Submission to consultation on National Preventive Health Strategy 2021-2030

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Women's Health VICTORIA
healthy • empowered • equal

Contents

Survey responses

1. Vision and aims

Are the vision and aims appropriate for the next 10 years?

Women's Health Victoria believes that directing prevention and health promotion efforts at addressing the social determinants or root causes of ill health is critical to improving health outcomes and creating a more equitable, inclusive and productive society.

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, social norms, social policies and political systems. Structural barriers including access to political power and resources, social isolation, economic participation, cultural beliefs and stereotypes, freedom from discrimination based on gender, race or experience of disability are all important social determinants which play a key role in predicting and affecting the health outcomes of individuals or groups. Priority should be given to addressing the broader causes of health and wellbeing - the social determinants of health - which will in turn bring about better outcomes in the other approaches identified, namely early intervention, better information and targeting risk factors.

Gender and gender-related inequalities play a profound role in shaping women's and men's lives and health outcomes across the lifespan. Gendered norms, practices and structures contribute to poor health outcomes for men, women and gender diverse people. A gender lens should be applied to all aspects of the Strategy, if the vision for the health of all Australians at all stages of life is to be realised.

A gendered approach is important because it makes visible:

- differences in health outcomes for women and men
- how gendered norms contribute to differences in health outcomes
- how health policies might be strengthened to reduce gender inequities
- how prevention programs might be reoriented to meet the different needs of males and females

To illustrate the relationship between gender and health, Women's Health Victoria has developed the Victorian Women's Health Atlas: https://victorianwomenshealthatlas.net.au/#!/. This ground-breaking interactive tool could be further developed to allow for similar national analysis.

Gender-based discrimination interacts with other types of lived experiences of inequality. This interaction, in which one experience impacts on another, is termed 'intersectionality'. Social and structural inequalities, such as class, race, sexuality, disability and residency status may act to increase women's vulnerability to negative and compounding health outcomes. For example, on all measures of social and economic participation (housing security, income, employment and education), women with disabilities are disadvantaged compared to women

and men without disabilities. Women with disabilities also experience higher levels of disadvantage than men with disabilities when it comes to employment and income levels. In order to be effective and to avoid reinforcing existing disparities, prevention strategies must take intersectional inequalities into account, and be tailored accordingly.

Examples of how consideration of gender will improve outcomes for each of the aims are provided below.

Australians have the best start in life

Structural barriers such as poverty, childcare responsibilities, single parenthood, insecure income, low wages, domestic violence, and sexual assault are just some of the factors that disproportionately impact women's health outcomes. These factors are all exacerbated during pregnancy and parenting during the 0-5 years and thus impact the start in life for their children.

For example, there is strong evidence demonstrating the link between mothers having their first baby and their increased risk of experiencing intimate partner violence, and both physical and psychological abuse during pregnancy have been linked to adverse birth outcomes. If we are going to provide children with the best start in life, the cause of intimate partner violence - gender inequality - must be addressed.

Having the best start in life also requires consideration of sexual and reproductive health, which is critical for good maternal health outcomes and the prevention of congenital conditions. This consideration should include pre and conception care, prenatal care and postnatal care.

Australians live as long as possible in good health

Gender is an important consideration in the context of living well for longer. There are gendered differences in the experiences of older people. While Australian women are more likely to live longer than men, the higher prevalence and incidence of non-fatal health problems among women results in more years lived with ill health and disability. Ageing presents particular risk factors for older women's mental health too, such as the experience of depression and grief following loss of close connections when partners and friends die.

Older age intersects with other determinants too. As the pandemic has demonstrated, secure, safe housing is important for good health. Older single women are the fastest growing cohort in Australia's homeless population, with many women having no previous experience of homelessness until they reach their older years. Some have gone through a relationship breakdown or death of a partner; others have had a lifetime of poorly paid and insecure employment and have few savings to draw on. Private rental is unaffordable to them, and public housing waiting lists are extensive. Given the ageing population, women's life expectancies, and women's financial insecurity in the older years, it is expected that homelessness among older women will continue to grow and must be addressed if all Australians are to live as long as possible in good health.

Australians with more needs have greater gains

The Consultation Paper (The Paper) acknowledges that *"some groups in our community have poorer health or particular health needs – including Aboriginal and Torres Strait Islander people, those experiencing social and economic disadvantage, those living in rural and remote areas, people with disability LGBTI people and those from culturally and linguistically diverse backgrounds*" (p. 11)

The Paper doesn't acknowledge the following key factors if Australians with more needs are to experience greater gains.

- The need to address racism as the **key** determinant of the poorer health outcomes experienced by Aboriginal and Torres Strait Islander people.
- Gender and gender-related inequity which play a profound role in shaping women's lives and health outcomes across the lifespan. For example, intimate partner violence causes the greatest burden of disease for women between 15-44, yet gendered violence is not mentioned.
- That various inequalities interact with one another compounding their impact. For example, rural women have limited geographical and economic access to preventive sexual and reproductive health information and services, leading to fewer options and limiting choice. The ten Victorian LGAs with the highest rates of teenage birth are all rural. Higher levels of poverty, limited public transport options and fewer bulk billing services all compound to limit SRH options.

These factors will need to be addressed if gaps in the burden of ill-health are to be eliminated.

Investment in prevention is increased

It is promising that the Paper recognises that currently "our health system is focussed fundamentally on the treatment of illness and disease" and that the purpose of The Strategy is to enhance the focus on prevention. This will of course require increased investment. To be effective, prevention strategies will need to address the social determinants of health. This will require innovative cross-sector partnerships spanning multiple settings including early childhood, schools, workplaces, community organisations and media, in addition to health settings. This work needs to be acknowledged and resourced accordingly.

Investment in prevention should include a workforce with specialist prevention skills to address the needs of people with poorer health outcomes. Entities such as specialist women's health services with skills in identifying and responding to the specific health risks experienced by women should be recognised, strengthened and embedded as a core feature of the preventive health system. These services play a key role in identifying and responding to the health needs of women including in relation to prevention of violence against women, and sexual and reproductive health, including access to contraception, unplanned pregnancy support and abortion.

These typically very small, under-resourced organisations have, with sustained effort and in partnership with government and community, identified numerous serious health issues for women that have otherwise been overlooked by generalist services and policy makers despite their prevalence, seriousness and preventability. Specialist women's health services have

worked tirelessly to undertake research, collect evidence, and design policy and health promotion programs and services, in order to render the health concerns and life experiences of women visible and important. By sharing this knowledge, specialist women's health services build the capacity of an entire region or network of service providers to ask the right questions, collect the right data, inform policy development, design best practice interventions, and support appropriate and effective engagement with men and communities.

Since the launch of Our Watch, Australia has had a national approach to building workforce capacity to prevent violence against women, supplemented by investment by state governments, notably in Victoria. The gains made through this national effort should be recognised and resourcing to ensure equitable involvement and impact across the country should be maintained.

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2. Goals of the Strategy

Are these the right goals to achieve the vision and aims of the Strategy? Why or why not? Is anything missing?

The goals of the Strategy have the potential to fulfil the Strategy's vision and aims, but each must be accompanied by specific indicators to measure progress against the social determinants of health i.e. changes in the social, cultural, structural, economic and physical environments that determine health outcomes, as well as changes in rates of illnesses. Setting measures and targets will help to drive relevant action.

Different sectors, including across governments at all levels, will work together to address complex prevention challenges

As the Paper notes "*the health of an individual is determined largely by the social, cultural, structural, economic and physical environments experienced throughout life, as well as various individual attributes including genetic make-up*." Pg 6 To ensure preventive strategies are effective, they need to address these social determinants which will require innovative cross-sector partnerships spanning multiple settings including early childhood, schools, workplaces, community organisations and media, in addition to primary health settings.

Services with specialist knowledge, such as Victorian Women's Health Services, Multicultural Centre for Women's Health and Women with Disabilities Victoria, should be resourced to support partnerships address social and structural inequalities, such as class, race, sexuality, disability and residency status, that influence outcomes in the multiple settings identified.

Prevention will be embedded in the health system

Whilst the health system has strong workforce capacity and well-developed pathways for learning and skill development in relation to early intervention and treatment, the specialist skills required for primary prevention and health promotion have been under-recognised and poorly resourced. This will need to be addressed if prevention is to be successfully embedded in the health system.

The essential role played by organisations with specialist knowledge, such as women's health services, in identifying and responding to the specific health risks experienced by women should be recognised, strengthened and resourced as a core feature of embedding prevention in health system.

Environments will support health and healthy living

As the Paper notes, creating environments that support health and healthy living is multidimensional and must take into account the environments in which people live, work, learn and play. Working towards creating healthy environments must include consideration of physical, social and economic factors and acknowledge that doing the same for everyone will not enable equal access. For example, supporting equal access to work requires consideration of the economic factors that enable access to affordable childcare for people with pre-school age children. Supporting women to remain in the workforce during pregnancy means that discriminatory social views which prevent their full participation need to be challenged.

Interventions to increase the participation of women in physical activity must consider the physical environment (e.g. women's actual and perceived safety), social norms (e.g. socially constructed body and beauty ideals) and economic inequalities (e.g. affordability).

As identified in the prestigious medical journal LANCET in 2009 *"Climate change is the biggest global health threat of the 21st century. Effects of climate change on health and wellbeing will affect most populations in the next decades and put the lives and wellbeing of billions of people at increased risk."* Creating environments that support health and healthy living also needs to include consideration of the ecosystems that sustain us and therefore should consider the impact of climate change. Action to address climate change must be included in any Strategy to promote health.

Climate change along with other environmental disasters impact men and women differently. Gendered differences in socio-economic factors exacerbate the impacts of climate change on women.

- Women's lower socioeconomic status means increased vulnerability to the rising costs associated with climate change.
- Women are more likely to live in rented or public accommodation, which is less likely to be climate proofed.
- Women have a longer life expectancy, and are more likely to be living with disabilities and chronic illness, rendering them vulnerable to heat-related illness and death during heatwaves.
- Men's violence against women is known to increase after disasters such as bushfires, extreme weather events, and in heat waves

Communities across Australia will be engaged in prevention

Engaging people in decision making is a fundamental principle of preventive health. This engagement should enable consumer leadership as well as participation. To do this successfully requires encouraging diversity of opinion and multiple strategies and approaches to ensure people with lived experience are central to the process.

The expansion of telehealth and other technological solutions in response to the COVID pandemic is an example of how technology can be harnessed to provide access to decision making for people across wide geographic areas. Solutions must be tailored to meet the specific needs of diverse groups, including recognition of the diverse technical capabilities and unequal access to and availability of computers and the internet. Specialist services such as the Victorian Women's Health Services, Multicultural Centre for Women's Health and Women with Disabilities Victoria and community leaders need to be involved in developing strategies for genuine engagement.

Individuals will be enabled to make the best possible decisions about their health

The Paper indicates that in order to make the best possible decisions about their health "*Australians from all backgrounds will have the options, knowledge and skills to make the best decisions about their health and the health of their families*" (p. 15)

In the context of individual decision making it is crucial to explore what is meant by 'options'. Options are determined by factors such as affordability, opportunity, safety and availability, and real options are created when these are addressed.

For example, cost is usually the most important factor determining the food-purchasing decisions of lower-income households, and the cost of fruits, vegetables and other healthy foods in Australia has been rising faster than the cost of less nutritious foods and the Consumer Price Index. Emerging research indicates that subsidising the price of healthier food is more effective than nutrition education. Price subsidies on healthy food have been found to increase the purchase and consumption of healthy food, however long-term impacts on consumption and cost effectiveness need to be examined. Policy packages of taxes on unhealthy foods, in combination with subsidies for healthy foods, are considered to offer the greatest potential from a health equity perspective. However, these policies must take into account the skills, resources, time and food literacy required to prepare the subsidised 'healthy' foods. Gendered norms and practices associated with food and food work must be challenged as the current norms and practices currently create a disproportionate burden for women in terms of time and skill.

In relation to physical activity, it has been demonstrated that more women than men intend to increase their physical activity, but women often face more barriers to physical activity than men, particularly women over 30, mothers and those from non-English speaking backgrounds. Common reasons include difficulty finding the time, a lack of appropriate facilities for women and caring for children. Gendered social norms mean that women feel the need to choose between work or family commitments and physical activity. Unless these factors and expectations are addressed, women will not have real options and will continue to be thwarted in their intentions to make the best possible decisions about their health.

Prevention efforts will be adapted to emerging issues and new science

Research and data collection systems will need to be resourced and coordinated to enable emerging issues to be identified. Strategic investment in new science including technological solutions should be targeted to meet the specific health needs of priority population groups, such as women in rural and regional areas, Aboriginal women, women from immigrant and refugee backgrounds, LBTIQ women and gender diverse people, and women with disabilities. Targeting of efforts to address health inequities will enable achievement of the aim that *"Australians with more needs have greater gains"*. Collaboration with priority population groups to co-design innovative approaches tailored to their needs is crucial for effective and sustainable solutions.

References for this section

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3. Mobilising a prevention system

Are these the right actions to mobilise a prevention system?

Women's Health Victoria supports the principle that to expand and enhance current prevention action will require a prevention system. For a prevention system to be effective over the long-term, clarity around the shared vision and the roles and responsibilities are important. All the systems enablers outlined are important but establishing clear Leadership and Governance will be critical and should be an early priority.

It is encouraging to see recognition that "*building the capacity and capability of the workforce both current and emerging will be integral to success*". Workforce analysis and capacity building should be specifically identified as a fundamental component of implementation.

Information and literacy skills

Successful health promotion approaches have repeatedly demonstrated that information and awareness raising alone are not sufficient for behaviour change. Efforts to improve information about how to stay healthy are only of benefit if people have the environment that supports such choices.

An integrated approach to health promotion acknowledges the need to work in multiple ways across the social ecology to mutually reinforce the efforts made at each of its different levels – the individual, family, community, organisational, institutional, systems and societal. For example, public awareness campaigns acting to influence individuals – knowledge, awareness and behaviours – can play a role in facilitating change if they occur within the context of other environmental changes. For example, cost is usually the most important factor determining the food-purchasing decisions of lower-income households, and the cost of fruits, vegetables and other healthy foods in Australia has been rising faster than the cost of less nutritious foods and the Consumer Price Index. Women face this challenge at a greater rate than men. Not only are women are largely responsible for food purchasing decisions and food preparation, women head 80% of single parent households, which are more likely to experience poverty. Unless healthy food is made more affordable it will remain out of range for many households and women will continue to experience this disproportionate burden.

Improving the way information is conveyed and building health literacy skills will only be effective in reducing the burden of disease if the social conditions in which people live that allow them to make the decisions that promote health are addressed concurrently. Relying on information and knowledge alone will increase inequalities and is not consistent with the aim "*Australians with more needs will have greater gains*."

Health system action

Primary prevention approaches work with the well population to address risk factors and social determinants using general and targeted population approaches. By definition this means primary prevention work takes place outside the health system. By the time people are in contact with the health system they already have a "health issue" i.e. they are already sick in some way. Whilst early intervention and screening and health protection, control of risk factors and management of condition (secondary prevention) and rehabilitation, preventing complications and improving quality of life (tertiary prevention), which are the focus of most prevention work within the health system currently, are all important, prevention resources must not all sit within the health system. This is further explored in discussion of "Partnerships".

In order to maximise the prevention effort that does occur within the health system we need an integrated approach across all parts of the system to support a seamless approach. This will require action across the various levels of government and public and private providers. *Baby Makes 3* is an example of this approach. This program aims to reduce violence against women by addressing the driver of this violence - gender inequality. The program challenges gender norms and practices within the perinatal period (primary prevention) at a time when gender roles are particularly evident for both the parents and the child in both maternal and child health settings (local government) and hospital-based ante and postnatal care (State government). Maternal and child health nurses and midwives in these settings are also trained in early detection of (secondary prevention) and response to (tertiary prevention) family violence and have well-established referral pathways to appropriate services, including family violence response services.

As action is taken to strengthen prevention within the health system, it will be important to pay attention to the different health needs of women and men, reflecting the evidence that women's health is impacted by social circumstances in different ways from men. Women also experience different health risks and needs over the course of their lives. A 'gender-insensitive' approach that fails to consider the differing needs of women will reinforce gender-based inequities and disparities in health outcomes. For example, a gender insensitive approach to encouraging women's participation in physical activity schedules sessions without consideration of caring responsibilities that may create barriers to participation. A 'gender sensitive' approach in this situation acknowledges and addresses the barriers women experience owing to childcare responsibilities and provides child care as part of the initiative. A 'gender transformative' approach would also challenge the gendered norms and practices that determine this is a women's responsibility, by supporting greater involvement of men in caring for children, thus enabling women to be physically active at times they choose.

It is important to maintain specialist services such as women's health services to enable contribution of specialist knowledge to inform appropriate action.

Partnerships

Ensuring preventive strategies effectively address the social determinants of health will require innovative cross-sector partnerships spanning multiple settings including early childhood, schools, workplaces, community organisations and media, in addition to health settings. For partnerships to be effective this work needs to be acknowledged as "real work" and resourced accordingly.

The Collective Impact model provides a blueprint for effective partnerships. The Collective Impact model describes how stakeholders across many sectors collaborate to address complex social issues, supported by a backbone organisation. The backbone organisation, which coordinates the combined efforts of the partnership, requires specific skills and resources. Sustained funding for entities that broker and build long term partnerships must be part of mobilising an effective prevention system. The success of regional action plans for the prevention of violence against women led by Women's Health Services across Victoria demonstrate the benefits of providing funding for entities that broker and build partnerships.

Victorian regional Prevention of Violence Against Women Plans

Plans led by the **regional women's health services** can be found at:

- **Barwon South West** – Preventing and addressing violence against women and children. Available at: URL
- **Eastern Metropolitan** – Together For Equality & Respect. Available at: URL
- **Gippsland** – Gippsland Free From Violence Coalition. Available at: URL
- **Grampians** – Communities of Respect and Equality. Available at: URL
- **Hume** – Respect and Equality for All. Available at: URL
- **Loddon Mallee** – Loddon Mallee Action Plan for the Primary Prevention of Violence Against Women. Available at URL
- **Northern Metropolitan** – Building a Respectful Community Strategy. Available at: URL
- **Southern Metropolitan** –Preventing Violence Together Strategy. Available at: URL
- **Western Metropolitan** – Preventing Violence Together 2030. Available at: URL

Specialist services, such as Victorian Women's Health Services, Multicultural Centre for Women's Health, Women with Disabilities, should be resourced to support partnerships addressing the social and structural inequalities, such as class, race, sexuality, disability and residency status, that influence outcomes in the multiple settings identified.

Leadership and governance

WHV endorses the Strategy's recognition of the need for strong leadership across all levels of government to create an authorising and supportive environment of prevention. A long-term and sustainable funding mechanism as identified will be critical to success.

This leadership and governance will need to extend to systems change in the private sector as well as the public sector in order influence the multiple settings for change identified within the Strategy.

Establishing the model for Leadership and Governance should be an early priority for action.

Preparedness

The COVID pandemic has not only "*highlighted the importance of having an agile and flexible health system"* but it has also shone a light on the circumstances which create unequal vulnerability to illness.

There is now substantial evidence to demonstrate that COVID-19 is having significant impacts on women's mental health, compounding existing mental health inequalities between women and men. The escalation in mental health issues among women is due, at least in part, to intensification of pre-existing gendered social and economic inequalities, such as the overrepresentation of women in casual and insecure employment, the disproportionate increase in unpaid care responsibilities for women, and women's greater likelihood of being in the frontline workforce.

Other forms of inequality and discrimination – in particular, racism, ageism and economic inequality – are compounding these mental health impacts for women. The frequency and severity of intimate partner violence also increases during and after emergencies, with confinement to the home creating additional risks.

Being prepared must involve addressing existing social inequalities. Unless we address existing social and economic disparities, public health emergencies, including climate change, will only further entrench health inequalities.

Research and evaluation

WHV supports the stated position on the need for strong and enduring relationships between researchers and policy makers to support knowledge translation. Practitioners should also be included in these relationships to ensure research is relevant to the issues being faced by the community, and that policy can be practically implemented.

As prevention outcomes are often long-term, funding for research and evaluation should also be long term and an integral part of all prevention initiatives.

Data specific to understanding the outcomes for particular sub-population groups should be required if the aim of "*Australians with more needs have greater gains*" is to be assessed. For example, collection of sex-disaggregated data and analysis should be part of all research and evaluation.

Monitoring and surveillance

As prevention needs to address the social determinants or root causes of ill health in order to improve health outcomes, monitoring and surveillance indicators must include measures which relate to action on these determinants as well as disease outcomes. For example, progress on improvements in gender equality (addressing the root cause) as well as the incidence of men's violence against women are important. This is particularly relevant in preventive health where the long-term health benefits will only be achieved if the root causes are addressed.

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4. Boosting action in Focus areas

Where should efforts be prioritised for the focus areas?

WHV believes that directing prevention and health promotion efforts at addressing the social determinants or root causes of ill health is critical to improving health outcomes and creating a more equitable, inclusive and productive society. The six focus areas largely address risk factors in relation to illnesses causing the biggest burden of disease, not the underlying social determinants of ill health. Taking this approach could lead to some key omissions which impact women's health and may not bring about sustained, long term change. For example, focusing on these six areas will not improve mental health or many facets of sexual and reproductive health. Although reducing alcohol intake may reduce the severity of some cases of physical violence against women, this approach does not address the underlying drivers and therefore will not prevent violence against women.

In relation to each of the six focus areas, WHV urges consideration of the following:

Reducing tobacco use

Specific factors and behaviours in relation to women and tobacco use:

- Concerns about body image and weight, themselves driven by gender norms about ideal femininity, are key reasons for smoking among girls and women. Smoking is associated with weight control as it suppresses appetite and speeds up the body's metabolism. Young women in particular, for whom the negative health benefits are distant, may choose to smoke as a way of controlling their weight.
- The tobacco industry targets women and girls through gender exploitative research and advertising.
- Smoking may be used as a coping device for women who have experienced sexual abuse, violence and other traumatic events, with higher rates of smoking seen among these women.
- In Australia, smoking rates are higher among women experiencing low socioeconomic status (SES). Twenty-eight percent of women living in the most disadvantaged areas report being daily smokers, compared to 11% of women living in the most advantaged areas. Women with low SES are more likely to experience risk factors for smoking such as financial stress, lower educational attainment, and unemployment.

Health promotion initiatives must address the underlying reasons why girls and women are using tobacco.

Improving consumption of a healthy diet

Specific factors for consideration in relation to women and consumption of a healthy diet:

While biologically determined factors of sex, age and physiological stage of life affect women's fundamental nutritional needs, it is gender and other socially and environmentally determined factors that mediate women's access to, motivation for and capacity to make healthy food choices. Gendered norms and social expectations influence women's diet, eating behaviours and health outcomes, contributing to and reinforcing gender inequality.

- Women's food access, behaviours and health outcomes are strongly influenced by the socio-economic determinants of income, education and location. Despite increased participation in the workforce, women are still expected to do the majority of a household's food work; it follows that they therefore cite time as the main barrier to healthy eating. Women who report time pressure as a barrier are significantly less likely to meet the Australian Dietary Guidelines' recommended intake of fruit and vegetables per day.
- Women living in areas of most disadvantage and women experiencing food insecurity are more likely to be obese, but this correlation is not observed in men.
- Food insecurity impacts women's psychosocial wellbeing more strongly than men's, and is associated with higher levels of stress, anxiety and depressive symptoms.
- Socially constructed idealised body image and normalisation of dieting and other weight control behaviours have influenced many young women to adopt a relationship with food that has little to do with nutrition. Being female is the strongest risk factor for the development of an eating disorder, and eating disorders are the third most common chronic illness among young women.

Health promotion campaigns and the narrative around a healthy diet must support access to healthy food and avoid reinforcing harmful gender norms, including by focusing on health rather than weight.

Increasing physical activity

Specific factors for consideration in relation to women and increasing physical activity:

While all Australians face barriers to being physically active, gender greatly influences engagement and expectations in relation to physical activity. The context of women's lives and societal expectations impact on their ability and motivation to participate in regular physical activity.

- Family and domestic duties, such as caring for family and taking primary responsibility for household duties, can impact on women's physical activity. Fourteen percent of Australian women cite family commitments as a constraint for sport or physical recreation - almost twice the reported proportion of men.
- Limited availability of public spaces that feel safe, welcoming and inclusive for women to be physically active.
- Sexist attitudes about the way women look - that first and foremost they must always look good and not sweaty or messy - can lead to negative body image perceptions, which inhibit some women from participating in sports and physical activity. Women in larger bodies often experience the additional barrier of discrimination, which can lead to withdrawal from physical activity.
- Women and girls in experience several significant and ongoing barriers to equal participation in sport and recreation, including a long tradition of prioritising and celebrating men's sport, facility design, perceptions of safety, and a lack of funding and promotion for women's sport.
- Gender stereotyping leads some women to believe that child rearing and domestic chores are 'women's work' and that their place is in the home and caring for others rather than themselves. This can mean they are less likely to exercise, owing to time constraints and feelings of guilt about taking time out for themselves.

- Other factors that can discourage women and girls' participation in sport are the underrepresentation of women in leadership positions within sporting organisations, low media and television coverage of women's sport, lower financial rewards and sponsorship opportunities available to elite women elite athletes compared to men, restricting and uncomfortable uniform requirements and a lack of access to appropriate sporting facilities.

Health promotion initiatives aiming to increase physical activity rates for women must address the gendered barriers to participation, including gendered expectations and stereotypes that encourage women to prioritise other activities over physical activity.

Increasing cancer screening

Australia has established national programs to screen for breast, cervical and bowel cancers, yet not all women are participating. Analysis of screening behaviour has been undertaken (AIHW 2018). A major limitation of the research was that it was based only on women who participated in at least one of the screening programs, which limited the study's capacity to explore why women choose not to participate. Identified barriers to participation include the ineffectiveness of the reminder system, issue(s) related to eligibility, that existing resources and campaigns are rarely tailored to address the needs of diverse population groups, including women from immigrant and refugee communities, women with disabilities and women in rural and remote settings.

Furthermore the AIHW study noted that "*cancer outcomes and screening behaviour were not explored for Aboriginal and Torres Strait Islander people. This is a major omission, given that it is known that Aboriginal and Torres Strait Islander people have poorer outcomes and lower participation*." Increased investment and extension of existing programs such as the Breast Screening Shawl Trial should occur nationally. Led by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Victorian Aboriginal Health Service (VAHS) the Breast Screening Shawl Trial was developed by Breastscreen Victoria. This project was designed to address the reports from Aboriginal women that lack of cultural awareness among health professionals, fear, shame and logistical barriers impact negatively on participation in breast screening. The project has been an enormous success. 160 Aboriginal women screened, a significant achievement for an under-screened group. 82% of the women who screened were new to breast screening or had lapsed. The experience was overwhelmingly positive, with 82% of women agreeing that the shawl made them feel culturally safe. 95% of women agreed that they felt more comfortable screening because the mobile screening service was located at their local Aboriginal health service.

Ongoing analysis of the reasons for non-participation must be resourced and inform appropriate responses.

Improving immunisation coverage

Whilst girls and boys are vaccinated at similar rates, women take overall responsibility for accessing healthcare for their children. Gendered barriers such as access to immunisation services that clash with women's working hours, can lower rates of immunisation. In addition to addressing the barriers it is important to encourage both men and women to take responsibility for children's health. As reported in a WHO 2010 study, making women the

primary target of information campaigns merely perpetuates the idea that taking children to be vaccinated is a woman's responsibility.

As identified in the National Immunisation Strategy 2019-2024, priority population groups for improving immunisation coverage are pregnant women, health care and social workers (79% are of whom are women), Aboriginal and Torres Strait Islander and migrant and refugee populations. An approach that includes a gender lens, which focuses on the experiences of these women and communities, and involves them in decision making about how to overcome the barriers to accessing immunisation will lead to improving immunisation coverage. For example, working with women to ensure that messages sent home with children from school are simple and tailored as appropriate.

Reducing alcohol and other drug-related harm

Men are more likely to drink at 'risky' levels than women, although women's rates of alcohol use and related harms are catching up with men's rates. Women start to experience alcohol-related health problems sooner and at lower drinking levels than men. This is due to women having less of the enzyme dehydrogenase which breaks down alcohol, a higher percentage of body fat and a lower percentage of body water than men, which affects how fast alcohol is absorbed.

While the literature tends to focus on the harms of women's drinking, there is a lack of research on their motivations for consuming alcohol. However, it is reported that stress plays a critical role in women's maintenance of alcohol use. Women who have experienced abuse are more likely to use alcohol as a coping mechanism. Further research into women's motivation for consuming alcohol is required if alcohol consumption is to be reduced.

Different expectations apply to men and women in relation to alcohol consumption. While men's behaviour is more likely to be excused, women are judged more harshly on behaviour and appearance if they have consumed alcohol. One in eight Australians believe that if a woman is sexually assaulted while she is drunk or affected by drugs, she is at least partly responsible.

It is important that public health interventions that are designed to reduce consumption of alcohol and other drugs do not reinforce harmful gender norms and social expectations, but instead take a gender-sensitive or ideally a gender transformative approach.

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5. Continuing strong foundations

How do we enhance current prevention action?

Australia has a proud history of success in many health promoting initiatives. We have fewer people dying of smoking related illnesses, we have reduced skin cancers in young people, we have addressed gun control, we were world leaders in containing the spread of HIV, we have reduced dental decay and we have reduced our road death and injury toll. We are also amongst world leaders in addressing violence against women with an integrated public health informed approach.

All of these successes have taken place over a long period of time with sustained effort and intersectoral action. However, in recent years much of the funding for preventive initiatives has been short term and project-based. It is difficult to take a comprehensive approach and build a skilled workforce with short term and insecure funding. It is also critical to ensure we take a comprehensive approach to health promotion. In recent years, efforts have often focused on social marketing campaigns that are not always supported by capacity building within communities, nor the structural changes needed to create health promoting environments. If we want to be able to continue our proud history and to demonstrate in 2030 that we have continued to make progress against the factors causing poor health in Australia, we need to take a long-term bipartisan approach to resourcing the prevention system in 2020.

And there are gaps in our successes to date. Aboriginal and Torres Strait Islander people overall continue to have far poorer health outcomes than the rest of the population, and we have not made significant gains in the area of mental health or environmental health, and the consequences of gender inequality continue to have a significant impact on women's health through the life course. The next era of preventive health needs to address these gaps, which are missing in the current Paper and need to be made more explicit.

References for this section

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Additional feedback or comments

Whilst the Paper presents some encouraging signs that a comprehensive and coordinated approach to preventive health could be developed in Australia in the coming years, there are some concerning omissions.

The Paper points to the specific health needs of Aboriginal and Torres Strait Islander people, those in rural and remote locations, people with disability, lesbian, gay, bisexual, transgender and intersex people, those from culturally and linguistically diverse backgrounds, and those experiencing social and economic disadvantage. However, it does not acknowledge that women and men have different health outcomes, and that gender is a determinant which intersects with each of the other factors mentioned. The following policy brief is presented to demonstrate how gender is currently impacting on health outcomes by outlining the consequences on women's mental health of the COVID pandemic: https://whv.org.au/resources/whv-publications/policy-brief-women%E2%80%99s-mental-health-context-covid-19-and-recommendations

It is encouraging to see health inequities and the need for increased resourcing for prevention within the health system identified in the Paper, however the particular prevention issues faced by Aboriginal and Torres Strait Islander people are not included. The unacceptable inequities in health outcomes for Indigenous Australians require serious attention, and preventing ill-health and promoting health and wellbeing needs to be central to this.

Other key omissions are a specific focus on mental health and climate change. Whilst the Paper does not focus on specific disease outcomes, action only within the current six focus areas will not bring about significant improvements in mental health. It is not possible to have good physical health without good mental health. The Paper talks about the impact of adverse weather events yet does not specifically mention climate change, which *The Lancet* identifies as "the biggest global health threat of the 21st century". We are already facing health effects of climate change through prolonged drought, unprecedented bushfires, effects on mental health and extreme heat. Preventive health needs to include actions to both prevent and mitigate the impacts of climate change.