are 25% of children living in families that live in poverty, and they are often headed by single women and they are struggling on a number of fronts, I agree.

Q. Amira Rahmanovic (Multicultural Centre for Women's Health). During this first half of the session, what I have realised, and this is something that I feel generally when I go to the women's health gatherings, services gatherings or conferences, the issue of culture, language, disability, Aboriginal women's issues, are somehow marginalised. They are not actually talked about in a way like it is talked about with the general women's health issues, like mainstream. I would like to see this as long as we put this in a perspective of another layer, like a layer of culture, a layer of disability, a layer of language, or Aboriginality or whatever. We will not ever address women's health needs and issues in a way we should. I see it as a cake that is made of many, many layers. You know, all of us make cakes or tarts for at least our kids' birthdays or our birthdays, and if one layer doesn't make up really nicely or straight or is not baked properly, all the tart or cake goes down. It's not nice.

HELEN KELEHER: I can relate to that.

Q. Barbary Clark (Gay and Lesbian Rights Lobby). In terms of lesbian health, they are at greater risk of breast cancer but there has never been any space for mammograms. I would like to get the panel's view on whether it is okay for the longitudinal study on women's health not to ask the question about sexual identity?

HELEN KELEHER: We both say we didn't know they didn't ask that. Have you written to them? What's the response?

BARBARY CLARK: I'll show you their response.

HELEN KELEHER: Okay.

MARILYN BEAUMONT: My understanding is that the Commonwealth Department of Health and Aging determines what the questions are that are asked. So the women's health longitudinal study researchers have some constraints placed on their absolute control over what questions they can ask. We have asked the question of the researchers as well.

Q. Jodie Sexton: My name is Jodie Sexton, and I live in Shepparton. So, I'm a country girl, born and bred. I'm the only deaf person here, I'm trying to face you all and.... Okay. Firstly, I would like to say thank you very much for the Women with Disabilities Network asking me to come along and then being from the country, it is quite difficult for me, also being a deaf woman, to try and access services myself. I travel so much around Australia, and I have seen Helen and I have seen her presentations and I know some of the women here today. But firstly I might like to say, we were talking about the 10-point plan and we were talking about the varying layers and looking through different lenses and so forth, but personally I meet four of the criteria there: I'm deaf, lesbian, Aboriginal and rural. And I'm a single mother. I'm left handed, I'll throw that in, and I'm blonde. A 10-point plan just isn't enough for me! I just want to say I think it's a wonderful opportunity for me to get up here and say something, because I don't live my life as a deaf woman or an Aboriginal woman or lesbian, or single mother or being in a rural area, or blonde or whatever – I'm a woman. I need to have access to good health services. That is what I wanted to say, thank you.

SUSIE REID: What Jodie didn't add to that was "activist".

PANEL SESSION 3 - WORKING TOGETHER FOR INTERSECTORAL COLLABORATION ACROSS POLICY AND PRACTICE

Chair: Kathleen Walsh

Speakers: Jenny Mikakos MLC, Professor Fran Baum and Maree Davidson

Facilitator: Marilyn Beaumont

Session 3: Priority Issues

- *Health is created by factors outside of the health system. The most successful health promotion activity involves participation at all levels and targets areas of women's lives other than just health; eg. environment, safety, education, different levels of government, etc.*
- *Explore examples of successful intersectoral collaboration in advancing gender across policy and practice*
- *How do we best engage the strengths of different organisations to improve women's health outcomes?*
- *What specific mechanisms can we employ for cross-organisation communication when we come with different expectations and ways of working?*
- *How do we put gender at the centre of these collaborative efforts?*

Moving into the afternoon session, we wanted to continue the conversation about women's health and intersectoral collaboration. A number of the comments made after this morning's session lead us into that really well.

Kathleen Walsh is chairing the session. She is Executive Director of Women's Health in the North, a social worker of 20 years experience. Women's Health in the North is the regional women's service for metropolitan north. This is their local region. Welcome, Kathleen.

KATHLEEN WALSH – EXECUTIVE DIRECTOR, WOMEN'S HEALTH IN THE NORTH (WHIN)

Thanks, Marilyn. I think it is probably safe to assume that collaboration is an important aspect of our work. Because, as it has been reinforced by speakers this morning, health is created by factors outside the health system, inter-sectoral collaboration on women's health and wellbeing is critical. This is a key element of the 10-point plan. The fact that the plan has been endorsed by over 40 peak bodies and organisations across community, health, welfare, education, government and non-government sectors is testament to the importance we place on working together to bring about successful outcomes on women's health.

To address this topic in more detail, I'm pleased to introduce a panel of three fabulous speakers. Their participation here represents inter-sectoral collaboration.

Jenny Mikakos MLC - Member for Jika Jika, Parliamentary Secretary for Justice

Jenny Mikakos addresses us as Victorian Parliamentary Secretary for Justice. She is a lawyer, the local Upper House member for Jika Jika and her office is also a stone's throw away from this venue. She is passionate about social justice and human rights, passions which serve her well in her parliamentary role in Justice. Jenny chairs a number of advisory and other committees across the Justice portfolio, including Aboriginal, Attorney-General's Advisory Committee on Gay, Lesbian, Transgender and Other Issues and the Women's Corrections Advisory Committee.

Thank you very much. I am delighted to be here today. You might be wondering why a lawyer, and someone with the Justice portfolio, might be addressing you, but I'm delighted to be speaking at this women's health summit, specifically about the "Better Pathways" strategy.

I do apologise for the fact that I don't have a PowerPoint presentation, but hopefully I'll have your undivided attention. But I do have gifts - at the front entrance, is the document that I will be speaking about, "Better Pathways". It is the orange document and I would encourage you to grab a copy on your way out later on. If we run out of copies, I understand that the document is also on the Department of Justice web site. (www.justice.vic.gov.au)

Can I say at the outset that I know that in reviewing the 10-point plan discussion paper, it has been circulated to our Members of Parliament, but page 15 of that document notes that the "Better Pathways" strategy is given as a good example of a joint approach by government, particularly in the development of social policy.

If I can digress for a moment, I would suggest to you that in the further work that will occur in developing the 10-point plan to government, that I also nominate the new family violence strategy as a very positive example. It's a strategy that Justice has had considerable involvement in with its development and implementation, obviously working towards addressing the largest contributor to the burden of disease for women aged 15 to 44 years.

We heard earlier about the change in Police procedures and, most importantly, police attitudes as to how they address family violence issues. However, I couldn't let something that I read in the media today not get commented upon, because I think there is some way to go towards changing attitudes within the community more broadly on the issue of family violence. That was the comments, as I read them in the media today, by the Shadow Police Minister, Kim Wells, in saying that police are spending too much time with family violence victims and this is taking police away from front-line policing. I was absolutely appalled to read those comments.

Those comments are, of course, predicated on the ridiculous proposition that family violence is a private matter. I guess you could say an extension of that is that it is not a crime. So I would - following up from what Kerrilie Rice had to say earlier - as a Parliamentarian, I would certainly very much encourage inclusion of violence as one of the key priority areas that you have identified so far in the 10-point plan. Also for the continued work that obviously needs to happen with some members of the community in terms of educating them that family violence is, of course, a crime.

Very quickly commenting on the 10-point plan generally, I certainly welcome the work that has gone into the development of the 10-point plan so far. I commend it. I thank all of the organisations involved - who are represented here today - for the work they have done.

I'm sure that it will be taken very seriously by the Victorian Government and should be part of the formulation, in my view, of a specific women's health strategy in the future.

Of course, we do currently have a health and wellbeing strategy that, I think, runs out this year, and I would certainly be advocating within government, as I'm sure my other colleagues will - in particular, my many female colleagues in the government - for a new health and wellbeing strategy to focus on the priority areas you have identified.

Getting back to the topic that I want to speak about - the "Better Pathways" strategy. That strategy was launched in November of last year. It was developed in response to the significant increase in the women's imprisonment over the last decade.

There are currently over 240 women in our prison system as compared to just over 100 in mid 1995. There are many reasons for this increase. Time today won't allow me to go into that, but they are expounded upon in the "Better Pathways" strategy and I would encourage you to read the document.

As you are all aware, entrenched disadvantage, which the majority of incarcerated women experience, is not only a contributor to their incarceration but a direct contributor to poor mental and physical health. In addition, the last decade has seen an increase of women in particular linguistic groups, particularly Vietnamese women, that have special health problems that require consideration.

The reasons for developing a program that targets women specifically are:

- that women more than men are likely to experience sexual, physical and psychological abuse;
- they are more likely to suffer from mental illness, substance abuse and trauma.

"Better Pathways" recognises you can't look at offending in isolation. It requires a coordinated and multi-disciplined approach from the government, legal system and community, taking into consideration the views of incarcerated women themselves. So what "Better Pathways" does is recognise there are gender differences between women and men who come into contact with the criminal justice system, and there are different reasons for their offending and re-offending behaviour. Of course, it recognises that women are a higher-need, lower-offender group than are men.

In June 2003 the process that we embarked upon, in terms of using "Better Pathways" as a model for collaborative practice in government, was the establishment of an interdepartmental committee. This consisted of representatives from departments of Justice, Human Services, Victorian Communities, Education, Training, Women, and Cabinet and Treasury. It was important that Finance, the bean counters, were there.

The interdepartmental committee was chaired by the Commissioner of Corrections, Victoria. An important way of doing business within government is this approach that we are embarking on with the Victorian Government more and more - set up interdepartmental committees with broad representation to try and develop a strategy across government. It is a recognition that the old silo approach of one department trying to tackle an issue on its own just doesn't work anymore. This is work that could be done in the women's health area more broadly.

I should point out that in the development of Better Pathways, the community sector also had input and the main form that that took was through input from the Women's Correctional Services Advisory Committee which I chair. This consists of broad representation from the community sector with I think 14 individuals on it, from a range of backgrounds. That Committee is also having an ongoing role in commenting on the implementation of that strategy as it is being rolled out. It has, in its terms of reference, to

advise the Minister for Corrections on other issues affecting women in the corrections system.

So “Better Pathways” is putting into practice interventions that address what we know: issues leading to women’s offending, including broader issues associated with disadvantage. Looking at women in prison, we know that:

- at least two-thirds report drug involvement in their offending;
- up to 80% have been victims of sexual or other forms of abuse;
- around three-quarters are unemployed and a similar proportion has not completed secondary school;
- at least one-third have been diagnosed with a mental illness - and I point out that a number of Australian studies report higher prevalence rates, up to 90%; and
- many suffer poor physical health with around two-thirds testing positive to hepatitis C.

In recognising the complexity, “Better Pathways” has taken a collaborative approach focusing on development of partnerships with government and community to reduce women’s imprisonment. It realises the importance of agencies, in particular justice and human services agencies, working together to address the many complex issues associated with women’s offending.

I should point out, as I said before, the collaboration hasn’t just gone into the development of “Better Pathways” strategies. We are also taking a collaborative approach with implementation. A steering committee has been established to roll out the various projects, initiatives and also to play a role in its eventual evaluation. I point out, in terms of evaluation that, obviously, it will consider issues such as reduction of women in the corrections system, but will also consider the impact of this multi-disciplinary approach and what has worked and hasn’t worked and what we, as government, can learn from the approach.

Specifically, “Better Pathways” was provided with funding in the 2005/06 State Budget with an allocation of \$25.5 million over four years, including \$18.3 million for programs to support women prisoners and offenders and \$17.2 for the Dame Phyllis Frost Centre. Twenty eight projects have been identified for funding to 2009.

Reducing women’s offending, re-offending and victimisation are the key aims. The projects raise a number of issues relating to mental health, substance abuse, children and family ties and strengthening those, physical health, sexual assault, family violence, housing, education and training, employment, gambling issues and transport. You can see it is a very, very broad range of issues. Obviously, time doesn’t permit me to go into all those 28 projects and that is why having a look at the document later is important. Today I will focus only on mental health which is one of the 10 point plan priority issues and is one of the most critical issues relating to the significant numbers of women in prison.

Mental health is a key factor impacting on the likelihood of women re-offending. Such problems may be exacerbated by the prison environment, and can impact on the prisoner’s ability and willingness to access services and support and participate in programs, which are a vital tool to their rehabilitation and integration into the community.

Under “Better Pathways”, 20 flexible intensive support places will be established at the Dame Phyllis Frost Centre. This includes 24-hour nursing staff for women prisoners with acute psychotic episodes, severe personality disorders, who are at risk of suicide or harm. Progress is under way in building a multi-disciplinary unit, and upgrading the medical centre to provide a new multi-purpose room for health promotion and consultation rooms for clinics, a dispensary centre and the opiate substitution therapy program. There are a range of other programs that will be delivered which directly target

causes for women with disadvantaged offending, including sexual assault counselling, advocacy and support for women's prisoners.

I should emphasise that the success of "Better Pathways" is not just about government, it is about working with the community sector. The strategy involves establishing better transitional housing for women on bail, including dedicated housing for use by indigenous women, providing employment and training opportunities for women offenders in prison, and providing practical support to women offenders on supervised community-based orders, including managing childcare responsibilities and accessing transport. In acknowledging the distinct profile of women offenders, a framework is being provided in gender responsiveness.

Can I say in conclusion, I think "Better Pathways" is a very exciting, innovative gender responsive strategy. It is designed to respond to the specific needs of women prisoners and offenders. I think it serves as a very useful example of positive collaboration across government and the community sector and, hopefully, can help to inspire work in developing a model for women's health in Victoria.

Professor Fran Baum - Director of Public Health, Flinders University - “Working Together for Health”

Professor Fran Baum is one of Australia’s leading researchers on social and economic aspects of health, She is a commissioner for the World Health Organisation on social determinants on health, and the regional representative in Australia and the Pacific and a member of its Global Steering Committee. A past national president of the Public Health Association of Australia, Fran currently is a leading investigator on the \$2.4 million grant titled Australian Health Inequities Program, funded by the Australian National Health and Medical Research Council. She is also head of public health at Flinders University and foundation director of the South Australian Community Health Research Unit.

It’s great to be here in Melbourne. I was asked to talk about inter-sectoral collaboration in health. Although I have researched this, I find it quite boring to talk about. So I reframed it away from the process. Working together for the outcome of health is important to stress, rather than working together for policy and practice which is process. I recognise it’s really important to think about the outcome - what we want is to work together for health.

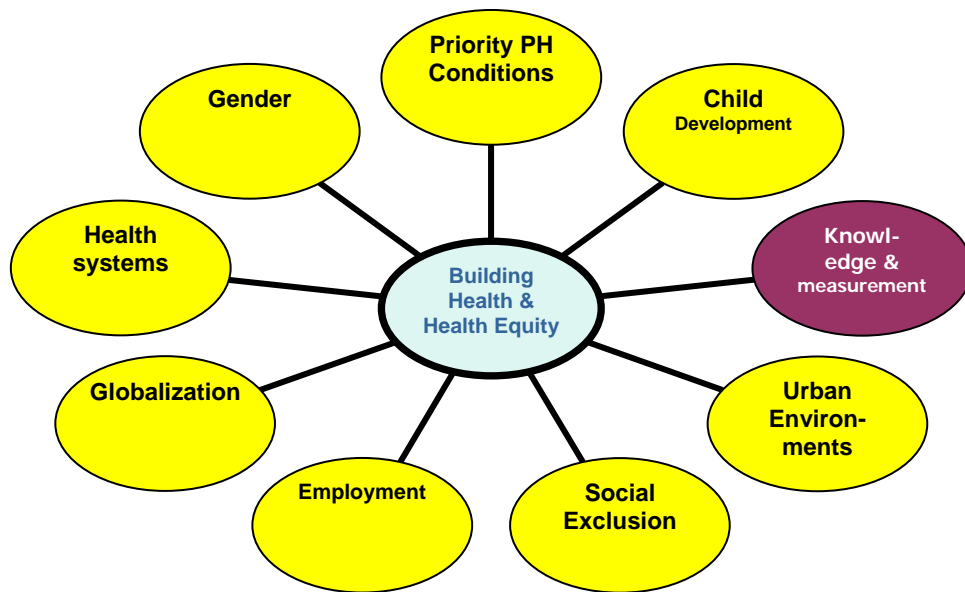
A lot of my thinking now about sectors has obviously been framed by the work I’m doing as a commissioner on the World Health Organisation (WHO) Commission on the social determinants of health. In a nutshell what our Commission is trying to do is to put social determinants firmly on the international health agenda. Not because it is new - we heard today people have been taking it on in Victoria for ages - we want to improve health and reduce health inequities within and between countries.

One of the crucial lessons is: if you want to get action going, you don’t go to the minister of health, you go to the head of state, whether it is the president or prime minister. Whenever we meet in a country, we aim for, and have so far met with that person. That is a much more effective way to get across to government the strategy that in starting with the health factor, everyone benefits.

The basic logic of the Commission is: what good does it do to treat people for illness and then to give them no choices but to go back to the very conditions that make them sick? Victoria’s “Better Pathways” document is acknowledging this in terms of prisons.

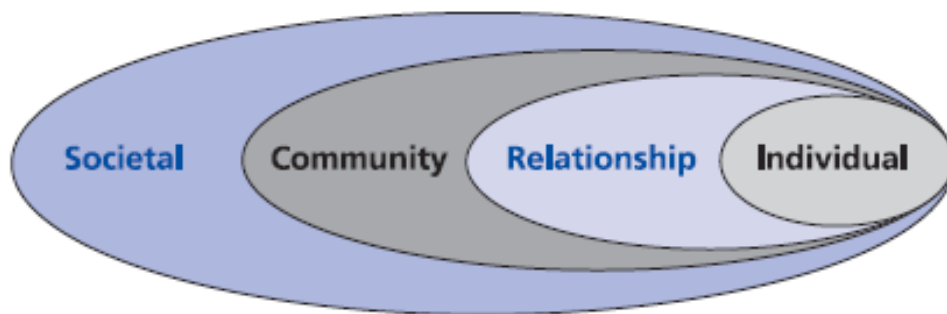
One of the Commissions key strategies is establishing a range of knowledge networks. You heard Helen (Keleher) mention earlier that she is a member of the gender knowledge network. Dorothy (Broom) mentioned Steven Lewis this morning. He is one of my fellow Commissioners and it is thanks to Steven the network is there.

One approach proposed was to weave gender through the other networks, and Steven came to the meeting and made an impassioned call on the basis of his work with HIV in Africa about the need to focus on women.



I looked at your 10-point plan and I thought violence would be a good example, from the work of the Commission, to think about inter-sectoral action. Violence is one of the most gendered areas of public health. It is one of those areas with strong the gender patterns – overwhelmingly, men are perpetrators and women are the survivors of violence. It is seems to be a good example. One of the things to consider - it is a case for inter-sectoral action - is how much upstream do we go?

Ecological model for understanding violence

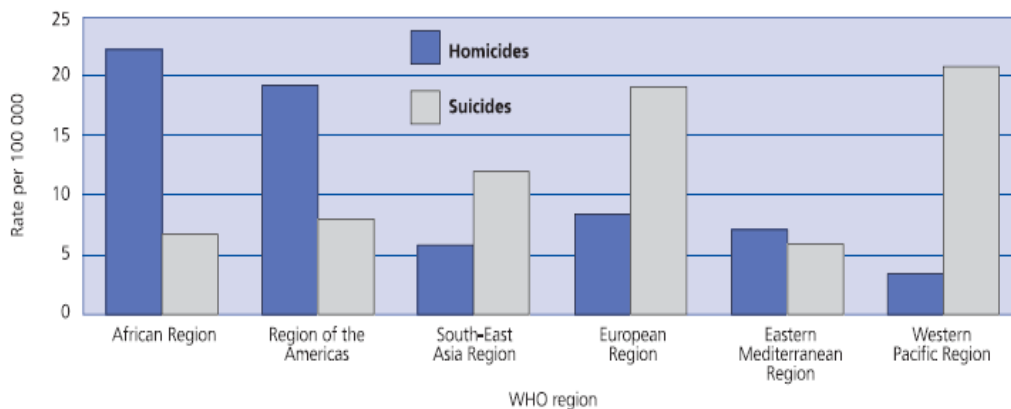


Source: WHO 2002

The current working paper on this from the Commission says that if we really want to look at violence, we have to look at social exclusion in a whole range of different ways. It may be that getting women on boards is a great way of preventing domestic violence. It is actually changing power, and it might be those things that are more important than the downstream things. But I would say about getting people in power - it is what they do with it when they get power.

We know the examples of women who get to positions of power and don't do as you might like. There is lots of data I could have picked, but I picked one that shows homicide and suicide rates by WHO regions. The light-coloured ones on the right are suicide, and the dark colours are homicide.

FIGURE 1.2
Homicide and suicide rates by WHO region, 2000



Why do we get a pattern across the world? Genderism, culture, socio-economic factors among other things. It shows when we talk about violence, there are some very distinct patterns. We have heard about some of the inter-sectoral approaches. In Australia we have much more responsive health services, people who are trained and, generally, willing to intervene. A legal system, refuges and shelters, education in schools are all clearly important.

I suspect the fact that Australia has been a leader might account for this slide, where you'll see that Australia is one of the countries where people are least likely to have not told someone about the violence, to have contacted the police, to have told their friends and family.

TABLE 4.3
Proportion of physically abused women who sought help from different sources, selected population-based studies

| Country or area | Sample (N) | Proportion of physically abused women who: | | | |
|------------------------|------------|--|----------------------|------------------|----------------------------------|
| | | Never told anyone (%) | Contacted police (%) | Told friends (%) | Told family (%) |
| Australia ^a | 6 300 | 18 | 19 | 58 | 53 |
| Bangladesh | 10 368 | 68 | — | — | 30 |
| Canada | 12 300 | 22 | 26 | 45 | 44 |
| Cambodia | 1 374 | 34 | 1 | 33 | 22 |
| Chile | 1 000 | 30 | 16 | 14 | 32 ^b /21 ^c |
| Egypt | 7 121 | 47 | — | 3 | 44 |
| Ireland | 679 | — | 20 | 50 | 37 |
| Nicaragua | 8 507 | 37 | 17 | 28 | 34 |
| Republic of Moldova | 4 790 | — | 6 | 30 | 31 |
| United Kingdom | 430 | 38 | 22 | 46 | 31 |

Source: Heise LL, Ellsberg M, Gottemoeller M. *Ending violence against women*. Baltimore, MD, Johns Hopkins University School of Public Health, Center for Communications Programs, 1999 (Population Reports, Series L, No. 11)

I would like to think that we have got some of the inter-sectional stuff right in Australia. But the questions are: are the responses really upstream? Is it responding to the root cause of violence? Is it the causes that we, on the Commission, think that we are thinking about?

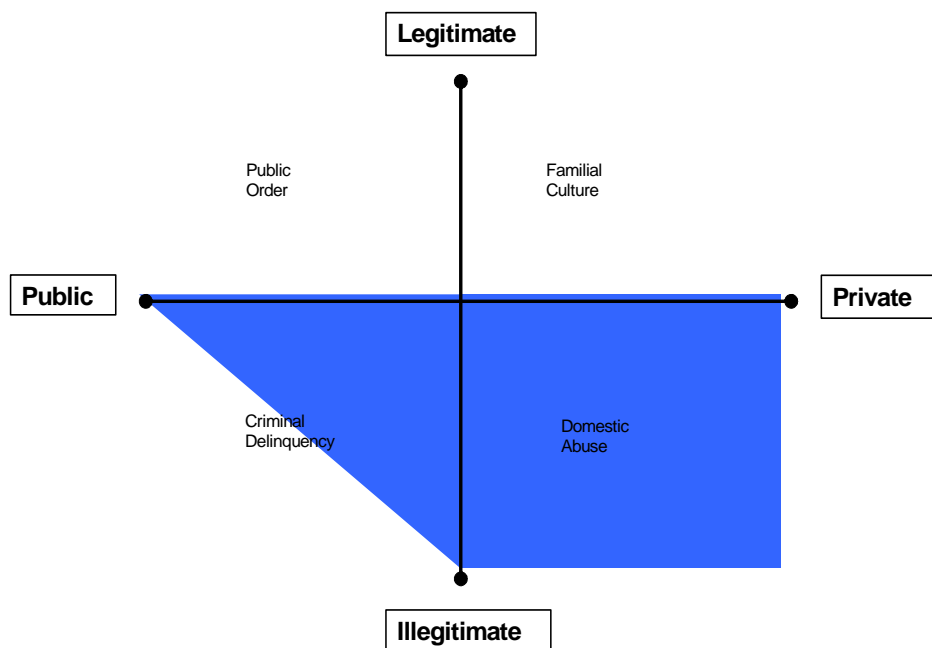
One of the reports that some of our people working in the secretariat have put together is that we live in a society where, all the time, there is violence by the state. These include:

- Budgetary allocations to military spending and defence of the realm;
- Policing, security and judicial institutions and practices;
- Penal systems of imprisonment, corporal and capital punishment;
- Extra-judicial killing, detention without trial, internment and torture;

- Slum clearance, eviction, deportation and population movement;
- Organised (or tolerated) pogroms, ethnicides and genocides.

This morning I was reading about the treatment of David Hicks in Guantanamo, an extreme form of violence against one person. That is tolerated, according to our Foreign Minister, because of what happened in India yesterday, an extreme form of violence justified the holding of the prisoners.

What message is that? Daily messages from Iraq, Palestine, sanctioned violence before our very eyes. One of the things the Commission is looking at is what are the synergies between legitimate and illegitimate? They have knock-over effects on how mainly men behave. We have to start thinking about these things and not saying things like the politician's comment about domestic violence not being mainstream policing, because that exactly reinforces the view. Of course it is mainstream policing, but somehow it is just viewed as being different. It is a really important point.



Source: CSDH, 2006

It seems to me that if we are very serious about upstream, having a look at the causes for violence, we need to look at primary prevention. In Australia we are in a really good position to move on. We have addressed some of the intersectional violence, institutions responding appropriately to violence, but now we have to look at questions of gender relationships, admissibility, statements, that are fashioning the social exclusion that leads to violence.

Finally, I think we really have to look at the social institutions and they're not exclusively the state, but mainly the state, which bear the responsibility for social order and actually influence the forms of violence that a society manifests. And look at how can we have the double standards about violence, where it is acceptable and not acceptable.

I suspect if we are going to get at causes of violence, it is the kind of state-sanctioned violence that we are going to have to start questioning as women and say, "This is not acceptable". Thank you.

Maree Davidson - Managing Director, Davidson Consulting

Maree Davidson has a background in education, community development, psychologist, marketing and public health. Maree now runs a consultancy that works across government, non-government and corporate sectors. Much of her work involves the development of strategies, campaigns and services addressing myriads of diseases, behaviours, body parts, and social issues. She is a member of several not-for-profit boards: Melbourne Writers Festival, Transport Ombudsman, Indigenous Leadership, Centre for Multicultural Youth Issues, Coalition Against Bullying and Women's Health Victoria.

Hello, everyone. It was quite fortuitous that after I was approached to speak today that I happened to be cleaning up my office, because I'm about to make a shift. It's nowhere near as cathartic as cleaning out the wardrobe or putting out the rubbish for the hard-rubbish collection, but there is something about going through 15 or 20 years of files to really reflect on what it is you do in your work and your life. And a lot of it, I thought, was very relevant to the topic today, because we live our lives in an inter-sectoral way.

We don't live a life that is necessarily governed by health or education - you might work in those ways, but we live our life across sectors, and we don't just live our life in the government sector or the philanthropic sector or the corporate sector. Our lives are influenced by, and we in turn influence, those things around us. Of course, for many of us, they have influenced differences, and some of us are included and some of us are excluded more so than others, and I think we have heard a lot about that today.

I thought I might spend some of my time speaking about the initiatives that I found when I was going through those files. Some of them might seem to you to be not-so relevant directly today, but one of the things I have discovered in life and my work is that sometimes the direct path is not the one that is going to get you the results that you are really looking for. Sometimes it is about the fortuitous path.

I remember what it was like 21 years ago. I wouldn't like the fortuitous path to take 21 years to go down, but there are some things we need to approach in a whole range of ways and perhaps get a lot of people on board before we are going to effect the kind of social change we are looking for. I would very much put women's health in that social change.

So, one of the things I was doing was looking through the files, trying to sort them in a way, and I had some help from a colleague. She was saying, "What classification system do you want to use? You might want to use a new one. When you move into the new office, corporate work, have a folder for that, and what about some of the government work?"

And she asked, "Shall I separate health, from education, from Department of Victorian Communities? And what about some of the Australian Government work, and then the work that you are doing with the British Home Office or the Government of Vietnam? Does it all come under government? What about some of the work that you do in the non-government sector for the Cancer Council and Heart Foundation, and some of the other organisations? What about the services and government and local government?"

We realised not only was it difficult, but every day we face this as well: you are dealing with a whole range of different audiences and relationships and you have got to make sense of them in some way. One of the things that complicates this is - and Kerrilie (Rice) before was talking about the lenses that we might use, or the fabulous layer cake - 'Do we go from an issue? Do we go from a social or a health issue? Do we use population groups in the big-picture initiatives that are happening or life stage?'

One of the things that became evident across all the work is they have all started somewhere but what happens is they somehow morph into something else. As an example, I was working with Holden - for good or bad - helping them to evaluate the effectiveness of their marketing campaigns, looking at their advertising and saying, "Is it helping to sell more cars?"

They caught on to the idea that I did work in other areas as well and I might have an interest in women. So they asked me if I would be prepared to assist them with looking at the purchasing experience, and the whole experience around owning and purchasing a Holden car for women. It went from design - which is a seven-year process - through to the purchasing experience, what they would like, the role of women as car dealers and sales people, through to what it is like for women when they are dealing with some of the male salespersons and then after-sales service.

So we started down this path. But then the marketing director, a woman at the time, started to get quite interested in why I was interested in women's health and wellbeing. It wasn't long before she was assisting some of my not-for-profit clients who have an interest in women and women's issues, to help those organisations with some of their communications work, marketing, leveraging dollars not only from Holden but from other parts of the corporate sector.

So that is just one little example, but the whole idea is that one of the difficulties is that sometimes, to effect change, that is how it is going to happen.

One of the things I have realised, and I know you have all realised as well, is that sometimes to effect change, what you need to do is to work 'outside'. So we can bond, but sometimes we have to bridge as well. Part of that is for others 'outside' to become our champions and work with us on this.

Sometimes we have the most unexpected allies. I would never have expected a few years ago that Holden would be improving health for women in Victoria or Australia, but it is one of the ways in which they see themselves. There are other examples.

I'm not sure if some here were involved in the Macro-Melbourne initiative. Anyone know of it? One person? A couple? Macro Melbourne is a fairly new initiative and it is a joint initiative between the Melbourne Community Foundation, the Community for Melbourne, Melbourne Cares and supported by government and a whole lot of other interests.

It works across those organisations; it is working across the corporate, philanthropic community and government sectors. It is looking at where do we find disadvantage, and looking at a 25-year time span, so looking towards 2030 and saying, "What do we need to tackle and what do we need to do? What are the implications for social policy?" And I suppose urban planning and a whole range of other things.

One of the challenges for those of you who might be involved in it, is that when you put gender in it, is that we will need to talk to people outside the sector, which might be uncomfortable. We will need to be engaging with big business, we will need to be looking at philanthropics. But if we want to make gender essential, we have to do it.

One of the things that is absolutely essential is for us to find the language with which to communicate inter-sectorally. I think sometimes we can be talking at cross-purposes, because we don't actually hear what the other partner in the discussion is saying. It may be that we do have some common ground. We just need to understand, and in many instances to develop, the common language. I'm sure you are used to doing that in the areas in which you work.

If we want to progress women's health in Victoria, we have to look outside government, women's health, joined-up government.

We need to be engaging with those who we know have influence in all sorts of ways: the media, business, and the philanthropics. It may be individuals out there we need to engage so we have a proper cross-sectoral approach to this and we can all benefit from it.

VicHealth has been mentioned a few times today and I was involved in the campaign, "Together We Do It Better", and I wholeheartedly believe it. If you find a way to work together, which is really resonating from what Fran (Baum) said, we can make a difference and we will find some of the solutions that we have been looking for, for so long. Thank you.

Session 3 - Questions & Answers

Chair: Kathleen Walsh

Q. *Tricia Malowney:* Just a question for Jenny. It is about the problems that women with disabilities face in accessing justice. Particularly in relation to no data collected on disabilities to report from, also difficulty in accessing police stations, physical access, but also being believed. There is a need for the voices of women with disabilities to be heard in justice. We have been trying for some time to get a seat on the state-wide steering committee to reduce domestic violence. We have a seat on some state-wide committees but one of the major problems, when we ask to be heard, they talk to service providers and not to people with disabilities. So I'm hoping that perhaps you can advise us on how we can get involved, get more involved, and ensure that the government does listen to us. There is definitely a feeling that government is aware that we do need assistance and are willing to do that, but it's how do we do it? One of the biggest impacts on women with disabilities, on their health and wellbeing, is the impact of violence. For example, women with intellectual disability, we believe, have sexual assault and rapes at 68%. How can we get more involved? How can we get a seat at the table? I guess that was more of comment, but it is a question as well.

JENNY MIKAKOS: I'm happy to feed that comment, and other issues that have come up during the course of the day, back to government. It is difficult for me to respond for particular Ministers, for whom particular requests may have been made. But can I just say that as a general point, it is always important for different advisory committees to have broad cross representation of needs and experiences. For example, on the committee that I chair, the Women's Correctional Services Advisory Committee, we do have a woman who is a former prisoner herself. Her insights are just fantastic. So I think it is important to convey that to government, I think basically, my advice would be keep plugging away at it, keep making that request because, as you say, government should hear not just from agencies but also from consumers, users of services, and they do provide a different insight for government that you will get from agencies. So I'm happy to talk to you later during the afternoon break perhaps about the specific committees for whom you have expressed that interest or people you know who have expressed an interest. But I say keep putting your hand up, people should write to Ministers, and say, "I've got the expertise". These things don't just get lost and tabled in a filing cabinet, these things get taken seriously and usually those names are kept somewhere on a database and when positions are filled, people who have expressed interest do get considered for those positions.

Q. *Joy Free (Women's Health West).* One of the points of the 10-point plan is looking at the structural processes and structures there are in maintaining gender differences and the idea that a framework needs to look at those in terms of the multiple and compounding disadvantage which goes into the layers of the cake. It was just a comment, if someone wants to comment on the framework.

PROFESSOR FRAN BAUM: I'm not quite sure what you mean, getting to the causes of causes, as I recall it. I do think that's really important and it's really hard because very often what you are doing is the phrase, "You're speaking truth to power, and it doesn't always want to be heard". That is the most challenging point. Because the difficulty is that so much of the things are things people take for granted, and how do you get them to see it in a different way? What I would say is, look back to where we were, say, with violence in intimate relationships in 1980 and look where we are now in terms of understanding, and people just see it differently. It is a very heartening thing, but now we need to do it in a whole range of other areas, distribution of power and health, I think your point is well taken.

KATHLEEN WALSH: Thanks for broadening out our thinking, but as you were speaking about the corporates, I was thinking this morning when Marilyn talked about posters and banners and the reason we need them, after 21 years we get asked on a daily basis, “Why women’s health?” How do corporates become interested?

MAREE DAVIDSON: I think we have to show we’re interested in understanding what corporates are on about as well. We like it as individuals if someone shows interest in us, and if we show them the relevance of what we are doing to their work, then we are more likely to engage with them. It is really about communication in many ways. If we are told something, and in particular if it is an implication that they are not doing as they should be doing, then they are not going to listen. We need to understand what their bottom line is, I suppose.

I can give an analogy from the environment sector. For many years we have been trying to get businesses to be much more responsible around their waste management, the reduction of waste - all of those things. So what we have been trying to do through the EPA and Sustainability Victoria is to sell the environment message. What they are worried about is the sustainability and viability of their businesses - they want that question answered first. Sometimes they are quite willing to do things, but they have got to know that the things that are fundamental to them are still going to be protected – like their livelihood of being able to put food on the table for those businesses.

I think in some cases the women’s health issue may be a little like that for businesses. So too for corporates. But the other thing I found is you can engage with key people in those organisations who have influence, and you can do it in a way that wins over a few of the influencers. Particularly if you are leaders in the organisations, then you’ll be able to influence the culture of the organisation. I think we have a lot to learn about the way in which we engage, but they have got to be willing and express an interest.

PROFESSOR FRAN BAUM: On this issue, we also have to remember these are deep-seated issues of power we are dealing with. Often the best way of doing that is through a state-driven regulatory framework and the best thing is doing it without giving them a choice. We have to remember in an area of deregulation, we should be arguing for entering an area of re-regulation, where the state says, “This is the kind of society we want and if you want to play in our State, then these are the rules we are setting,” rather than just relying on persuasion. If you look at many public health instances, a change has been achieved because of regulation. It is a powerful instrument and it has proved to be very powerful for women.

MAREE DAVIDSON: I absolutely understand the power of regulation, but I would also say that it is about the combination. You had a speaker this morning who spoke about looking at changing behaviour with providing regulatory legislative framework and I think it is a combination. But I think we are going to progress faster, more quickly, if we have got a combination. I think that the carrot-and-stick approach is really going to get us much further than just the stick.

Q. Nola McLeod (State President of the Country Women’s Association). I’m here representing over 7,000 women throughout Victoria. We have been involved in a number of partnerships with government. Trafficking of women is very high on our agenda. We have been working with Positive Women and I would like to commend to some of you ladies in Melbourne for the play ‘In The Family’, which is coming to Saint Martin’s Theatre in early August, and it is the story of some of the women who have contracted AIDS.

But what I would like to talk about is the lack of services in rural areas and this is impacting on women’s health. The lack of obstetric units - people in the western part of the State are having to travel down to Horsham to give birth. There was a piece in the

Weekly Times a couple of weeks ago. I'm working with the Rural Doctors Network on formulating some strategies for that. Before suicide was even on the agenda with Beyond Blue, we ran suicide awareness programs around the State because we were very concerned with that.

At the moment, and for the last 12 months, I have been burning the midnight oil. Our organisation was given \$760,000 from the Federal Government's drought relief. I still have some funding left, and for some of you people from the drought areas (the exceptional circumstance areas) if you would like, I can assist some of your families and I can pay up to \$1,000 per family to help with household accounts - petrol, food, those sorts of things. There is also potential here if you want to run a community event to run for the betterment of women's health. Thank you.

KATHLEEN WALSH: Thank you for that important reminder about women in rural areas, and in particular sexual and reproductive health. We know it is a crucial issue.

Q. Christine Leavy, (Melton Shire Council). In the preparation of the "Better Pathways" document, I don't think you talked to anyone from Melton Shire Council about it. We support a lot of the families that have women in the service and we don't even hear from Corrections Victoria until they sort of send someone down for counselling in the Shire, but the question is: all these grand plans and good ideas, are we developing a channel of communication with the Department of Education and those who are involved with developing the curriculum? We talked about being upstream, we need to present and model a radical change of thought with our young people in these areas. I don't think we are talking about working with that silo today. That is unfortunate. Thanks.

JENNY MIKAKOS: I will make sure that Corrections do talk to the Council in the future.

Q. Val Johnston: I have got a particular interest in health from a woman's perspective, but also believing - I guess my basic principle is that healthy individuals make healthy communities so that's my sort of modus operandi. My issue I'm going to raise - and I think all of what was said this afternoon is fantastic - but I'm still going to go back to an issue from this morning, which even the Minister identified as something that is current, was to do with the issue of actual social connectedness.

If you look at the data, and if we don't talk about evidence-based health practice, we say we know all these parlances - we know that women live longer, we know there are an increasing number of single-person households and a number of those are women, and yet there are less and less places for women to actually connect if they do not want to connect in a formalised way. I feel that that is something that local government needs to address at various levels and you know, all the males on hand need to be aware of that, all the community health centres that are involved with PCPs, they need to particularly have that lens, as it was described this morning. It was very mainstream that the strategies that are used and they need to have the lens, without naming the name of the city that I belong to, their mandate is that, "We have so many kilometres of footpaths," and I said, "Excuse me, people don't just need footpaths, they need to go somewhere". And women, above all, need that to nurture their emotional needs, and we need to be sustained. I think that is really the issue that I would put on the table and I would see that as an issue that needs to be addressed by all of us. It is our right.

PROFESSOR FRAN BAUM: I think what you are saying is really important. I don't know what unit it is in the Victorian government, but they had a great report on housing, safer structures - it was fantastic. But also a researcher in America who has looked at third places and says all successful communities have these places that are not necessarily homes, and not commercial, but places people can meet to get to know each other, welcome strangers to the community. So for me, if we're talking about strategies for

health promotion, the connectedness is far more important than trying to change people's behaviour directly. Very important.

Q. Amanda Tattam (Key Centre for Women's Health in Society, Melbourne University). We are one of the endorsing organisations for the strategy. I just want to make a couple of points, and an observation. First is that a colleague and I noticed today that the average age here today is about 40 or 50 – apologies to anybody who is young, but it is a bit of a disappointment. If we are going to make some real changes we need to think of ways to engage younger women. That leads to my second point about the use of media and the worldwide web. We have got more women's magazines than we can poke a stick at, but how many talk about women's health? We need to build a portal about women's health, a one-stop information stop, not just a clearinghouse, but something that is accessible to women in the bush, of all ranges of ability and disability, and I wonder what the panel and the State Government think about that idea?

MAREE DAVIDSON: I'm interested that you and a colleague were making a comment about the age of people. That was a discussion that I had with someone at morning tea. To start with – please put your hand up if you're under 30? Keep your hands up under-30s. If you're under 40, put your hand up as well. Over 70? Where are our elder stateswomen? We do have a good critical mass of younger women. I think that the issue around young women and communications and where they access their information and the quality of the information that is available to them, it is an important point. I think there are those things around setting up something, or Women's Health Victoria and a whole range of other organisations here have accessible web sites, but it's about do young women know that they are available, and how do we promote that to women? The other part of it, too, is if we have any influence about what the content and the approach of that, the whole range of women's magazines that are out there, and I don't know if we do, but there are a couple of options there to go on.

Q. Dorothy Broom: It's a suggestion that one of the ways we can speak across sectors a bit is to repeatedly make the point that the gender lens is not some sort of special thing to bring in. Many have gender. If there is no explicit gender analysis, it is not gender neutral. It is actually going to be gendered in all sorts of hidden ways. So I think we have to keep repeating that, just constantly, and showing the specific cases how, in fact, there will be implicit gender data if we don't do a special conscious and self-aware gender analysis.

KATHLEEN WALSH: Thank you for sharing with us examples of successful inter-sectoral communication.

PANEL SESSION 4 - ENVISIONING THE FUTURE

Chair: Diane Wilkinson

Speakers: Dale Fisher, Libby Mears and Sue Clarke

Facilitator : Marilyn Beaumont

Session 4: Priority Issues

- *Focus on the strength of specialist women's services working in conjunction with organisations engaged in local catchment and regional approaches.*
- *Advancing gender in health requires strong political action, broad participation and sustained advocacy (adapted from the Bangkok Charter for Health Promotion)*
- *How can women in positions of leadership help advance gender in health?*
- *While much of the fundamental evidence of gender in health is known, the translation of it is still relatively poor. How do we encourage policy makers to draw on this and the gendered expertise that exists?*
- *What needs to happen to enable organisations to place gender on their agenda? How can we build the capacity of others to do this?*

I would like to introduce the chair of the session, Diane Wilkinson. She is from another vast region of the state, and has over 20 years experience in numerous administrative capacities in the health sector in the Latrobe Valley, community health and acute hospital settings. Dianne's background is in business management, resource management and training and is also currently chair of the Wellington Primary Care Partnership. Thankyou Dianne.

DIANE WILKINSON, EXECUTIVE DIRECTOR, GIPPSLAND WOMEN'S HEALTH

SERVICE: Thanks, Marilyn. And thank you to all the stayers. A tough gig at the end of a very long and interesting day. I'm sure we have still got a lot to learn and listen to. Envisioning the future - I suppose it is about taking the knowledge and evidence and extending the premise of those inter-sectoral collaborations to really talk about and to enable the inclusion of the strength of specialist women services working in conjunction with other organisations in other catchment and regional areas.

One area that women's health services are involved in quite extensively is the area of the integrated family violence strategy. I know they are working on that particular issue. As we have heard today, advancing gender in health requires strong political action, broad participation and sustained advocacy. We have also heard about women now coming more and more into positions of leadership, so it's about how do we utilise those women in those positions of leadership to be able to advance gender in health?

We have heard about the evidence, we know there is evidence out there. While that evidence is known, the translation of it is still relatively poor. It is so important to take that knowledge and understanding and move it forward.

How do we encourage policy-makers to draw on the evidence and gender expertise that exists? What do we need to do to enable organisations to place gender on their agenda? And how do we build the capacity of others to do this? To help us in our consideration of these pretty important issues, we have three excellent speakers across the acute health, local health and government health sectors.

Dale Fisher – CEO, Royal Women’s Hospital

Dale Fisher was appointed Chief Executive of The Royal Women’s Hospital in July 2004, the first woman Chief Executive in The Women’s 149 year history. For three years preceding the appointment, Dale was the Executive Director of the Hospital. Dale is a leader and advocate for women’s health and has focused her career on leading and managing quality public health care services to the Victorian Community. Dale practiced as a Registered Nurse for over 10 years before pursuing studies in business management, completing a Bachelor of Business and recently a Masters of Business (MBA). In addition Dale is a member of the Board of the Queen Elizabeth Centre, an early parenting centre in Melbourne, and is an Associate Fellow of the Australian College of Health Service Executives.

Dale Fisher’s presentation has not been reproduced. Permission for publication has not been given.

Libby Mears – Mayor, Surf Coast Shire - “Envisioning the Future – where Local Government leads the way”

Libby Mears’ professional background and academic studies is in the area of health promotion particularly in policy development and project management. Libby has worked in State Government, within community organisations and as a health promotion consultant. Libby’s Masters’ degree thesis explored the role of health promotion practice and internet-based technology. In November 2004, Libby was elected as a local government councillor in the Surf Coast Shire after a number of years as an activist in her local community lobbying for issues affecting women, children and families in particular. Since becoming involved in local government, Libby’s passions for health and wellbeing and the connection to place and communities have merged and she feels incredibly fortunate to be able to use her voice to place these issues high on the local government agenda. In November 2005 Libby was elected Mayor of the Surf Coast Shire.

I would like to acknowledge my local government colleagues here today. I’m really pleased to be here, to be part of this really important discussion. I’m energised by the momentum that is coming over today. I think the opportunities are going to be there for us.

Because we have got the hardest session, I decided to put up a provocative title for you to think about. I find myself in an unusual position, spending the last 15 years passionately in health promotion. Dr Rae Walker started teaching me about it in the late 1990s and I have been there since in the traditional settings of the Department of Human Services, community health, and primary care partnerships, etc.

Now I find myself a Mayor and I am thinking about things differently. It is an interesting lens - we have been talking about it a lot today - to look through. I hope, today, I will bring you along and convince you that partnership with local government provides a tremendous opportunity to advance the health and wellbeing of women - particularly marginalised and disadvantaged women - for a range of reasons. But because of the strong connection local government has to the communities, we need to be clear we are talking about upstream activities.

The local government does keep women and people well in a number of ways. To quickly outline the approaches: one is through policy. Council policy documents need to reflect health and wellbeing. Whether it is the council plan, corporate plan, community statements - there are a heap of them - they need health and wellbeing embedded in them.

In our local government planning document, we have mandated something like 143 different plans. Again, lots of the linkages, whether it is the municipal plan, the access-inclusion plan etc., need to reflect elements of health and wellbeing. Through the provision of Council services and programs, we are doing things like home and community-care programs, children's services, recreational services, support for our neighbourhood houses and support for play groups.

Finally, importantly, through our advocacy, coordination and partnerships in bringing people together to discuss our issues, facilitating networks, supporting grassroots activities, women's singing sessions, book clubs, local art programs - it is, again, connecting people within a community. I guess I'm encouraging you to envisage the future where local government does all this in partnership.

Certainly, hearing today the work around gender analysis and gender frameworks, it is a great opportunity. I know it is happening in the Borough of Queenscliffe - there is work to look at the role of local government through a gender framework. That is where your skill can merge with local government.

To take you on a quick journey down the coast, (See Map below) this is where I live, work and play. This is what I look at and think about when I think about my community. It is a rapidly growing area. The main areas of growth are in Torquay and Jan Juc. It is going to double in the next 10 years. People are moving into the shire, young families and older adults.



We have 79 local governments across Victoria and they are all a bit different. It makes it hard to work the same way across Victoria. It is a setting that is unique – similar, but unique in each area.

When I think about my community and what their needs are, the things that pop to my mind are:

- Issues of child care for women in Lorne. There is no child care.
- How we provide services for our ageing population to stay in their own homes and stay connected to the community.
- How we provide affordable community housing so we can have diverse communities, where we have housing that suits people if they want to downsize from a large home to a small home and stay within the community.
- Employment challenges - can people live and work in the same place or commute every day?
- Social connectedness is absolutely critical in a community that doesn't have any public transport, that has a whole lot of people moving in and they don't know anybody. How do they find entry points into the community?
- How do we support people who have been there for a long time and feel the community is changing, and they are concerned about that and withdrawing?

These are issues that I see as social determinants, the core work that I'm working with my Council to try and address. But there is no doubt that over the years, Councils are becoming more aware of the role they play in improving the health of the community. On Tuesday we were talking about this kind of thing. There are opportunities for local government to really influence their communities and their health and wellbeing. You only need to really look at the recent edition of the 'VicHealth Letter', which came out the other day:

"Many have embedded health in their social, economic and environmental planning. They have accepted their leadership role ...because of this, local councils are important partners in health promotion.

They can directly influence factors like municipal planning, employment, social support, transport and community participation – all which contribute to good health."

VicHealth Letter, 2006

That is actually showing a whole range of wonderful examples of work that Councils are doing as partners and advocates and facilitators in the quest of advancing health and wellbeing of the communities, and women in the communities. They have had a chance to talk to some of the women Mayors. Today you heard about the great stuff they are doing as women leaders in the community.

I know there is some fantastic work that is being funded by VicHealth and Latrobe University. It is cutting-edge work and it shows us where we can draw together our expertise and, I guess, our focus on the issues in it the way that we talked about today, particularly violence and women.

Why do I say we are connected to community? I say it because we really are. It is a priority that is really moving through the local government sector. Community planning is now the norm.

How we determine what we spend our budgets on is by understanding what community priorities are all about. We are really looking at understanding what our communities value, what they see as issues, as solutions, and our plans to respond to community issues.

We need to know our community, understand their needs and priorities. It is clearly on our agenda, and it is a really important thing that health services can tap into. The work that we do in engaging the communities, certainly on the Surf Coast, is high profile and

across most of the sectors, and fantastic work is being done in the Council. It is viewing people as the priority. When Council does that, it can make a positive impact on the health and individuals in the communities.

One more slide, which is just to let you know that the Victorian local government sector really has a commitment to women and this is through the Victorian Local Government Women's Charter, which is a document endorsed by the Local Governments Association and the Women's Participation in Local Government Coalition.

The Women's Charter has three key principles:

- Gender Equity
- Diversity
- Active Citizenship

It is about saying we need women involved in decision-making structures so they can shape the future for women. There has been a lot of work in trying to ensure we do get representation. This is the first time we have the highest number of women Mayors, it's not enough, but you need to use these women to try and also heighten women's issues. Don't be afraid to get on to your local councillors and tell them about these issues.

Gender equity is one of the key principles, diversity about including a range of experiences which they bring with them, and active citizenship - trying to increase numbers of participation of women in public life. If you want to know more about it, I'm happy to talk to you. It is a way to honour work which advances women in the community.

A challenge from me to you is: how can we, and possibly even within the 10-point plan, talk about it more, the opportunities that the local government sector offer?

Just to reiterate the wonderful words of Kay Setches this morning: capacity and coalitions to take women's health and further than where we are now. Thank you.

Sue Clarke – CEO, Bendigo Community Health Service

Sue Clarke has been a nurse and a pre-school teacher, ANZOG Fellow and a member of the Australian Institute of Company Directors, as well as having post graduate qualifications in Social Science and Business Management. Sue is a member of the Board of the Victorian Healthcare Association and Deputy Chair, Community Health Victoria Council. She is a founding member of the Bendigo and Central Victorian Community Foundation and a member of the Bendigo YMCA Board of Directors. Sue currently holds the position of Chief Executive Officer of Bendigo Community Health Services and has been in this role since 2000.

Good afternoon.

I guess my talk comes from a slightly different perspective to those before. I really wanted to take us on a very short, sharp journey considering the elements of futures thinking in visiting the future. It is an interesting topic at the end of a very long day. As the last speaker, I'm hoping that you'll indulge me a little as I present my observations to you.

My intention today is to use symbols and experience to discuss how they influence us as individuals, members of families, communities and organisations. And, therefore, how this in turn influences how we think about the future.

I would like to present to you a fantastic group of people. Mainly women, but not exclusively. They are members of our Healthy, Active and Living Program.



This is the group that has gone from strength to strength over the past 18 months. Fun and sharing is critical as part of the group's activity. They love to party. Without any ado, they will stop, have a conversation, have a cup of tea, gather together, share experiences. Some of us might say as professionals, they are evaluating their group, where is it going? What will happen next?

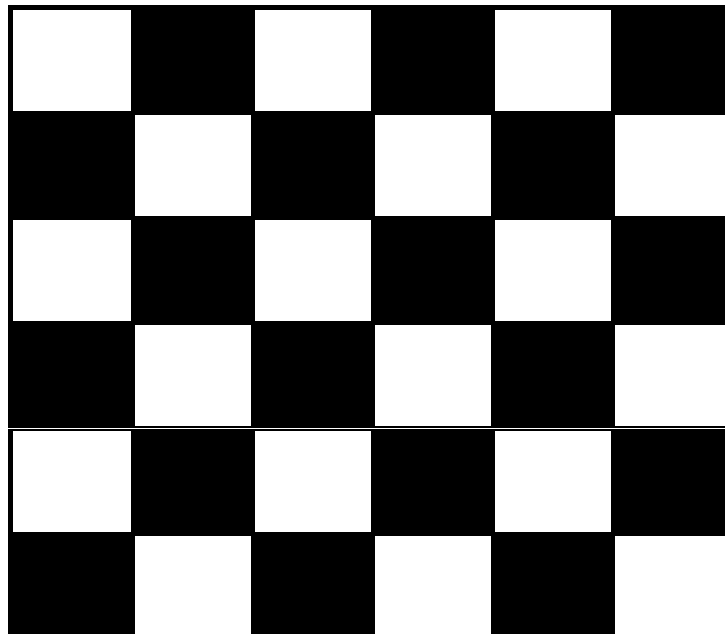
Elizabeth is a member of this group who made quite an impact last week. She disappeared for a few moments and then made a grand entrance. Queen Liz.



She obviously felt safe and was prepared to share her amazing likeness to Queen Elizabeth. I would say she took a risk to stand out, to take centre stage and certainly make an impact on the gathering. There was quite a lot of bowing happening, even from the staff. I expect that she may well have given others permission to take centre stage on another occasion.

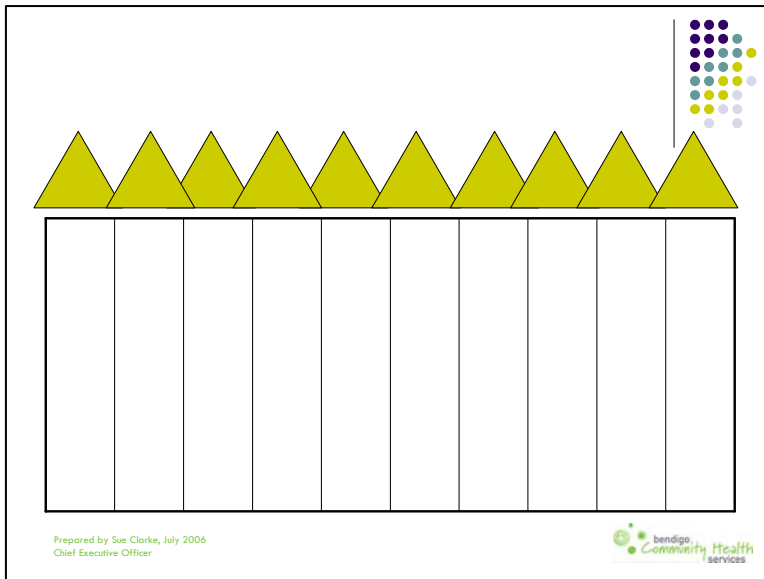
Our experiences certainly do impact on how we think and feel. There are often enormous constraints on being different, on having a view that does not fit the norm. We are captured, to a large degree, at least in the community health sector on compliance and performance. System and experiences can conspire to constrain thinking about the possibilities and the future.

I would like to take a few minutes of your time to remind us all that we do need to take time to break free from, perhaps, that imposed thinking and take a risk to consider the impossible. A quiz: In taking a look at this slide, I would like to ask you - what do you see?

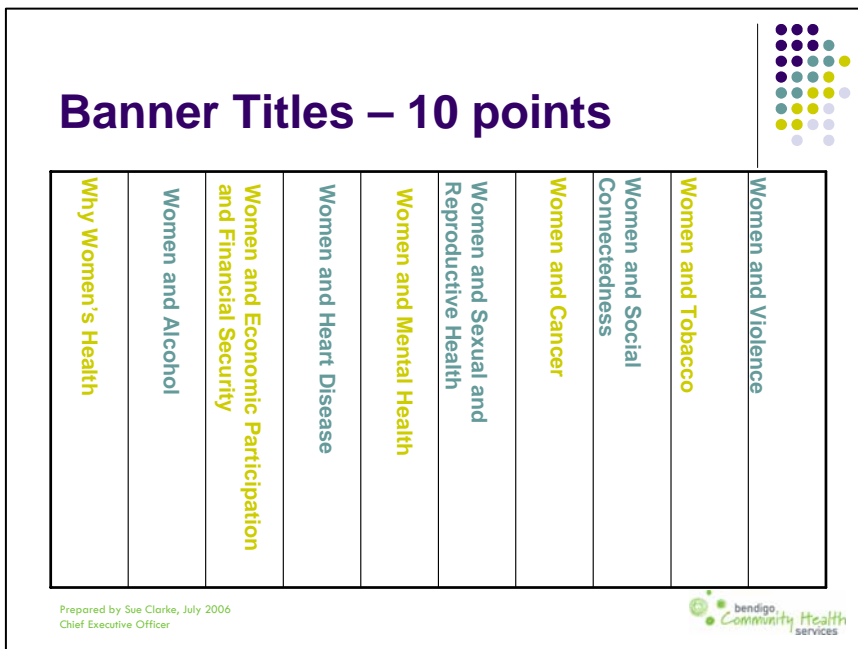


Is anyone willing to tell me? Chess, draught board? Fuzzy dots. Anything else? I have got a few more. Black-and-white squares. Vertical and horizontal patterns, and my husband is an absolute car fanatic, so you know the flag that starts or finishes a race?

How you see a future is influenced by your past experiences. Again, I wonder what you think this might represent?



What does it represent to you? Anyone willing to have a go? Picket fence? Christmas tree? Cabins at the beach? I've got walls of a castle, a sandcastle perhaps, a fence, a gate. And funding silos!!!



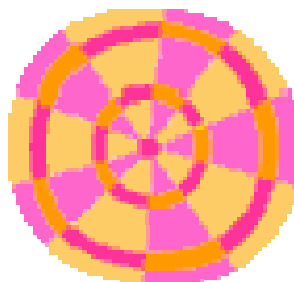
The 10-point plan: Women's Health Matters 2006-2010.

This plan has not just come out of the blue. It has been built on the past. I'm sure there has been a great deal of goodwill, not only from the women's health services but across the broader system. But I ask you: what about the future? How do you envisage there is an inclusive approach, not only to create greater silos.

Many women never know about women's health policy, a 10-point plan, a strategic communication process or research. They will, however, be dealing with drought in rural Victoria, and its impact on their lives and their community. They will, perhaps, be experiencing depression, or maybe a lack of access to services.

Women do think differently. The challenge for the future is not to give up this right. We need to be different. Perhaps it's how you dress, perhaps it's how you communicate, or how we influence policy. We cannot afford for women's health to become a fencepost, a point on a plan. It must be, at the very least, a gateway to making a difference.

In looking for a symbol that I thought could make us think differently, I found this on the internet:



I was very proud of myself that I was able to find this on the net: a birthday cake, perhaps a target, but I prefer a birthday cake. It has got 10 points to it, and many layers. If we join all the parts, the people and the intent, together we can be so much more powerful.

This is the way of considering and thinking in the round, so to speak. 10 points of a circle, perhaps, representing the 10 points of our plan. What is the thinking of now and the future? How do we build on the local, national and international learning to inform our thinking for the future?

Incorporating the social, economic and cultural factors, which has been defined and identified in the background paper for this summit - perhaps as has been said elsewhere, we could add technology. However, having a piece of cake, a circle, is not enough. It needs to be seen as the body. We need strong legs and arms and a sound, but creative, head to build a preferred future for women - not just enact an official future for government.



Leadership is critical now and in the future. The history of leadership within the health system has a gender bias. It is difficult for women to find a voice within mainstream health systems, and more particularly with policy development. Gender mainstreaming, as part of the dual strategy, provides both the opportunities and also the challenge. However, it must not be captured by accountability and reporting, it must influence how and the why and the way - why women's health matters. It is because it is an investment for the future, for the whole population.

The social, economic and cultural factors are women's business - as is technology, not only for technology to do things to women, but technology for women to use for their own benefit. Specific knowledge must underpin gender mainstreaming, not bureaucrat approaches. I am asking us all here today to take the lens, build on what you know, but don't get caught up in what you see the first time.

Our future is built on the past. Our challenge is to consider the future and how we inform that official future of government. Are we prepared, and able, to step outside the scope and create a preferred future for women? One which is built on the strength of collaboration, continues to ensure and reinforce the role of women in planning and influencing policy and practice; engages women and their communities in various ways including conversation, technology and other mechanisms that build on the local whilst informing the global; builds evidence that informs women and government and reinforces the rights of women.

A future that creates a space and expectation of choice where it is a right of women to have a preferred future, not just a gift. Thank you.

Session 4 – Questions & Answers

Chair: Diane Wilkinson

Q. Glenys Janson (Midwife). Thank you for your presentations this afternoon. My question is to you, as a midwife, a profession that is 99% women, a profession that (Federal Minister for Health) Tony Abbott has decided needs to be supervised by general practitioners. I'm concerned in North Shore that women have to travel to Geelong. I understand that midwives can't provide birthing services, even though the World Health Organisation recognises them as the most appropriate carer for normal pregnancy, labour and birth. So I understand the State Government is trying to allow midwives to open birthing units so that women can birth in their own community to provide choices for women in birthing. Do you know of what is happening in your local Council in that area?

LIBBY MEARS: We haven't had any approach to council about the issue, but it would interest me greatly. Just from personal experience, a wonderful woman who I know well, has embarked on the training to be a midwife, as an immediate-entry program. She gave birth to her four beautiful boys at her house around the corner from mine in Airey's Inlet. It is something our community celebrated and watched in wonder, quite frankly. I will be interested to see if it comes through Council, if it gets to Council, but we should be having those kinds of issues. When I talked to the CEO of Health the other day, I said, "It's time to sit down and talk about our strategic planning, what is going to happen to the future of our communities." She said, "We have never done it before." It is time.

Q. Robyn Gregory, (Women's Health West). I wanted to ask Dale a question, in particular. Also, I wanted to make a quick comment. I thought the presentations were terrific and I was interested that two of the presentations concentrated on leading the way, and I thought maybe a reminder that we are going with collaboration. We all like to lead the way, but others have to do it another way. Dale, I was interested particularly in what impact the move of the Royal Women's Hospital is going to have, the move to the Royal Melbourne Hospital site, on women's health and the ability to stay separate. I think in particular of the impact that the move the Queen Vic had to the Monash Medical Centre, and it has disappeared. What do you think?

DALE FISHER: The impact on the services is that it will be an improvement. Currently, the hospital is independent. Peter Mac is a cancer hospital, it is seeking to move to Parkville to be a partner with Royal Melbourne in order to survive. One of the issues is technology, access to human resources to give safe tertiary care. We want to promote mid-wife care at a tertiary centre, as well as high-risk obstetrics.

There is no doubt that there will always be a threat of takeover and integration. I did work with the women's program at the Monash, which was the Queen Vic service. The major impact there was that there was plenty of women's health going on, but it never got any discussion at executive and board level. Resources were always hard to fight for and there was no advocacy at all. Maintaining independence, which I learned, is very important.

Whilst Royal Melbourne might be setting a high standard for health professionals, integration is the way of the future. It will happen eventually. It should not happen. But the best way to avoid it will be to always be on alert. And I think the onus on us is to actually perform better, demonstrate why it is an important not to integrate and, again, I allude to the fact that we have been one of the few metropolitan hospitals to do so, because we have worked very hard at building our credibility around women's health services. We need partners like that, but we don't need to be taken over. It will be an ongoing battle

and we will need to be very vigilant. Having our own board is part of the independence as well.

LIBBY MEARS: I was being deliberately provocative for the afternoon session, but really just inviting collaboration. You are right quite, but let's get around the table together. We have all been working very hard and doing some wonderful work, but fairly independently. It is starting. There are a lot of partnerships happening but we do have a way to go. A provocative statement.

Q. Kerrilie Rice (Women's Health Victoria) I was really interested in the local government charter. If you could talk about how widespread it is, the number of local governments that have adopted it and what seems to be the general mood around it, and also where you see it might go.

LIBBY MEARS: I know I really rushed over it, and I'm going to handball the answer to someone who is far more informed than I am. Linda Bennett from the Victorian Local Governance Association.

LINDA BENNETT: Yes, the local government charter has a memorable history, going back to at least 1997 which doesn't seem all that long in one way, but we have moved a long way since then. There is a lot of information on our web site which can be found just by searching for "women's participation local government coalition".

The important thing for the Women's Charter is that we are at the stage where we have created an award for practice of three principles. We are inviting Councils and community groups to apply for that award and show - either in very simple ways, because they are at the beginning of their journey, or in more complex and rich diverse ways - how they are moving towards achieving the principals. So, those awards applications close in early August, which isn't much time left now, but we are flexible enough, of course. We work in that beautiful, flexible fluid way where if people have an expression of interest, they can put in their expression of interest and put the application in shortly after that. That creates a bit more flexibility around the deadline. That is a really good opportunity to highlight any bits of work that you are considering doing and there is information on the web, or you can contact me through the Victorian Local Governments Association.

The take up? Look, I think the charter has been taken up not formally, very frequently in many Councils, and it gets back to the whole discussion about gendering and what a challenge it is for us all. We see it as the beginning of that journey, really, and even from today I can see it is going to expand out from here. The challenge, too, even for the Councils who sign off on it, it then is the challenge of how they are practising it. It is easy to have it displayed at the front of the Council. The challenge, we say, is to put it into practice. We are at the beginning of the journey and we are looking forward to moving along, hopefully, with everyone in the room.

Q. Caroline Atkins, (Victorian Council of Social Services). We are one of the endorsing members of the 10 point-plan. My question is to Sue. I think your presentation highlighted the need for us to reflect on the ways our experiences and our perceptions do impact on our capacity to move forward. I think that is something that many of us often don't take the time to do and it's a fairly critical thing for us to do. I would just like to get your perspectives in terms of progressing actions to promote the health and wellbeing of women. What do you see as the broader scheme of organisations in envisioning a better way forward in improving women's health?

SUE CLARKE: Fundamentally, it is about accepting responsibility and providing gender services to women. Whether it sits in your service plan or not, in a DHS point of view, it is part of your responsibility. As part of Community Health Victoria, and Victorian Healthcare Association, taking those conversations up through that opportunity that it provides. In

terms of the broader sector of the community, I think it's more difficult, and it's more difficult particularly in rural communities unless you have got some good leaders. Leadership is critical.

I didn't talk about communication, I talked about conversation. I think it's really critical to have leadership where we create opportunities for conversations around the table in a variety of ways, whether it is using structures - like primary care partnerships or others - and the responsibility that it brings. I don't think there is any one pathway, there are a number of them, but it predominantly sits back with taking that responsibility.

OUTCOMES OF THE DAY

Chair: Marilyn Beaumont

I would like to ask the speakers who are still with us to come up and flow on from some of the points I have to make, which are reflections of what has been said, into a final discussion and a few take-home messages.

The messages in the contributions from the speakers through the day which I have in my mind are:

- **Kay Setches** - was wonderful in setting the agenda and saying clearly it is a political process, it is deeply fraught, even where you have got insiders on your side and, that you need to support them.
- **Dorothy Broom** - Public health will fail without incorporating gender. Mainstreaming is well and good but it can dissipate responsibility – we need to make the role of specialist health promotion organisations such as Women’s Health much more explicit in showing leadership as change agents alongside the mainstream.
- **Robert Hall** - Gender is a key feature of health status. There is evidence that improving the status of women improves the health status of both men and women. In terms of improving the population’s health the most popular discussion is about lifestyle changes – this limits the possible benefits which could be achieved. Patterns of health and disease are largely a consequence of how we learn, live and work. In response to questions he agreed that intimate partner violence must be a health promotion priority, that gender must be a part of any health promotion strategy and advised that DHS are working on gender as a health determinant.
- **Helen Keleher** - Gender neutrality and gender blindness is not acceptable, it flies in the face of evidence. Health is not created by the health system. Health priority setting is currently dominated by mid stream thinking – the health promotion and women’s health sector want upstream thinking. All health services, including women’s health, should be mandated through priority setting and funding and service agreements to mainstream gender in policy and practice. Inclusion of gender is about doing the thing right and doing the right thing.
- **Kerrilie Rice** - Three priorities in the 10 Point Plan are not new. Strong intersection in women’s lives across the three. Need to consider health across social determinants plus a variety of lenses – gender is one, others are disability, culture, ethnicity, sexual orientation. Local government are natural partners in upstream issues. There should be a framework of principles for local government with an outcomes focus, VicHealth have a good model. Improve the collection of data so we do have evidence on language, culture, Aboriginality to name a few.
- **Jenny Mikakos** - 10 Point Plan should inform the next Women’s Health and Wellbeing Strategy. “Better Pathways” model for gender in policy and practice re women and the corrections system. Interdepartmental committees are a good way of working across departments alongside a community committee.
- **Fran Baum** - Social determinants of health are on the world agenda but success only comes when heads of state are engaged with this. Are intersectoral health

promotion responses as we know them really upstream? eg. how much does this approach tackle legitimised violence by states? Need to address state sanctioned violence. Strengthen primary prevention in understanding what fashions social exclusion that leads to violence.

- **Maree Davidson** - We live our lives in inter-sectoral ways, and must speak across sectors. Engage with those we know have influence across a broad range of sectors. Gender framework approach, speaking the truth to power is a difficult process – not always want to be heard. We need to make sure the state specifies what sort of state it is within which business works in order to have all contributing to health from a social determinants view. Education system must be involved. Provide spaces for women to connect informally and be sustained (third spaces not home, not commercial).
- **Dale Fisher** – We need more honesty. It is a myth the women’s services work in partnership; this is not so unless there is a commitment from leadership to change the way we work. It is a myth that the health professions embrace women’s health as a priority. Conditions for success – sharing advocacy priorities eg abortion, women’s safety, marginalised women, access and when women’s health is based on evidence. Must have leadership at the highest level and move from collective consensus to strategic action. Priorities must not only be for the women’s sector but state leader priorities.
- **Libby Mears** - Local govt varies from Council to Council. Need to understand variations. Local Govt have developed a women’s charter as a way of taking a common agenda forward, needs to be a process to engage with this sector.
- **Sue Clarke** - Have fun and share. Celebrate difference. Take risks, take centre stage and give others permission to do so. Funded health services are faced with systems and conformance. This needs to be managed in a way which does not stifle change. The women’s health plan must be a gateway, not just enact a government agenda.

In addition to these:

- Having 13 partner organisations working together on the Women’s Health Advocacy Action Plan, Nov 05 to Nov 06, of which this Summit is a part, is very powerful for the future.
- 40 organisations endorsing the 10 Point Plan is a strong basis for new ways of working in the future, across areas beyond our traditional arrangements, endorsements will continue with individual local Councils considering endorsement.
- Our 10 ‘Why Women’s Health’ banners were very successful, and orders from community organisations to borrow them for displays have started already.
- Agreement that we have to get our work away from only mid stream and down stream (health care after the event) to upstream (health promotion to prevent the need for health care). Role of specialist services working with the mainstream in this needs to be made clearer.
- Need State leadership.
- Focus on violence against women not just intimate partner or domestic violence.
- Sexual and reproductive health policy includes getting abortion out of the Crimes Act.
- Focus on young children - boys and girls.
- Across sectors including education.
- Strong support to find new ways to make the evidence we have impact on what is funded
- Collaboration takes time, resources and the development of trust.

The other thing, I think, is the understanding of connections working in different ways at State and local level. If you have got local government varying between different Councils, you have got the women's health services varying between different regions: different relationships around community health, acute care, ambulatory care - the variety is enormous and we do tend to talk about them and think about them as if it operates the same.

Understanding the difference, taking advantage of the difference and learning about what is strong in other areas is, I think, a really big challenge but one that we can work on together. The fun in sharing - the need to do that. Don't be pulled so much into systems and conformance, keep celebrating difference, taking risks, standing out, sharing spaces like this.

They are all the messages that I'm taking home. We are going to write this up into a document so that you can engage with further conversation about it. Are there any other things that you want to make sure that we take with us away from here?

Any questions of the panel?

Q. Ingrid Hindell: I have just had recently an example of policy not being put into practice. A friend of mine had a hospital situation, a rehabilitation situation. Because she can't talk properly, they treated her really badly, a discrepancy between policy and practice.

MARILYN BEAUMONT: So this was a hospital stay? A rehabilitation stay? So the point is being made there is a big disconnect in policy.

Q. Ingrid Hindell: Sometimes, not always. This is one example. But it is a good organisation. In this case, there was a big discrepancy between policy and practice.

MARILYN BEAUMONT: In a way, the need to have systems and shared stories which call organisations to account when, if they say they offer a particular type of service and sensitivity in offering that, but you find that it doesn't deliver.

DALE FISHER: It is a challenge. I think there is a lot of rhetoric in policy in an organisation such as the one I brag about (RWH), in terms of our quality of care and our difficulty is to actually measure that. But I also think that one of the themes that is happening is that bigger is better. I think that we need to go back to smaller organisations. I think that going back to smaller organisations and getting government and management attention on the care and continuity is very important.

Q. Amanda Tattam (Key Centre for Women's Health in Society.) Now, I'm going to say something provocative. I would like to just emphasise, there are a lot of people, even in our university, who say they work in women's health but they work in a biomedical framework and we shouldn't leave those people out of our work and lobbying. Lots of GPs, lots of people working in cancer screening, psychologists, all sorts of people who are on our side who have a very biomedical approach. I think we need to include them in what we do.

Q. Fiona Strahan (Hepburn Health Service). In 1995 at the 4th World conference of Women in Beijing I remember seeing Israelis and Palestinian women talking about peace and saying when the men stop being the key negotiators for peace, when it is women we have a chance of success...I want an equally healthy future for all women regardless of, but also because of, disability (disablement), sexuality (homophobia) ethnicity (racism).

These are not lenses, they are oppressions; our differences become disabling because of power – differences instead of just being differences neither good nor bad – become *less than*. Power benefits from exclusion, when we are absent. If we keep forgetting to identify the lenses (or oppressions) when talking to women about women we are left with a very small group of middleclass, heterosexual temporarily able-bodied women.

I remember reading that disabled women are oppressed by capitalism and patriarchy - we are seen as not being able to produce fast, efficiently, cheaply enough and assumptions about our reproduction sees us as unable to make wives and mothers...a bit damned whores god's police. This is disablement. When we speak about women and we mean all women, then we should say that. If we are to speak truth to power then we must speak the whole truth.

MARILYN BEAUMONT: Any more insights? Then, could you join with me in thanking the speakers. Also, join with me, in particular, in thanking the organising committee for today's Summit. Kathleen Walsh, Liz Chatham, Dianne Wilkinson, Chris Hazell, Petra Begnell, Kerrilie Rice.

We have had an amazing journey getting to this day, let me tell you, but it has been immensely worthwhile in seeing so many of you who have come from a whole range of different places into this conversation. It is wonderful to have the level of commitment from the organisations that have wanted to endorse the 10-point plan. It has given us great heart and provides us with a wonderful platform for a new type of working together in Victoria. Thanks very much for coming.

PARTICIPANT FEEDBACK

- I just wanted to say congratulations for [the Summit]. The amount of work from you and your team was clearly evident and the banners are terrific. Personally, I found the information presented on the day to be both frustrating and motivating and I was particularly inspired by Kay Setches.
- Congratulations on the success of the Summit - the hard work you all put in is appreciated and you can all be proud of what you achieved.
- Thank you for the opportunity to participate in the Women's Health Summit yesterday. I found it to be very informative, worthwhile and professionally organised, as well as an enjoyable day - quite an achievement.
- Great day... well done to all.
- Thank you for organising the Women's Health Summit. I found it stimulating and reconnected with many women.

Attachment 1 - Women's Health Matters: From Policy to Practice- 10 point plan for Victorian women's health - 2006-2010

10 Point Plan Partners



Women's Health Matters: From Policy to Practice 10 point plan for Victorian women's health 2006-2010

As at July 2006, all the organisations listed below have endorsed the 10 point women's health plan 2006-2010.

The 10 point plan outlines a vision for women's health in Victoria over the next 5 years. It recognises the impact of gender in health and health inequalities and seeks to address these. Advocacy in seeking commitment to the Plan from the major Victorian political parties is strengthened by this endorsement.

Endorsed By

| | |
|---|--|
| Arthritis Victoria | Tweddle Child and Family Health Service |
| Australian Institute for Primary Care | Union of Australian Women (Victoria) |
| Australian Women's Health Network | Victorian Aboriginal Community Controlled Health Organisations |
| Carers Victoria | Victorian Alcohol & Drug Association |
| CASA Forum (Centre Against Sexual Assault Forum) | Victorian Community Health Association |
| Centre for Culture Ethnicity and Health | Victorian Council of Social Services |
| Country Women's Association of Victoria Inc | Victorian Local Governance Association |
| Domestic Violence Victoria | Victorian Women with Disabilities Network |
| Eastern Domestic Violence Outreach Service Inc | WIRE Women's Information |
| Elizabeth Hoffman House Aboriginal Women's Ser | Women's Domestic Violence Crisis Service |
| Family Planning Victoria | Women's Health Association Victoria |
| Gippsland Women's Health Service | Women's Health East |
| Health Issues Centre | Women's Health Goulburn North East |
| Immigrant Women's Domestic Violence Service | Women's Health Grampians |
| Key Centre for Women's Health In Society | Women's Health in the North |
| Multicultural Centre for Women's Health | Women's Health in the South East |
| Municipal Association of Victoria | Women's Health Loddon Mallee |
| Public Health Association of Australia (Victorian Branch) | Women's Health Victoria |
| Queen Victoria Women's Centre | Women's Health West |
| Royal Women's Hospital | Victorian Women and Mental Health Network |

Women's Health Matters: From Policy to Practice

10 point plan for Victorian women's health

2006-2010

Why do we need a new way forward?

Women are different from men. Their social experience of that difference, expressed as 'gender', impacts on every area of their lives.

- Victorian women's average weekly earnings are 20% lower than those of Victorian men¹
- The average earnings of employed women are still substantially lower than those of men²
- 15% of families with children under 15 are one-parent families. Of these 83% have a female head of family³
- Even when employed women are still largely responsible for looking after their homes and families
- 20% of Victorian women speak a language other than English and close to one in five women living in Victoria is an immigrant⁴.
- The number of Victorian women who identified as Indigenous in the 2001 census was 14,047⁵
- Women constitute a particularly large segment of the older/senior population⁶

There is growing evidence of the relationship between gender and health and understanding of gender as an important determinant of health and wellbeing. Although the difference is not news to most of us, it is still being discovered in many areas of health. Often, health has been dispensed as a 'one size fits all' model. However women need health care tailored to women's bodies and mindful of women's social roles⁷.

There are some conditions that affect more women than men, such as arthritis, osteoporosis and eating disorders. There are some conditions that affect women differently than they affect men. Heart attacks and HIV/AIDS are two of the more serious conditions that doctors sometimes overlook in women, because the signs and symptoms look different than they do in men. And there are some conditions that only affect women, such as pregnancy, childbirth and menopause. Too often, reproductive health is what 'women's health' is seen to be. But women's health is much more than this.⁸

Despite the growing international recognition of gender as a determinant of health, this awareness has yet to be incorporated into mainstream health policy and the design and delivery of programs and services.

An investment in women's health is an investment in the health of all the community.

¹ Office of Women's Policy (2005). Facts and Figures about Victorian Women

² *ibid*

³ Australian Bureau of Statistics (2004) Household and Family Projections, Australia, 2001 to 2026. Cat. No. 3236.0

⁴ Federation of Ethnic Communities' Council of Australia (2001). Age-Gender Profiles for Selected Birthplace Groups Victoria- 2001 Census

⁵ Australian Bureau of Statistics (2001) Population Characteristics Aboriginal and Torres Strait Islander Australians, Victoria. Cat. No. 4713.2.55.001

⁶ Australian Bureau of Statistics (2004) Population by Age and Sex, Australian States and Territories. Cat. No. 3201.0

⁷ With acknowledgements to the Canadian Women's Health Network

⁸ *ibid*

10 Points for 2006-2010

What are the fundamental elements?

1. Social Determinants of Health Approach

There is a need to create a comprehensive Victorian women's health policy that focuses on social, economic and cultural risks using a health determinants approach. This approach recognises that many factors in addition to access to health care services determine the health status of an individual. One of these factors is gender. Health should be promoted from the agreement that the 12 highly interactive determinants of health are:

- Income and social status
- Employment status
- Education
- Social environment (including social support and social exclusion)
- Physical environment (including access to food, housing and transport)
- Healthy child development
- Personal health practices and coping skills
- Health services
- Social support networks
- Biology and genetic endowment
- Gender, and
- Culture.⁹

2. Gender as a Determinant of Health

A new Framework should encompass the components of gender based analysis. The components include gendered data, gender impact assessment and gender awareness raising. It requires that legislation, policies and programs are responsive to the evidence base regarding sex and gender differences and women's health needs. A lack of gendered data leads to ineffective service planning and reduced cost effectiveness of outcomes. The strategic use of women's health services to inform planning processes is thus essential.

The gender based analysis framework should be overlaid with a diversity analysis that considers factors such as race, ethnicity, geographic isolation, level of ability and sexual orientation.

A good example of a gender based analysis application is 'Better Pathways: An Integrated response to women's offending and re-offending'¹⁰.

3. Overarching Values

Most Western countries, including the United Kingdom, Canada and New Zealand, have a national Human Rights Act or equivalent¹¹. And although human rights laws operate within the jurisdiction of the Australian Capital Territory, Australia is the only Western country without a national Human Rights Act. In addition, Australia has no plans to ratify the UN Convention on the Elimination of All Forms of Discrimination

⁹ Health Canada's Women's Health Strategy 1999 p13

¹⁰ 'Better Pathways: an integrated response to women's offending and re-offending'. A four year strategy to address the increase in women's imprisonment in Victoria, 2005-2009. Victorian Government Department of Justice, November 2005.

¹¹ Rights, Responsibilities and Respect. The Report of the Human Rights Consultation Committee. Victorian Government Department of Justice, November 2005

Against Women and is the only developed nation to not be a signatory. In the absence of any Australian constitutional entrenchment of equality for women at the federal level, moves by the Victorian Government to enact a Bill of Rights are welcome.

In implementing a gender based-analysis framework, it is recommended that human rights underpin the overarching values of this framework. It is recommended these include the creation of a society within which women have

- the right to live safely and free from violence and fear
- the right for women to fulfil their potential
- the right to informed and real choices.

4. Priority Issues

Priority issues for action over the next 5 years should be:

- statewide reproductive and sexual health policy and funded programs
- end violence against women
- emotional and mental health.

There should be a commitment to fund research in 5 identified women's health priority areas.

How can this be implemented?

5. High Level Cross-Government Leadership

Establish new Ministerial Women's Advisory Committees within each of the critical portfolio areas, including Women's Health, and develop a mechanism to achieve cross-portfolio collaboration.

6. Inclusive Approach

A process should be established which involves women's health advocates in priority setting and investment in translation of knowledge into policy development and health system and practice change.

7. Honesty and Transparency

Build honesty and transparency into consultation processes and turn consultation into action. When government is consulting with women it should be made clear from the outset where the results of the consultation will be visible, or whether the consultation is an information session, or whether it is an education session or other specific purpose.

8. Resourcing and Accountability

Allocate resource responsibility for carrying forward the gender based analysis approach in the women's action plan or health plan and make accountability for moving a women's agenda forward shared and visible.

The women's action plan or health plan should be an accountability tool for government departments to implement gender-based analysis in their policy, planning and funded service agreements.

Within Victoria currently, the apparatus in government for accountability to move a women's agenda forward is not clear. For example:

- Growing Victoria Together is not gendered.
- Challenges in Addressing Disadvantage in Victoria data analysis is not even sex disaggregated on those areas which inform the report such as school leavers unemployed, behavioural risks and socio-economic status, family violence reports and, unemployment. This is the paper which outlined the

nature, extent and distribution of disadvantage in Victoria and led to the policy document *A Fairer Victoria*. The result is that *A Fairer Victoria* is not gendered. Visibility for accountability for moving a women's agenda forward is further diminished now that the *Forward Plan for Women* and the *Victorian Women's Health and Wellbeing Strategy* have been rolled into *A Fairer Victoria*.

9. Women's Specific Services

The authentic place of standalone specialist women's health services and programs ensures that research, policy and practice address the economic, social and cultural obstacles that prevent women from reaching their potential.

Renew commitment to women-specific services and centres of excellence and further develop the roles of statewide, regional women's health services for intersectoral collaboration between the settings within which health is impacted.

10. Collaborative Frameworks

Maintain and properly fund specialist women's health expertise while supporting those collaborative frameworks that women's health services are currently in, or could potentially work in. These work across health promotion settings and environments and health treatment services in primary and acute care.

Required action

Victorian organisations continue to be asked to endorse this 10 point plan as a way forward for the next 5 years. Those who have endorsed it to date are listed on the front of the document.

We ask that you take what action you can to implement 'Women's Health Matters: From Policy to Practice' 10 point plan for Victorian women's health 2006-2010 as Victorian Government policy.