Response ID ANON-5GWD-ZWCZ-5

Submitted to **Establishing a National Women's Health Strategy for 2020 to 2030**
Submitted on **2018-11-02 16:49:02**

SECTION A – DEMOGRAPHICS

1 Please provide your name (optional)

Name:
Dr Amy Webster

2 Where are you based?

VIC

Other location:

3 Are you providing your response on behalf of an organisation?

Yes - please provide the name of the organisation below:

Organisation:
Women's Health Victoria

4 What is your email address?

Email:
amy.webster@whv.org.au

5 What is your area of expertise?

Area of expertise:
Health promotion, advocacy and support in relation to women's health. Priority areas include prevention of violence against women, sexual and reproductive health and gender equity.

6 Are you providing your response as:

Other - please specify below:

Other occupation:
a women's health service

7 Do you identify as an Aboriginal or Torres Strait Islander person?

No

8 Priority population group status

None of the above

9 Does your organisation represent one of the priority population groups?

Yes - please specify below

Priority population group:
As a statewide service Women's Health Victoria advocates for and provide support to women from all of these population groups.

10 In which country were you born?

Australia

Country born:

SECTION B - THE STRUCTURE OF THE STRATEGY

11 Overall structure of the Strategy

Yes

12 Overall structure of the Strategy - comments

Strategy structure - comments:
WHV congratulates the government on the draft strategy.

The overall structure of the strategy is clear and logical. Furthermore, we support the approach taken in relation to the policy principles and priority areas identified by the strategy. The focus on priority populations and a life course approach is appropriate.

We do, however see opportunities to strengthen the strategy, specifically:

• A greater engagement with primary prevention and universal strategies to address gender inequality as a driver of health outcomes for women (in addition to early intervention). Structural gender inequality continues to impact health outcomes for women eg. visa status, income support, childcare, etc.

• Making addressing and preventing violence against women an additional stand-alone priority area

• Greater consideration of sexual and reproductive health beyond fertility, pregnancy and maternal health including abortion and contraception, menopause, polycystic ovarian syndrome, etc.

• A lack of attention to addressing contributors to women's ill health such as poor body image and sexualisation/objectification.

We would also urge sensitive consideration of language used in relation to overweight and obesity and related interventions. Work in this area should prioritise a 'first, do no harm' approach and focus on addressing structural barriers and enablers for health living rather than individual behaviour.

13 Adequate context and background for the Strategy

Yes

14 Is anything missing from context and background?

Adequate context and background:
The context and background for the strategy is strong. In particular, WHV welcomes the clear articulation of

• The need for a dedicated strategy for women's health
• The need to strive for women's equality as well as equality amongst women
• Recognition that the men's and women's health strategies should work in tandem – acknowledging the biological and societal factors that impact men's and women's health.

We do, however, see an opportunity to more clearly articulate gender inequality as a driver of poor or uneven outcomes for both men and women, and to integrate primary prevention efforts across the two strategies.

WHV is pleased to see reference to the need for gender sensitive and gender-specific approaches. In relation to Figure 1, it is worth noting that Victoria is in a unique and strong position, having both a gender equality and sexual and reproductive health strategy at the statewide level, as well as statewide strategies relating to violence against women. In addition, a Gender Equality Bill is currently being drafted. Victoria also benefits from a unique statewide women's health and gender equity infrastructure through the Victorian Women's Health Program.

In relation to Figure 2, WHV suggests delineating between women and girls with disabilities, and their carers (whilst acknowledging that supports and wellbeing for both are often interlinked). Improving the suitability of, and confidence in, social supports and services for people with disabilities who require care would reduce the need for unpaid care, which is predominantly provided by women.

At the same time, carers are a diverse group who face distinct health and wellbeing challenges of their own and could be considered a priority population within the draft strategy. Also important is the need to transform gendered norms so that unpaid care work is shared more equitably between women and men.

WHV supports the life course approach taken in the draft strategy and agrees that education campaigns and health services should be age appropriate, gender-sensitive and integrated to respond to women's interrelated mental and physical health needs. However, WHV would recommend inclusion of the following key health issues for women which are not specified in Figure 3, despite being common and significant health concerns for women at different life stages:

• Sexual and reproductive health beyond fertility, pregnancy and maternal health, including abortion, contraception, and polycystic ovarian syndrome.

• Poor body image and sexualisation/objectification

15 Strategy blueprint, Policy principles and Strategy objectives

No

16 Strategy blueprint, Policy principles and Strategy objectives - comments

Strategy blueprint etc - comments:
WHV supports the Policy Principles and Strategy Objectives set out under the Strategy Blueprint. In particular, we agree that gender equity should be the first principle in recognition that

• Gender inequity is a key driver or determinant of poor or unfair health outcomes for women and girls

• Improving gender equity (including support for specialist and gender sensitive services) will improve women's physical and mental health outcomes

• Improving gender equity is our best overarching primary prevention strategy for violence against women

It is also critical to note that gender is not the only factor impacting unfair or uneven health outcomes for women, and that specific groups of women experience relative privilege and disadvantage on the basis of factors such as racism, ableism and homophobia. For this reason, we support that Principle 2 under the strategy:' health equity between women'.

However, the strategy objective accompanying Principle 2 would be strengthened by acknowledging in more detail the factors that contribute to uneven health outcomes between women (for example visa status an insurance coverage for international students), and the need for interventions or efforts directed at specific groups of women to be led by women within the targeted community groups. Specific actions should also be included in relation to health equity for LGBTIQ women and people.

The Strategy objective under Principle 3, 'A life course approach to health' should also be re-worded to remove the word 'lifestyles'. The term 'lifestyle' indicates that women (in this case) are making a free, unimpeded choice about things like nutrition, alcohol consumption, smoking or participation in physical activity, when in fact a range of factors, many of them gendered, such as income, care responsibilities, cost, location, trauma, education and access to services all have a profound influence in shaping and limiting women's 'choices'.

Principle 4, 'A focus on prevention', should include the need for investment in primary prevention specifically, in addition to 'early intervention and holistic person-centred care'. Primary prevention refers to universal strategies (tailored to meet the specific needs of different audiences) that the underlying drivers (gendered norms, practices and structures) that lead to poor health outcomes for women and girls. It is important that the strategy acknowledges the many structural levers that exist at the national level and includes (or links to) initiatives that address these. Such levers include: income and child support, workplace gender equality, paid parental leave and child care, advertising regulation, superannuation, etc.

SECTION C - PRIORITY AREAS

17 Do you agree with the priority areas identified for the Strategy?

No

18 Priority areas - comments

Priority areas - comments:
WHV supports the high-level priority areas identified in the draft.

However, we would recommend adding violence against women as an additional stand-alone priority area (rather than as an 'overrepresented condition'. Violence against women is the greatest contributor to the overall disease burden in Australia for women aged 18-44 years, contributing more to the burden than any other risk factor for this group, including well known risk factors like tobacco use, high cholesterol or use of illicit drugs. (ANROWS 2016). We suggest moving 'Adopting a multifaceted approach to eating disorders' (which currently sits under 'overrepresented conditions') under mental health and wellbeing.

A holistic approach to improving women's health and wellbeing should take into account the fact that the priority areas overlap, and that there are high rates of co-occurrence of, for example, poor sexual and reproductive health, poor mental health and wellbeing and experiencing violence/sexual assault.

19 Priority area 1 – Mental health and wellbeing

No

20 Priority area 1 - anything missing?

Priority area 1 - anything missing:
As noted in response to question 18, we believe eating disorders could be moved to sit under Priority area 1. Furthermore, WHV would recommend:

• Making specific reference to the need for primary prevention (as well as education and awareness for consumers and health professionals)

• Including poor body image and anxiety as specific areas requiring attention

• Highlighting the need for gender sensitive resources and support services, including training for service providers on how sex and gender impact mental and health and wellbeing for women and girls.

This reflects recent Australian evidence that:

• Girls and boys have comparable levels of mental health and self-confidence before puberty. However, during adolescence, young women's mental health outcomes worsen compared with young men's (Hankin, Young, Abela, Smolen, Jenness, Gulley, et al., 2015). Evidence strongly indicates that this discrepancy is driven by sex and gender-based expectations and experiences.

• More than half of Australian girls report that they are most often valued for their looks, rather than their brains and ability (IPSOS Australia, 2016). Young women

report considerably higher concerns about body image than young men (41.1% compared with 17%) (Mission Australia, 2016).

• Approximately one third of young women in Australia (aged 18-23) have been diagnosed with or treated for anxiety or depression (Mishra, Loxton, Anderson et al. 2014).

• Young females are three times more likely to be hospitalised for intentional self-harm than young males (Australian Institute of Health and Welfare, 2008).

• A lack of understanding by health professionals and parents, and feelings of shame and guilt, can be barriers to seeking help (Robinson, McCucheon, Browne and Witt, 2016).

(For further information see WHV's recent issues paper, 'Growing Up Unequal: How sex and gender impact young women's health and wellbeing.')

21 Priority area 2 - Chronic disease and preventive health

No

22 Priority area 2 - anything missing?

Priority area 2 - anything missing:
WHV supports the actions listed under Priority area 2. In particular, we endorse the goal of tailoring programs, interventions and initiatives to meet the needs of women and girls, and the aim of increasing health literacy to enable self-advocacy and empowerment. WHV also strongly supports the need to 'allocate specific, sustainable funding for women's health programs and services' at both the state and national level, including those which focus on specific groups of women such as Women with Disabilities Victoria and Women with Disabilities Australia.

Some chronic conditions, such as cardiovascular disease may appear to be gender neutral on the surface, but (as noted in the draft) involve different risk factors and symptoms for women and men and require different treatments and responses. Chronic mental health conditions such as anxiety and depression also require a gender sensitive approach.

The co-occurrence of chronic mental and physical health conditions, and the need to provide a holistic and gender sensitive response over the life course, should have greater prominence in the draft strategy. For example, women who experience endometriosis and polycystic ovarian syndrome – complicated, painful and relatively common conditions among women – report higher rates of mental health concerns (Jean Hailes for Women's Health, 2016).

While we support the 'prevention focus', we would once again urge the inclusion of action that relates to primary prevention, rather than early intervention or 'the creation of lifestyles that promote long term wellbeing'. Key risk factors for chronic conditions identified in the draft, including tobacco and alcohol consumption, high body mass index, etc, are impacted by a whole range of biological, structural and community factors and are not easily modifiable. Gendered factors such as caring responsibilities, safety, income and trauma impact women's ability to 'choose' a healthier lifestyle. Stress, stigma and discrimination impact women's mental health and their willingness to engage with health professionals.

Prevention strategies should address these social and structural determinants of women's health. Both structural and behavioral strategies aimed at lowering risk factors for women should be gender sensitive and avoid reinforcing disadvantage.

23 Priority area 3 - Sexual and reproductive health

No

24 Priority area 3 - anything missing?

Priority area 3 - anything missing?:
Overall, this section of the strategy reads as being too focused on fertility and pregnancy and perinatal care. The focus on childbearing is inconsistent with the strategy's life course approach.

Greater attention should be given to common conditions such as polycystic ovarian syndrome and endometriosis which, despite their prevalence and serious, often long-term impacts for women's physical and mental health, have been neglected by health professionals and health service systems. Greater attention should also be paid to puberty, severe period pain and heavy bleeding, contraception, abortion and menopause.

Structural factors at the national level continue to limit women's sexual and reproductive health and wellbeing. These include cost barriers for long acting reversible contraception and abortion, unequal access to services in rural and regional areas, short consultation times, a lack of training for the primary care workforce and the Medicare rebate system.

WHV supports recognition of the need to tailor service delivery and information to ensure cultural safety in maternal and perinatal care for women. We also recognise and support the importance of bilingual peer education and peer support models for women from culturally and linguistically diverse backgrounds. We would, however, recommend including actions related to ensuring equity for women with disabilities in relation to sexual and reproductive health, reflecting that women with disabilities have been (and continue to be) subjected to specific forms of discrimination in relation to contraception and pregnancy.

Given that pregnancy is a time of high risk for the first experience of, or an intensification of, family violence, we believe that family violence risk assessment warrants specific mention. The need to assess for and address reproductive coercion, a specific form of violence against women that intersects with sexual and reproductive health, and includes forced pregnancy, forced abortion, sabotaging contraception, etc. should also be specifically mentioned under Priority area 3.

Care should be taken not to add to the stigma, anxiety and scrutiny many mothers experience during pregnancy, in particular women who smoke, consume alcohol or drugs during pregnancy or have a high BMI. Shaming pregnant women will only discourage engagement with health services and add to their anxiety.

A sensitive, strengths-based approach should guide work with these women, which recognises that mothers are often expected to make rapid changes in their health behaviour when they become pregnant in a way that non-birth partners are not.

25 Priority area 4 - Conditions where women are overrepresented

No

26 Priority area 4 - anything missing?

Priority area 4 - anything missing:
WHV strongly supports the inclusion of violence against women as a priority within the draft national women's health strategy. As previously stated, violence against women is the greatest contributor to the overall disease burden in Australia for women aged 18-44 years, contributing more to the burden than any other risk factor for this group. We recommend specifically naming violence against women, including sexual assault as its own standalone priority area.

In terms of actions to prevent and address violence against women, these should be guided by and consistent with key national frameworks such as Change the Story and the National Plan to address violence against women and their children, as well as state-based gender equality and violence prevention strategies. This includes the roll out of respectful relationships education programs in schools, workplace interventions and improved risk assessment by health professionals. The strategy should identify the need to for a statewide infrastructure for the prevention of violence against women in every state and territory to implement of Change the Story across all settings (following the example of Victoria).

The underlying driver of violence against women is gender inequality, including gendered norms, practices and structures. Importantly gender inequality, and specifically expectations around masculinity, also have negative impacts for men's health and wellbeing such as increased risk taking, unhealthy alcohol use and a reluctance to seek help from health professionals. This represents an opportunity to link the national women's and men's health strategies together, foster relationships between the two sectors and integrate health promotion activities.

Actions to address eating disorders (which are currently the only other condition listed under 'overrepresented conditions') could be moved under mental health and wellbeing.

Finally, WHV sees the need for strategies to address sexist advertising which is regulated at the Commonwealth level. Sexist advertising contributes to the drivers of violence against women by perpetuating stereotypes and sexualised representations of women and women's roles. Exposure to sexist advertising and sexualised images of women also contributes to poor body image and anxiety, especially for younger women.

27 Priority area 5 - Healthy ageing

No

28 Priority area 5 - anything missing

Priority area 5 - anything missing:
WHV supports 'Healthy Ageing' as a priority area under the draft strategy. WHV strongly agrees that 'closing the gap' in life expectancy experienced by Aboriginal and Torres Strait Islander women is an urgent and critical priority. Services and supports for older women in rural areas and for women on low incomes are also key priorities.

Women's longevity is increasing, but there is a need for actions to support women to have the best possible quality of life as they age. As noted in the draft strategy, with increasing age women are likely to experience multiple chronic conditions simultaneously. Furthermore, the socio-economic status of older women is often profoundly impacted by a lifetime of gender inequality that sees women retire with significantly fewer financial resources than men. This is also reflected in increasing rates of homelessness among older women.

As recognised under this priority area, loneliness is an emerging issue for older women. WHV supports looking into innovative ways to address loneliness and support social inclusion for older women. WHV recommends that in addition to loneliness, other factors significantly impacting older women's health such as dementia, falls and elder abuse should also be included, reflecting the evidence below.

• It is estimated that a greater proportion of women than men have or will have dementia across all aged groups higher than 65 years (AIHW 2016).

• Women are hospitalised at higher rates than men as a result of falls both at home and in residential facilities (AIHW, 2017).

• Elder abuse includes intimate partner and family violence, as well as violence and abuse experienced in institutional care facilities. Older women are significantly more likely to be victims than older men, and most abuse is intergenerational (i.e., involving abuse of parents by adult children), with sons being perpetrators to a greater extent than daughters (AIFS 2016).

SECTION D - RESEARCH, PARTNERSHIPS AND PROGRESS

29 Investing in research

No

30 Investing in research - anything missing?

Investing in research - anything missing:
WHV supports many of the actions detailed under this Priority, including the focus on research into violence against women and its intersection with other health

issues for women, dementia, chronic pain and menopause. In addition, WHV has identified other research priorities for women's health.

As the consultation paper suggests, there is a high co-occurrence of mental and physical chronic health conditions for women (eg. depression, diabetes and cardiovascular disease).

o How can we integrate prevention, risk assessment and response for these women?
o How can we best support holistic recovery?

Understanding and quantifying how poor body image is impacting Australian women's health and wellbeing.

o Body image is often not taken seriously as an indicator of poor mental health. There's a need for up to date large scale Australian research.
o Young women report poor body image at high rates. We need to understand to what extent this is driving anxiety and depression and other health issues in adolescence and later life.
o We know young people with poor body image are also more likely to engage in risky health behaviours eg. unsafe sex. How can we mitigate these risks?

Research on best practice for endometriosis, polycystic ovarian syndrome and severe period pain/heavy bleeding.

o How do women manage this? How does is impact their mental health and participation in school/work?
o Anecdotal evidence suggests that women are still feeling dismissed by health professionals for these common, often long-term conditions. What training do health professionals require in order to assist women more effectively/holistically?

Research and action required to urgently reduce rates of lung cancer in women.

o How is gender contributing to the widening gulf between women and men?
o What opportunities are there for gender sensitive responses?

Research into health promotion strategies for women in larger bodies that take a 'do no harm' approach by not reinforcing poor body image and self-objectification.

31 Strengthening partnerships

No

32 Strengthening partnerships - comments

Strengthening partnerships - comments:
Specialist women's services play a critical role in providing information, advocacy and support for women's health. They have also been at the forefront of efforts to prevent and respond to violence against women and promote gender equity for decades. As such, they are an essential partner to support governments and health services/professionals to identify and respond to women's needs, experiences and priorities. Funding for the Australian Women's Health Network should be restored, while additional funding for state-based services would enable them to engage more effectively at a national level.

There is also an opportunity for stronger integration of sexual and reproductive health care across primary care (Commonwealth) and community health and hospitals (state) to ensure a streamlined experience for women accessing services. Primary Health Networks have an important role to play in facilitating this integration.

33 Achieving progress

Achieving progress:
Gender equity, and equity between women, are the two foremost guiding principles for the draft strategy (which WHV strongly supports). This creates the opportunity to link the strategy to related gender equity strategies in terms of data collection, promising practice and measuring change over time. It will be important to measure and report against gender equality targets.

Indicators that could be considered include:

• The number of GPs and pharmacies in different areas able to prescribe and provide medical abortion
• Rates of anxiety and depression in young women
• The National Community Attitudes Survey (in relation to attitudes that support violence against women)

Gender equity measures that could be considered include the gender pay gap, uptake of flexible work arrangements and shared paid parental leave.

The Implementation Steering Group could support this by including cross sector gender equity experts. The Implementation Steering Group must also include strong and equitable representation of women from different groups including women with disabilities and Aboriginal and Torres Strait Islander women.

Special attention should be given to improving data collection about priority groups (for example Aboriginal and Torres Strait Islander women and girls), and setting appropriate and tailored targets for specific population groups.

The Victorian Women's Health Atlas (developed by WHV and accessible online: https://victorianwomenshealthatlas.net.au) provides a useful and highly relevant example of how multi-faceted data can be collected, displayed and compared across geographical regions, enabling change to be measured over time. The Atlas uses innovative, tailored software to bring together a myriad of indicators related to women's health, gender equity and broader social determinants of health

including sexual and reproductive health, mental health, avoidable mortality, violence against women and social inclusion.

SECTION E - OVERALL COMMENTS

34 Do you have any additional comments? (200 word limit)

Overall comments:
WHV congratulates the government on a strong draft strategy. As stated throughout, the most significant changes we suggest are: inclusion of and a deeper engagement with primary prevention strategies, in addition to early intervention; the creation of violence against women as its own dedicated priority area; and a more comprehensive approach to sexual and reproductive health, including access to contraception and abortion. We look forward to playing a key role, together with women's health services, in the implementation of the strategy.