

AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020



WOMEN'S HEALTH VICTORIA

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23 December 2008

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INTRODUCTION

Women's Health Victoria is a statewide women's health promotion, information and advocacy service. We are a non government organisation primarily funded by sections of the Victorian Department of Human Services. We work with health professionals and policy makers to influence and inform health policy and service delivery for women.

The work of Women's Health Victoria is underpinned by a social model of health. We are committed to reducing inequities which arise from the social, economic and environmental determinants of health. These determinants are experienced differently by women and men. By incorporating a gendered approach to health promotion work that focuses on women, interventions to reduce inequality and improve health outcomes will be more effective and equitable.

The vision of Women's Health Victoria is for a society in which there is an accepted approach to health that is empowering and respectful of women and girls; one that recognises the importance of gender in determining health outcomes and utilises a sound gender analysis in policy making and in health and community service design.

We work towards achieving this vision by incorporating the principles of integrated health promotion. This is implemented by:

- Having a strong focus on working in partnership with other organisations and opinion leaders. We use credible tools to determine and strategically plan for the creation of new partnerships and the development of existing ones.
- Using a mix of health promotion interventions that are focused at the population level to achieve our vision – a significant amount of our activity is spread across evidence-based health information provision, policy support, advocacy, social marketing and sector based capacity building.
- Clearly defining our community of interest as individuals and organisations that work in areas which influence health outcomes. Our community of interest includes but is not limited to health promotion practitioners, service and information providers, policy and opinion leaders, and researchers and educators.

SUBMISSION

Thank you for the opportunity to contribute to the Preventative Health Taskforce's work in developing a National Preventative Health Strategy. Please accept Women's Health Victoria's submission in response to the Taskforce's discussion paper: *Australia: the Healthiest Country by 2020*.

Women's Health Victoria welcomes the general framework and ideas developed in *Australia: the Healthiest Country by 2020*. This submission responds to some of the questions asked in the primary document and then offers comments on aspects of the individual technical papers.

1. LEADERSHIP AND COORDINATION

'Do you support the development of a National Prevention Agency to lead and guide coordinated action for prevention? Is the suggested approach adequate? If not, or if you have other suggestions, what else should be considered?'

Women's Health Victoria supports the proposed establishment of a National Prevention Agency (NPA). We are interested in how the NPA will be coordinated, where the national agency will be located, how the 'relatively small group of credible leaders in prevention' will be chosen, and from where the NPA will draw its funding.

We also question whether the targets are realistically achievable within the given timeframe? A concern is that if the NPA is not adequately set-up, co-ordinated and resourced for the long-term, nominated targets will not be achieved and failure in this will provide critics with an example of how *prevention* does not work. This has the potential to more widely harm prevention strategies as a whole.

We would like for it to have been clearer about how the NPA will exert influence for change. Does it do this through fund holding or through increasing co-operation and collaboration across multiple other agencies funded from a variety of state and Commonwealth services, which is currently what happens. If it is the later then what power will the NPA have that will make a difference in already congested territory?

Our final comment on this section relates to the naming of the agency. The 'National Prevention Agency' does not point to the area of prevention. It could refer to anything. Why is 'health' not a part of the title? For example, why not the National Health Promotion Agency? As it stands, the title is unclear.

2. CHOOSING PERFORMANCE INDICATORS

'Are these measurements appropriate? If not, what would you propose?'

With regards systems for collecting data on indicators, Women's Health Victoria welcomes the inclusion of sex disaggregated data. Again, evaluation would need to be adequately resourced, measurable and importantly, as stated in the discussion paper, they would need to enable comparative assessment. We would also like to see the inclusion of a more broadly applied gendered approach that recognises gender as a determinant of health. This is discussed in more detail in the next section.

3. GOVERNANCE PRINCIPLES

'Common Frameworks'

Women's Health Victoria welcomes proposed components of the framework, but would add to it a gendered approach and the inclusion of a gendered health framework.

Implicit in this framework is the acknowledgement that gender is a determinant of health. The first step in this is the application of a social model of health, which the discussion paper and its accompanying technical papers appear to take. A social view of health is one that concentrates on improving the health and wellbeing of a population through addressing the social and environmental determinants of ill health concurrently with the biological and medical factors which influence health and wellbeing.

A social view of health draws on key social factors or social determinants that influence broader patterns of health and illness within any given population, including socio-economic status (of which income is an indicator), race, ethnicity, gender and geographic location. Absent from this list of social determinants of health are culture (in its broadest understanding), disabilities and sexuality. There is evidence that poor outcomes as a result of discrimination and marginalisation occur within all of the determinants.

Women's Health Victoria recognises the importance of all health determinants. Our particular concern is with understanding the impact of gender on health and well being in diverse populations of women.

When we speak about gender, we are referring to the experiences of both women and men. Women and men experience health differently. Biological sex differences are responsible for health issues traditionally regarded as women's health or men's health issues, like reproductive health and sexuality. Gender refers to the different social and cultural roles, expectations, and constraints placed upon men and women by virtue of their sex. When analysing the different experiences and impacts of health on women and men, differences relating to gender, in addition to biological sex, need to be considered. Neither women nor men should be treated as another special interest group. Nevertheless it is indisputable that there are substantial differences in the lives of women and men, even within the same cultural, ethnic, age, and religious groupings.

Gender differences in our society can influence both women's and men's:

- Exposure to risk factors;
- Access to and understanding of information about disease management, prevention and control;
- Subjective experience of illness and its social significance;
- Attitudes towards the maintenance of one's own health and that of other family members;
- Patterns of service use;
- Perceptions of quality of care.

Policies and programs that do not account for gender differences may have a detrimental impact on both women and men. Given the social context of women's lives, women are more likely to experience more significant detrimental consequences as a result of policies that ignore potential gender impacts.

This is where a gendered health framework can be beneficial. A gendered health framework is a tool that encourages the development of policy and practice to take account of and be responsive to gender. It is predicated upon the following:

- All policies and practice impact on women and men;
- Policies and practice affect women and men differently;
- Diversity exists between individual women and men and within groups of women and men

The framework can help identify, understand and address health issues such as tobacco use, alcohol consumption and overweight/obesity as they are experienced by women and men differently.

The framework consists of three elements:

- *Gendered data*: gender disaggregated statistics can be used pro-actively in planning and are critical in gauging the extent to which women and men benefit or are affected by policy and practice;
- *Gender impact assessment*: monitor new and existing policies and practice for gender impact and use knowledge to adapt existing or proposed policies and practice to promote gender equity in planning and implementation; and,
- *Gender awareness raising*: take opportunities to build capacity and understanding of how policies and practice can cause or lead to discriminatory effects.

Using a gendered health framework would assist in the identification, evaluation and modification of prevention and intervention strategies that target particular population groups. For example, it would be useful when addressing the prevalence of binge drinking in young women (36). In order to move effectively from *what* questions that are used to identify problem areas, to *how* those areas might be addressed, *why* questions need to be asked. The application of a gendered approach to prevention strategies would help to answer the *whys* that sex disaggregated data elicit. It would assist in the targeting, planning and implementation of those strategies and increase the potential success of programs.

The Victorian Department of Human Services has an excellent tool that complements this framework: *Gender and diversity lens for health and human services: Victorian Women's Health and Wellbeing Strategy Stage Two 2006-2010*¹. This resource could be adapted for use in the development and implementation of prevention and intervention strategies in any of the proposed areas.

4. OBESITY IN AUSTRALIA

Comments that Women's Health Victoria has regarding this technical paper refer to:

- target realism
- urban environments
- increased skills
- food security
- body image
- gendered behaviour
- Government responsibility
- women and socio-economic status
- breastfeeding support

Body Image and Disordered Eating

Women's Health Victoria raises the question about whether the target of 'halting and reversing' overweight and obesity in Australia is realistic. In particular, we are interested in how reversal of overweight/obesity will occur without employing measures that may be interpreted as victim blaming or as reinforcing cultural discourses around women's bodies as needing regulation and control. Many studies show that body dissatisfaction is high among girls and women in Western countries². We would want to see any overweight/obesity campaign informed by research about this, including women's body image influences, dieting behaviours, and issues linked to disordered eating. When shame and control are common features of eating disorders³ a campaign against overweight and obesity needs to be mindful of how it is marketed. Such a campaign needs to distinguish very clearly between healthy eating and being thin, where the former is the health aim and the latter is an unhelpful cultural ideal. Without this clarification, the campaign runs the risk of simply perpetuating the 'thin is good' myth, which contributes to negative body-image and influences disordered eating and associated behaviours^{2,4}.

'Reshape urban environments'

One of the major actions proposed in the Obesity technical paper is to reshape urban environments towards healthy options. Women's Health Victoria strongly supports this proposal that would encourage greater levels of physical activity and consciousness around health food

supply. It is a strategy that removes potential for victim blaming rhetoric and pressure on the individual by providing a more expansive solution to the overweight/obesity issue. One of the factors that we would like to see considered in any reshaping of urban environment would be attention to safety. Here again, a gender lens would be helpful in determining what spaces women consider safe, how to plan for safety and to market spaces as safe. This will help to ensure the use of healthier options by women.

Food Security

One of the greatest barriers to healthy eating is food insecurity. The availability and cost of healthy and nutritious food was deemed to be one of the current most crucial health issues by Victorian Health Minister Daniel Andrews⁵. A campaign on overweight and obesity needs to consider food security. This is particularly so for those in lower socio-economic regions, remote areas, and for some migrants who for example, cannot access familiar foods and turn to the more easily accessible but not necessarily as healthy foods. It also means more than simply providing information about nutrition and healthy eating behaviours. Beyond accessibility and affordability, food security also entails skill development. People without cooking skills are less likely to prepare healthy food. Campaigns that target disadvantaged communities and groups need to consider the practical aspects of food affordability, access and preparation. Information alone is not enough. It is also where reshaping urban environments can contribute with communal gardens for growing food and similar community projects that foster education and skill development around healthy food choice and cooking. Minister Andrews made the following statement: 'We also need a stronger healthy food culture in schools to foster knowledge of food and nutrition, cooking skills, growing food and the social value of making meals and eating together.' We can extend this to not only schools, but communities at large.

Pregnant Women and Breast Feeding

The section on breast feeding in the technical paper for obesity is an example of how this discussion paper targets women only in relation to their reproductive capacity. Women's Health Victoria has a concern with the focus on 'pregnant women' perpetuating a blaming discourse that serves to alienate, surveil and control women in pregnancy. Rather than focussing on the individual as the problem site for overweight and obesity, an approach might be to look at how to increase advice and support measures for pregnant women. One recent interview with the president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists reported him stating that poor breastfeeding rates in Australia was in large part due to the ineffectual maternity care system which is 'fragmented and underfunded'⁶. It is important that preventative strategies consider more than the individual and ensure that information and services are readily available and accessible.

5. TOBACCO CONTROL IN AUSTRALIA

A general comment that Women's Health Victoria offers is about campaign strategy. We wonder at what point the threshold is already met when targeting Australia as a whole. A suggestion is that less money be spent on mass media campaigns and more on targeted population groups such as Aboriginal and Torres Strait Islander and youth. We agree with the prohibition of all tobacco advertising and restrictions on packaging and promotion, and would advocate for a reduction on the availability of tobacco products by limiting the places where they are sold.

We would also like to offer comments on the following topics:

- Increasing the price of tobacco products
- understanding determinants of health
- equity and discrimination

Increasing the Price of Tobacco Products

Women's Health Victoria has concerns about the revenue raising strategy involving the increase of excise and customs duty on tobacco products in an endeavour to make them unaffordable. It is stated in the technical paper on tobacco that revenue raised from increased product cost will assist

in prevention activities, 'including those in lower socio-economic status groups' (vii). A brief look at the research provided one article that links lower socio-economic groups with the highest expenditure on tobacco consumption and the lowest rates of expenditure on health related items and activities such as food, medications and social participation⁷. It may be worth while to investigate other research that investigates those for whom increased tobacco prices may not lead to a reduction or cessation in tobacco use but perhaps a reduction or cessation of expenditure on health related goods and activities. Of particular relevance to Women's Health Victoria is the high prevalence of smoking among women who are single parents and in the lower socio-economic groups. Would increased tobacco prices reduce tobacco use amongst this population or would women simply go without in other areas so as to afford the rise in cost? Additional research and close monitoring of this would need to occur in order to ensure that one health related goal was not achieved at the expense of others.

Understanding Determinants of Health

Any successful health prevention strategy needs to have a firm understanding about the determinants of health. What exists around people? What are the broader aspects of tobacco use? What are the gaps in those broader areas? How might they also be addressed? One example of this is the link research makes between cigarette smoking and women's equality⁸. The Canadian report *Turning a new leaf* (2006:11) highlights the connection between long-term tobacco use, women's health and equality:

While there has been some correlation between equality-seeking and the initiation of tobacco use among women, it is clear that the long-term consequences of tobacco use lead to poorer women's health, which will in turn compromise women's prospects for economic health and gender equity.

The report also states that women who experience the most inequality are also the most likely to remain smokers. It advocates for high-quality tobacco control measures designed specifically for women, which we agree is necessary to the reduction of women's tobacco use.

Equity and Discrimination

As with the other documents, sex disaggregated data is used in the tobacco technical paper, but attention is given in greater detail only to women in sections relating to pregnancy. Pregnant women come under the section for 'highly disadvantaged groups'. This section also refers to Indigenous women who are pregnant and smoking, and highlights the lack of research and researcher interest in interventions. Potentially concerning is one of the proposed actions where healthcare agreements would require all women receiving maternity care through public hospitals to be screened for smoking status. Those women found to 'smoke' would then be referred to counselling. This level of policing around individual behaviour seems highly problematic, particularly targeted at already marginalised groups with histories of oppression. A great degree of diplomacy, community consultation, respect and awareness would need to precede any such prevention strategy.

6. PREVENTING ALCOHOL-RELATED HARM IN AUSTRALIA

Women's Health Victoria welcomes the reduction in advertising, removal of tax deductibility and other similar measures proposed in the technical paper on alcohol. We also propose consideration of limiting access to alcohol by reducing the availability of alcohol products and outlets that sell alcohol. We very much welcome the proposed modification of the social, cultural and community context in which drinking occurs. It is one of the areas we comment on below:

- cultural changes
- health inequalities

Cultural Changes

The technical paper claims that the modification of the social, cultural and community context in which drinking occurs could prevent or ameliorate harmful consumption of alcohol or harmful

consequences (30). The key ingredient stated 'to ensure the efficacy of strategies that aim to alter drinking contexts' in the prevention of harmful alcohol consumption is stated to be 'effective law enforcement' (30). The paper goes on to highlight the various penalties, threats and policing activities that come under the 'effective' law enforcement umbrella. Women's Health Victoria argues that various law enforcement strategies are not enough in and of themselves. This places problematic alcohol consumption in the public sphere and does not account for problematic in-home alcohol drinking that can contribute to domestic and sexual violence as reported on page 14 of the report. A modification of cultural context in which drinking occurs needs to go beyond law enforcement and look at the wider cultural factors that dictate community, 'mateship', sport, parties and celebration, and other national identity markers.

Health Inequalities

A section titled 'Health Inequalities' identifies risk populations but doesn't offer an analysis of the inequality status of those populations. For instance, what contributes to Aboriginal and Torres Strait Islander people being listed under this section? What is the inequality? Possibly there is assumed knowledge here as there is no context provided; nothing about socio-economic status, health, displacement, colonisation, education and so on. This is the same for 'young Australians'. Again, the document highlights research linking adolescent risk-taking behaviour and alcohol use, but does not discuss the socio-cultural context in which this occurs:

'Drinking contributes to the three leading causes of death among adolescents – unintentional injuries, homicide and suicide – along with risk-taking behaviour, unsafe sex choices, sexual coercion and alcohol overdose.[18]' (16)

Perhaps this was not the scope of the document, but it seems that at some point it would occur in order to better target prevention strategies.

This is also the case with gender. Sex disaggregated data is provided without gender analysis. Of the 31, 000 alcohol related deaths the document claims occurred in Australia between 1992 and 2001, the most were attributed to acute causes, relating to acute intoxication, rather than chronic conditions (11). It goes on to cite that deaths of acute causes are most common among young people aged 15-19 years (11). Considering that the document previously highlights the greater prevalence of drinking at levels of risky/high-risk of harm in young women, one would consider that some socio-cultural and gender analysis would need to be present. This again highlights the need for a gender health framework and the application of a gender lens.

7. CONCLUSION

Women's Health Victoria welcomes and broadly supports the discussion paper and its accompanying technical papers, and advocates for prevention strategies in addressing the issues of overweight and obesity, tobacco use and problematic alcohol use. This submission has outlined various comments and suggestions that we have around socio-cultural context, equity, gender as a determinant of health, and the structure and function of the proposed National Prevention Agency. A general concern that Women's Health Victoria has with the papers is the positioning of women as vessels for babies and children, and not as individuals in their own right with their own health concerns. This is evident across all technical papers and is an example of how a limited approach to gender difference may appear. In this, women's health is regarded as peripheral to the primacy of her reproductive function. The application of a gendered health framework and a gender lens would help to ensure that the differences between women's and men's experiences of health issues are acknowledged and this will aid in more appropriate targeted interventions for women and men.

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