Australian Women's Coalition Inc

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Submission on the development of a new National Women's Health Policy

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Disclaimer

The Catholic Women's League of Australia, and the National Council of Women Australia, two of the member organisations of the Australian Women's Coalition, are pleased to be associated with development of the new National Women's Health Policy and support the majority of the recommendations in this submission. However, the organisations cannot endorse all the points under Section 5.1.1. In particular, neither organisation endorses:

- Provision of a full range of contraception and community information strategies
- Legal, safe, accessible and affordable pregnancy termination services.

Executive Summary

The Australian Women's Coalition (AWC) is one of four national women's Alliances funded by the Office for Women. The AWC aims to:

- increase communication within the women's sector;
- clearly identify the needs of women represented by the partners of the coalition;
- initiate policies, programs and partnerships to address these needs; and
- advocate on women's issues to government and the community.

We have 19 member organisations representing approximately 3 million women in Australia.

To inform this submission, the AWC held a forum with member representatives on 17 May, 2009, and members provided further input and commented on the draft document by email. The submission follows the format of the Consultation Discussion Paper[1], responding to each of the Objectives and Principles proposed for the new National Women's Health Policy and reviewing the priorities of the 1989 Women's Health Policy. In addition, we provide examples of the work of the AWC relevant to the new policy.

The Australian Women's Coalition strongly endorses the approach taken in the Consultation Discussion Paper in preparation for the new National Women's Health Policy. The focus on the social determinants of health; gender and health inequity; social inclusion; preventive approaches and in particular, the health status of Aboriginal and Torres Strait Islander, migrant and refugee women are all timely evidence-based approaches to women's health which are in line with the values and policies of the Australian Women's Coalition.

We include specific recommendations to ensure that the new policy will provide concrete benefits to Australian women, particularly those most at risk of poor health. Of the 28 recommendations, Recommendations 1-7 are of particular importance to AWC.

[1] Australian Government Department of Health and Ageing (2009). *Development of a New National Women's Health Policy- Consultation Discussion Paper 2009*.

Recommendations

Overview

Develop Implementation and Evaluation plans as part of the new National Women's Health Policy. **[Rec 1]**

Ensure that the new National Women's Health Policy is clearly linked to other key State and national policies that have relevance to women's health. **[Rec 2]**

Aboriginal and Torres Strait Islander women

Consult further with Aboriginal and Torres Strait Islander women to develop the policy, and consider whether a whole-of-population, companion or Indigenous specific women's health policy is most likely to deliver positive benefits to Aboriginal and Torres Strait Islander women. **[Rec 3]**

Health professional education in the impact of gender on health

Establish a national academic unit to coordinate health professional education, training, research and policy on issues related to gender and health. **[Rec 4]**

Access to appropriate health care, particularly in rural and remote areas

Ensure that all women in Australia, particularly those in rural and remote communities, have equitable access to gender and culturally sensitive health care. **[Rec 5]**

Women on health decision making committees

Ensure that every federal health decision making committee includes a female consumer and a female health provider, and implement a mechanism to report on this. **[Rec 6]**

Gendered analysis of health policies

Review all policies relevant to health in Australia from a gendered perspective. **[Rec7]**

Review the programs and activity of the *National Health Priority Area- Cardiovascular Disease* from a gendered perspective, and use this as a basis for developing targets and strategies for the prevention of cardiovascular disease in women. **[Rec 8]**

Young female offenders

Recognise that although the number of incarcerated women is proportionally much smaller than men, incarcerated women are much more likely than men to be primary and often sole carers of children, thus inflating the familial and generational health and welfare costs associated with poor outcomes in this population group. **[Rec 9]**

Older women on low incomes

Review the Medicare Safety Net to ensure equity between single people, couples, families, women and men. **[Rec 10]**

Prevention of osteoporosis

Extend the Medicare rebate for Bone Mineral Density (BMD) testing to enable all women to have a screening BMD test at the time of menopause and another 5-10 years later. **[Rec 11]**

Accord the prevention of osteoporosis higher priority in policy making. In particular, consideration should be given to extending Pharmaceutical Benefits Scheme listing for biphosphonates for prevention of osteoporosis, and better management of those with a first fracture to prevent further fractures. **[Rec 12]**

Subsidise low cost exercise programs for older women in their local areas to prevent a range of diseases, including osteoporosis and osteoporotic falls. **[Rec 13]**

Sex and gender disaggregated data

Ensure that key Australian Bureau of Statistics publications, all government policies relevant to health and health research funded by the Australian government are 'gender competent', starting with disaggregation of all data by both sex and gender. **[Rec 14]**

Maternal health and early intervention approaches

Recognise the specific needs of women's mental health throughout the lifespan, particularly around the time of childbirth. Culturally appropriate mother and baby residential units should be accessible to all women if they are required. **[Rec 15]**

Support continued upscaling of early intervention approaches for the promotion of maternal health and the prevention of childhood abuse and neglect. **[Rec 16]**

Priorities of the new policy

Include primary, secondary and tertiary prevention of cardiovascular disease as a priority in the new National Women's Health Policy. **[Rec 17]**

Reproductive health and sexuality, including menopause

Take account of the rationale for a national Sexual and Reproductive Strategy and the implications of this for a new National Women's Health Policy. **[Rec 18]**

Prioritise research and funding for cervical screening programs that target Aboriginal and Torres Strait Islander women and those from culturally and linguistically diverse backgrounds. **[Rec 19]**

Increase funding for specific physiotherapy and bladder retraining, including in pregnancy, to improve prevention and management of incontinence and pelvic organ prolapse. **[Rec 20]**

Increase public funding for infertility services so that access to assisted conception is not dependent on socioeconomic circumstances. **[Rec 21]**

Emotional and mental health

Support the recognition of mental ill health in women as arising from a combination of biological, social and psychological factors, and being inherently gendered, necessitating approaches that are broader than the administration of psychotropic medications. **[Rec 22]**

Violence against women

Coordinate policies addressing violence against women across all relevant strategies, including the new National Women's Health Policy. **[Rec 23]**

Urgently address the shortage of refuges and safe houses for women escaping violence in Australia, particularly in rural and remote areas and for women for whom English is not their first language. **[Rec 24]**

Recognise the significance of personal histories of abuse and neglect in the profiles of 'criminalised' women and girls by making them a priority population group in the National Plan to Reduce Violence Against Women and their Children. **[Rec 25]**

Health needs of women as carers

Recognise that women who are carers are at particular risk of poor health and consider targeting preventive strategies to these women. **[Rec 26]**

Improvements in health services for women

Support ongoing, sustained funding for specific women's health services and centres in Australia. **[Rec 27]**

Research and data collection

Support the continuation of Women's Health Australia, the National Longitudinal Study on Women's Health. **[Rec 28]**

2. The Australian Women's Coalition

The Australian Women's Coalition (AWC) is funded by the Office for Women as one of four national women's Alliances. The AWC aims to:

- increase communication within the women's sector;
- clearly identify the needs of women represented by the partners of the coalition;
- initiate policies, programs and partnerships to address these needs; and
- advocate on women's issues to government and the community.

We have 19 member organisations representing approximately 3 million women in Australia.

Members of the Australian Women's Coalition[2]

Aboriginal Legal Rights Movement Inc
Australian Church Women
Australian Bosnian Women's Cultural Association Inc
Australian Federation of Medical Women
Catholic Women's League Australia Inc
Conflict Resolving Women's Network Australia
Council on the Ageing National Seniors Partnership Australia Ltd
Girl Guides Australia
Hindu Women's Association of Australia
Mothers Union Australia
Muslim Women's National Network Australia
National Council of Jewish Women of Australia
National Council of Women Australia
Pan Pacific and South East Asia Women's Association Australia Inc
Soroptimist Australia Inc
The Salvation Army
UNIFEM Australia
VIEW Clubs of Australia
Zonta International District 24 and District 23

The Australian Women's Coalition welcomes the opportunity to present this submission on the new National Women's Health Policy, which was developed with our member

[2] Appendix 1 provides a summary of AWC member organisations

organisations. In Section 4 we discuss specific issues under each Objective and Principle proposed for the new National Women's Health policy. Section 5 reflects on the priorities and action areas of the 1989 Women's Health Policy. Examples of our work are included in the submission, and descriptions of specific AWC projects relevant to the policy are provided in Section 6, with full reports included as Appendices.

3. Overview

The Australian Women's Coalition strongly endorses the approach taken in the Consultation Discussion Paper[3] in preparation for the new National Women's Health Policy. The focus on the social determinants of health; gender and health inequity; social inclusion; preventive approaches and in particular, the health status of Aboriginal and Torres Strait Islander, migrant and refugee women are all timely evidence-based approaches to women's health which are in line with the values and policies of the Australian Women's Coalition. The AWC also supports the consultation processes engaged with so far in preparation of the Policy.

However, to be effective the policy development process must consult further with important stakeholder groups, including Aboriginal and Torres Strait Islander women, and must be strongly linked to a published plan for both Implementation and Evaluation of the proposed policy. The progressive loss of specific funding for the implementation of the 1989 National Women's Health Policy is a cause for concern. The Implementation Plan should be developed at the same time as the development of the national policy. It should be detailed and costed, and informed by consultation with stakeholders, including affected communities and service providers, who will have key insights into possible barriers in implementation.

The policy also needs to be clearly linked to other key State and national policy documents that have relevance to women's health. Representation of this in the form of a diagram with hyperlinks to other policies would be ideal.

Recommendations

Develop Implementation and Evaluation plans as part of the new National Women's Health Policy. **[Rec 1]**

Ensure that the new National Women's Health Policy is clearly linked to other key State and national policies that have relevance to women's health. **[Rec 2]**

[3] Australian Government Department of Health and Ageing (2009). *Development of a New National Women's Health Policy- Consultation Discussion Paper 2009.*

4. Review of the Objectives and Principles of the New National Women's Health Policy

4.1 Key objectives of the policy

4.1.1 Improve the health and well being of those women most at risk

Aboriginal and Torres Strait Islander women

The health issues facing Aboriginal and Torres Strait Islander women are well documented in the Discussion Paper. The paper considers the use of the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009* as appropriate to guide the development of culturally relevant, gender based policies and service delivery. A useful document to guide in the process of policy development is *Making the Connections- Guidelines for effective approaches to Aboriginal and Torres Strait Islander Public Health*, National Public Health Partnership, June 2005.[4] In particular, this document discusses the three possible approaches to policy development relevant to Aboriginal and Torres Strait Islander Health: integrated, whole of population strategies; companion strategies; and separate Indigenous specific strategies. It is important to determine, in consultation with Aboriginal and Torres Strait Islander stakeholders, which is most likely to deliver positive outcomes to Aboriginal and Torres Strait Islander women. This is particularly important given that the 1989 Women's Health Policy was criticised by both Non-English Speaking Background (NESB) and Aboriginal women for taking a 'one-size-fits-all' approach that was not adequate to address their specific health concerns.[5]

[4] National Public Health Partnership (2005) *Making the Connections: Guidelines for effective approaches to Aboriginal and Torres Strait Islander Public Health* available at: http://www.nphp.gov.au/publications/making_connections.pdf

[5] Schofield, T (2004) *Boutique health? Gender and equity in health policy*, Australian Health Policy Institute, Commissioned Paper Series 2004/08:5

'The decision about whether to take an Indigenous specific approach, or whether to address Aboriginal and Torres Strait Islander health needs as a component of a whole-of-population Strategy, should be based largely on the extent to which the health issue, and the means through which it needs to be addressed, is very different for Aboriginal and Torres Strait Islander peoples.

In many cases, National Public Health Strategies can aim to achieve the benefits of both Indigenous specific approaches and an integrated effort, by developing "companion" Strategies for Aboriginal and Torres Strait Islander populations which link closely with the relevant mainstream whole-of-population Strategies'

National Public Health Partnership, 2005

Recommendation

Consult further with Aboriginal and Torres Strait Islander women to develop the policy, and consider whether a whole-of-population, companion or Indigenous specific women's health policy is most likely to deliver positive benefits to Aboriginal and Torres Strait Islander women. **[Rec 3]**

Women from new and emerging communities

The AWC welcomes the focus in the discussion paper on migrant and refugee women. Many of our member organisations have direct experience with providing services and programs to women in these communities, and have first-hand knowledge of the barriers that they face. Women from new and emerging communities in Australia may have little knowledge of basic health services available in Australia. In the experience of AWC members consulted for this submission, such new migrants are often unaware of immunisation programs, cancer screening, violence against women services, mental health programs and health promotion initiatives. In addition, older migrant women were identified as being at risk of 'falling through the gaps', particularly those who are also carers of members of their families.

4.1.2 Encourage the health system to be more responsive to the needs of women

Health professional training in the impact of gender and culture on health

Despite strong international[67] recognition of the need for appropriate training of health professionals in the impact of gender and culture on health, there remains no systematic method to ensure that all health professionals in Australia are adequately equipped to provide high quality health care to both women and men. This has serious implications for women's health: without training at both undergraduate and postgraduate levels on the type of issues discussed in the Consultation Discussion Paper, women will continue to receive care that is not, or is only partially, responsive to their needs.

Members of our organisations have been researching and advocating on this issue for some years. In 2003, the Office of the Status of Women funded the Australian Federation of Medical Women to investigate the current status of women in medicine. The project documented the professional barriers that women doctors experience in their careers; explained why these should be recognised by governments, hospitals and universities; and argued for the valuing of gender differences in medical practice.[8] In 2004, the Medical Women's International Association, in partnership with four universities and the Australian Women's Coalition, investigated how the medical workforce could be equipped to care for women of all cultural backgrounds in Australia- that is, with 'gender/cultural competence' (see Section 6.4).

Women wanted their doctor to have an understanding of gender issues and particular knowledge about women's health, be sensitive to their needs and have the right attitude to women[9]

Whilst most training institutions address the diversity of Australian society at some level, the approach is ad hoc and underfunded. Some universities- in particular Monash University in Melbourne[10]- have implemented innovative 'gender and medicine' curricula. However, most

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[6] Sen G, Ostlin P & George A. (2007). *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health - Why it exists and how we can change it* (Final Report to the WHO Commission on Social Determinants of Health: Women and Gender Equity Knowledge Network). Stockholm: Karolinska Institutet

[7] World Health Organization (2007). *Integrating gender into the curricula for health care professionals*. Meeting Report 4-6 December 2006, available at http://www.who.int/gender/documents/GWH_curricula_web2.pdf.

[8] Australian Federation of Medical Women (2004*). Moving On From One Size Fits All: towards gender mainstreaming in medicine*, Sydney.

[9] Australian Federation of Medical Women, Centre for Culture and Health UNSW and Australian Resource Centre for Healthcare Innovations (2005). *Achieving gender and cultural competence by Australia's medical workforce*, Report to Office for Women, 21 June 2005: 39

[10] http://med.monash.edu.au/gendermed/

medical schools primarily teach obstetrics and gynaecology, reducing women's health issues to their reproductive function. Anecdotally, cultural issues are addressed more systematically, but the important interactions between culture, gender and other determinants of health may be dropped.[11]There are no data on exactly what is being taught where, and to our knowledge the teaching of gender and health is not included in accreditation processes for health professional training institutions. There are a number of barriers to teaching gender and health, including few faculty members with the appropriate expertise, limited research to inform evidence-based teaching, and curricular materials such as textbooks that fail to acknowledge gender differences.[12]

In 2006 the World Health Organization hosted a meeting of global leaders in medical education to review the best methods for integrating teaching of gender into health care professional curricula.[13] The meeting produced a Consensus Statement on gender and medical education (see box). The meeting also defined a set of core competencies for 'gender-competent' physicians and public health professionals.

The WHO Consensus Statement on gender and medical education recommended that health educators and institutions:

1. Ensure that doctors and other health professionals are offered training with a gender-competent and human rights perspective

2. Encourage and train health professionals to advocate for gender equality and health equity and to serve as agents for change

3. Offer this training across all disciplines and along the learning continuum from undergraduate through continuing professional development

4. Work towards establishing accreditation standards on gender competencies within curricula

5. Establish networks for supporting gender competency within and across institutions, disciplines and sectors in order to promote sharing of resources and integration models in gender and health

6. Support, document and evaluate educational initiatives in gender and health and prioritize capacity building for teaching in this area

7. Support the integration of gender into all research and support new research initiatives in gender and health including analysis of existing databases.

World Health Organization 2007

[11] Personal communication, A.Rutherford, June 2009

[12]Dijkstra A, Verdonk P et al (2008). *Gender bias in medical textbooks: examples from coronary heart disease, depression, alcohol abuse and pharmacology*. Medical education 42(10):1021-8.

[13]World Health Organization (2007). *Integrating gender into the curricula for health care professionals*. Meeting Report 4-6 December 2006, available at http://www.who.int/gender/documents/GWH_curricula_web2.pdf

There is an abundance of literature that can be used as the basis for promoting the teaching of gender competence throughout heath care training institutions in Australia.[14][15][16][17] We recommend that a national academic unit is established to coordinate the teaching of gender and health throughout all health care training institutes in Australia. This would apply to both women and men, and could be a joint outcome of the new National Women's and National Men's Health Policies.

We are delighted that the federal Department of Health and Ageing is committed to developing and implementing new women's and men's health policies. However, without adequate education and training about the impact of gender on health to health care professionals, we can expect little to change. We believe this is a significant omission in the Discussion Paper.

Recommendation

> Establish a national academic unit to coordinate health professional education, training, research and policy in issues related to gender and health. **[Rec 4]**

Access to appropriate health care, particularly in rural and remote areas

During our consultations, access to appropriate, high quality health care in rural and remote areas surfaced again and again. This is coupled with difficulty in accessing transport to attend health care. The current Patient Access Transport Scheme is patchy, differs between States, provides very limited funding, and makes no provision for childcare, accommodation or family support.[18] This impacts particularly upon women, who may be unable to afford transport or organise alternative carers so they can attend medical care in larger centres.

The Australian Women's Health Network documents some of these barriers, including reduced access to bulk-billing in many parts of Australia; lack of women-specific services in rural and remote areas; unmet preferences for female doctors especially in rural and remote areas; low levels of access to culturally appropriate health care services for Aboriginal and Torres Strait Islander women and cultural minorities; and lack of sensitivity and

[14]Stevens I & Lamoen IV (2001). Manual on Gender Mainstreaming at Universities. http://www.kuleuven.be/diversiteit/publicaties/manual.pdf
[15]Nobelius AM & Wainer J (2004). *Gender and Medicine: a conceptual guide for medical educators*. Monash University School of Rural Health, Traralgon, Victoria.
[16]Medical Women's International Association (2002). *Training Manual for Gender Mainstreaming in Health*. http://www.mwia.net/gmanual.pdf
[17]Council of Ontario Faculties of Medicine (2008). *Gender and Health Collaborative Curriculum Project*. http://www.genderandhealth.ca/
[18] Personal communication, M.Cross, June 2009

understanding of the needs of certain groups of women, such as same sex attracted and transgender women, refugee women, women with disabilities and older women.[19]

Geographic disadvantage is very real in Australia. Those that live in a rural or remote area in Australia have higher all cause mortality and higher morbidity: life expectancy decreases with increasing remoteness.[20] Whilst some of this can be explained by determinants of health, such as income, education, employment and housing, it is also the case that people living in rural and remote areas have much poorer access to high quality health care. Anecdotally, this situation appears to have worsened over the last decade. Some of our members living in rural areas reported the withdrawing of funding for specific services such as cancer nurses, and women reported particular difficulty accessing chemotherapy and radiotherapy services.

A number of our organisational representatives reported that some older women in rural and regional areas whose first language was English were having considerable difficulty communicating with their doctor who spoke English as a second language. Cultural sensitivity for these women is also important.

Discrimination on the basis of geography should not be supported in Australia. Our constituents called for continued attention to providing equitable access to gender and culturally sensitive health care, particularly in rural and remote areas of Australia. Ensuring that the medical workforce in rural and remote areas is of a comparable standard to that received in major cities should be a priority for the Australian government.

Recommendation

> Ensure that all women in Australia, particularly those in rural and remote communities, have equitable access to gender and culturally sensitive health care. **[Rec 5]**

[19] Australian Women's Health Network (2008). *Women's Health: The New National Agenda*, Position Paper March 2008.
[20] Australian Institute of Health and Welfare (2008). *Australia's Health 2008*, No 11, AIHW cat. no. AUS 99

4.1.3 Actively promote participation of women in health decision making and management

Women on health decision making committees

Members of our organisations are actively involved on a wide range of health decision making committees, particularly as consumer representatives. The AWC supports the strong involvement of adequately supported consumers on health decision making bodies. However, it was noted that many decisions in health are made without the input of either female consumers or health care providers. Female health care providers also bring a unique perspective to policy making. This is recognised by key international bodies, who regularly seek the opinion of the international arm of the Australian Federation of Medical Women.

The AWC recommends that further action is taken to ensure that every national health decision making committee includes a female consumer and female health care provider. A reporting mechanism should be implemented to document this. This may be possible through the Government Boards Reporting System, which could be made more transparent and report back periodically to the four Alliances.

> *'There are a lot of committees that decide about women's health that are a group of male doctors or male politicians sitting in a room and there is no female consumer on those committees'*[21]

Recommendation

> Ensure that every federal health decision making committee includes a female consumer and a female health provider, and implement a mechanism to report on this. **[Rec 6]**

4.1.4 Promote health equity among women

Health equity among women is addressed below.

[21] Australian Women's Coalition Consultation Forum, 17 May 2009

4.2 Principles of the new National Women's Health Policy

4.2.1 Gender equity in health

Gendered analysis of health policies

As noted in the Discussion Paper, the World Health Organization and other key entities argue strongly for a 'gender mainstreaming' approach to health. Whilst the National Women's Health Policy is extremely important, it will be of added value if it is used as a platform to argue for attention to gender in other policies relevant to health. This cannot be effectively achieved as a bureaucratic process, and rather requires that an ongoing review of health related policies and the ways in which they have and have not taken gender into account is conducted. A very useful outcome from the development of the new National Women's Health Policy would be that the most important policies relevant to health in Australia are reviewed from a gendered perspective. It is encouraging that such a review is about to be conducted in the Department of Families, Community Services and Indigenous Affairs, and that the government has established a Women's Interdepartmental Committee.[22]

In addition, a gendered analysis of the current National Health Priority Areas would be timely.

The Public Health Association of Australia recommends that a gender perspective be mainstreamed into 'all national, state, territory and local formulations of policy that impact health, including ageing and aged care; income and family support and Medicare; employment and workplace relations; unpaid family care; childcare reform; judicial and correctional services; transport; and the provision of public and recreational space'.[23]

[22] The Hon Tanya Plibersek MP, Minister for Housing, Minister for the Status of Women, Australian Women's Leadership Symposium, Canberra, 17 June 2009.
[23] Public Health Association of Australia (2008) *Gender and Health Policy* http://www.phaa.net.au/documents/policy/20081002newGenderandHealth.pdf

'Gender mainstreaming in government and non-government organizations has to be owned institutionally, funded adequately, and implemented effectively. It needs to be supported by an action-oriented gender unit with strong positioning and authority, and civil society linkages to ensure effectiveness and accountability.'[24]

Sen et al, 2007

Members of the AWC have noted that women are not always included in general preventive health programs. This is particularly illustrated by the example of cardiovascular disease, which remains popularly perceived as a men's disease.[25] In fact, women have unrealistic perceptions of their risk of dying from heart disease: a recent survey of pre and postmenopausal women found that 27% of all women perceived breast cancer and 11% perceived heart disease as a health risk, whereas the actual female mortality figures are 3% and 41%, respectively.[26]

The AWC commends the OFW for its attention to the prevention of cardiovascular disease in the Discussion Paper. A gendered analysis of Cardiovascular Disease as a National Health Priority Area would be illuminating.

Recommendations

Review all policies relevant to health in Australia from a gendered perspective. **[Rec7]**

Review the programs and activity of the *National Health Priority Area- Cardiovascular Disease* from a gendered perspective, and use this as a basis for developing targets and strategies for the prevention of cardiovascular disease in women. **[Rec 8]**

[24] Sen G, Ostlin P & George A. (2007). *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health - Why it exists and how we can change it* (Final Report to the WHO Commission on Social Determinants of Health: Women and Gender Equity Knowledge Network). Stockholm: Karolinska Institutet

[25] Guillemin M (2004). *Heart disease and mid-age women: Focusing on gender and age*. Health Sociology Review 13 (1): 7-13

[26] Deeks A, Zoungas, S, Teede H (2008). *Risk perception in women: A focus on menopause*. Menopause 15(2): 304-9

Gender equity in health: Women with Disabilities

Of all health consumers it is evident that women with disabilities have more issues than most. They are high users and there is a significant cost unless they have bulk billing from their doctor. Sometimes the doctor isn't totally aware of their specific needs. Many doctors don't have adjustable examination tables – it is impossible for a paraplegic or quadriplegic woman to climb onto a standard examination table!

The lack of disaggregated data about services for people with disabilities leads to misinformation and misunderstanding about the services provided to women with disabilities. A state budget which lists services to people with disabilities under one heading can hide the fact that the majority of funding for services goes to high needs users (usually young men with significant injuries from car crashes or accidents) and nowhere near a similar amount is spent on women with generally low needs. It appears equal but it is not. This leads to shortages in critical areas such as home services support and keeping younger women out of nursing homes.

Money has been allocated to the states for providing specific high needs care for young people in nursing homes but the only state which has spent any money and provided a purpose built facility is Victoria. More pressure needs to be put on the States to provide suitable housing and care for younger people with high needs disabilities who are presently living in nursing homes because there is nowhere else to go.

Margaret Findlater Smith, National Council of Women Australia

4.2.2 Health equity between women

Social stigmatisation and exclusion- young female offenders

The six priorities of the National Social Inclusion Agenda[27] are:

- addressing the incidence and needs of jobless families with children;
- delivering effective support to children at greatest risk of long term disadvantage;
- focusing on particular locations, neighbourhoods and communities to ensure programs and services are getting to the right places;
- addressing the incidence of homelessness;
- employment for people living with a disability or mental illness; and
- closing the gap for Aboriginal and Torres Strait Islander Australians.

[27] www.socialinclusion.gov.au

Young female offenders fit many of the criteria above, and are at high risk of being socially stigmatised and excluded, often with little recognition of their personal histories and circumstances of their offending behaviour. Social exclusion, homelessness and poor mental and physical health outcomes affect not just incarcerated girls and women but their children as well. We discuss issues related to young female offenders more fully in a current AWC project which is summarised in Section 6.3.

Antenatal care and financial literacy for imprisoned women

Soroptimist International of Brisbane recently identified a lack of specific antenatal care and support for pregnant women within the Brisbane Women's Correctional Centre (BWCC). Soroptimist obtained funding through the Queensland Government Community Benefit Fund and implemented a pilot program in association with the Childbirth Education Association/Birthtalk Queensland. The program included antenatal classes and the provision of pre-natal packs for each of the women involved. Although the program was very successful the club has not yet been able to gain ongoing funding.

Soroptomist International of Brisbane, in partnership with Career Employment Australia (CEA), has also designed a program to provide imprisoned women with the financial skills necessary to be successful in their transition from prison to the community. Financial literacy is defined by CEA as the ability to live within financial constraints (the amount of income received), balance a bank account, prepare budgets, set financial goals, make informed judgements and make effective decisions regarding the use and management of money. The program is funded from the sale of BWCC 'Women in Custody' calendars and the AWC. The longer term goal of the project is to break the cycle of poverty and reliance on Centrelink benefits.

Leigh Ellwood-Brown, Soroptomist International

Recommendation

Recognise that although the number of incarcerated women is proportionally much smaller than men, incarcerated women are much more likely than men to be primary and often sole carers of children, thus inflating the familial and generational health and welfare costs associated with poor outcomes in this population group. **[Rec 9]**

Older women on low incomes

Our research has identified that lack of access to dental care, inadequate opportunities for free or low cost health promoting programs and lack of access to public transport impact significantly on the health of older women and preventing declining health as women age (see Section 6.1). Preventive health care, in particular, is perceived as unaffordable for women on low incomes.

One of our members also pointed to serious inequity affecting women related to the Medicare Safety Net. The Medicare Safety Net is the same amount for single women, couples and families. Older single women, even with a number of chronic conditions, may not reach the Medicare Safety Net in a year, leading to significant financial disadvantage.

Recommendation

> Review the Medicare Safety Net to ensure equity between single people, couples, families, women and men. **[Rec 10]**

4.2.3 A focus on prevention

AWC welcomes the focus on prevention taken in the Discussion Paper, and the recognition that sex and gender differences should be taken into account when developing and delivering preventive health strategies and programs. Further discussion of the value of settings based health promotion would be of value. In line with Recommendation 7, we support the consideration of gender in all policies that effect health through the built and natural environment. For example, women are differentially impacted by lack of public transport and safe recreational spaces.

Prevention of osteoporosis

Osteoporosis will affect 1 in 3 women in their lifetime and 1 in 2 women over the age of 60 years will sustain an osteoporotic fracture.[28] Osteoporosis is a major cause of morbidity and a significant cause of mortality in Australia. It is a 'gendered' disease given that it is much more common in women.[29]

Prevention of osteoporosis should occur before menopause as lifestyle changes throughout life, such as adequate calcium intake, weight bearing exercise, adequate Vitamin D,

[28] Ebeling PR, Haikerwal A, Walker M & Stenmark J (2007). *Burden of Brittle Bones. Epidemiology, costs and burden of osteoporosis in Australia,* Osteoporosis Australia and International Osteoporosis Foundation

[29] Australian Institute of Health and Welfare (2008). *Arthritis and Osteoporosis in Australia*, Arthritis Series No 8, AIHW cat no. PHE 106

stopping smoking and reducing alcohol intake can prevent osteoporosis. Medication use in those at risk for osteoporosis can prevent osteoporotic fracture.

Bone mineral density (BMD) testing identifies current or risk of future osteoporosis. It is currently only subsidised for women (and men) 70 years of age or over. By this time, many women will have established osteoporosis. The AWC believes that BMD screening should be available to women at the time of the menopause, to identify women at high risk who should be offered preventive therapies. BMD testing can also help guide decisions about the use of hormone replacement therapy. A further test 5-10 years after menopause will guide ongoing treatment and prevention of fracture.

> *'Having a Bone Mineral Density Test at 70 is a bit late for preventing osteoporosis!'*[30]

In addition, biphosphonate medications, used to treat osteoporosis, are only subsidised on the Pharmaceutical Benefits Scheme for those who have had a fracture. Once a fracture has been sustained, osteoporosis is often well advanced.

Secondary prevention of osteoporosis is also important. Currently only 10-30% of people who have a first fracture are adequately treated to prevent a further fracture.[31] Better identification of those at risk and adequate intervention are needed.

Our consultation identified that lack of access to low cost exercise programs for older women in local areas was a barrier to maintaining health in older age.

Recommendations

> Extend the Medicare rebate for Bone Mineral Density (BMD) testing to enable all women to have a screening BMD test at the time of menopause and another 5-10 years later. **[Rec 11]**
>
> Accord the prevention of osteoporosis higher priority in policy making. In particular, consideration should be given to extending Pharmaceutical Benefits Scheme listing for biphosphonates for prevention of osteoporosis, and better management of those with a first fracture to prevent further fractures. **[Rec 12]**
>
> Subsidise low cost exercise programs for older women in their local areas to prevent a range of diseases, including osteoporosis and osteoporotic falls. **[Rec 13]**

[30] Australian Women's Coalition Consultation Forum, 17 May 2009
[31] Teede HJ, Jayasuriya IA & Gilfillan CP (2007). *Fracture prevention strategies in patients presenting to Australian hospitals with minimal-trauma fractures: a major treatment gap,* Internal Medicine Journal, 37(10):674-9.

Healthy ageing

The AWC Healthy Ageing Project, summarised in Section 6.1, identified that unhealthy ageing can be prevented by attention to broad health promotion at key life transitions, such as menopause and retirement. The concept of preparing for healthy ageing, which is of particular relevance to women, who on average live longer than men, could be further developed in policy making and practice.

4.2.4 A strong and emerging evidence base

Sex and gender disaggregated data

Our consultation has identified a problem with the lack of sex *and* gender disaggregated data on health issues. This is part of a broader problem of 'gender-blindness' in health research. Gender imbalances in the research process include 'non-collection of sex-disaggregated data in individual research projects or larger data systems; research methodologies are not sensitive to the different dimensions of disparity; methods used in medical research and clinical trials for new drugs that lack a gender perspective and exclude female subjects from study populations; gender imbalance in ethical committees, research funding and advisory bodies; and differential treatment of women scientists'.[32]

Only one state (SA) seems to keep sex-disaggregated data on issues relating to women. This lack of sex-disaggregated data was of concern to the UN when the 4th and 5th Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) reports were submitted in 2005 and it will be once again an issue when they read the 6th and 7th reports recently submitted.

Good policy needs to have accurate information to work on and unless this is broken down by gender the figures are meaningless and do not reveal the inconsistencies and inadequacies in the health system. In order to provide services appropriate to the user there needs to be some indication of specific need rather than a general approach of one size fits all. Policy makers and planners need to know where to spend the money and how to get the best outcomes from the money spent.

Margaret Findlater Smith, National Council for Women Australia

[32] Sen G, Ostlin P & George A (2007). *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health - Why it exists and how we can change it* (Final Report to the WHO Commission on Social Determinants of Health: Women and Gender Equity Knowledge Network). Stockholm: Karolinska Institutet

The development of gender competent policy starts with all data being disaggregated by sex and gender. The AWC recommends that the Department of Health and Ageing consult further with the Australian Bureau of Statistics, the National Health and Medical Council and other relevant bodies to ensure that research funded by the Australian government is 'gender competent'.

Recommendation

> Ensure that key Australian Bureau of Statistics publications, all government policies relevant to health and health research funded by the Australian government are 'gender competent', starting with disaggregation of all data by both sex and gender. **[Rec 14]**

4.2.5 A Lifecourse approach

Maternal health and early intervention approaches

There is indisputable evidence obtained over several decades of the importance of early childhood experience for positive outcomes in adulthood, including in adult health. Addressing maternal health has substantial benefits for the whole community. Women are at a particularly vulnerable time after having a baby: those with the least support are at most risk. Women's health policies should be complementary with those addressing the health of mothers and their babies.

Initiatives such as the National Action Plan for Perinatal Mental Health[33] stress the importance of supporting screening programs that are based in existing maternity and early childhood services with secondary and tertiary mental health facilities. Access to inpatient mother and baby mental health services needs to be increased as well as access to culturally and gender appropriate counselling services.

Early intervention approaches to the prevention of child abuse and neglect have considerable promise. We welcome the substantial new investment in intensive early intervention programs announced as part of the *National Framework for Protecting Australia's Children.*[34] The AWC also believes that the new Paid Parental Leave Scheme is a very significant milestone that will benefit the health of women and of their babies and families.

[33] beyondblue:The National Depression Initiative Perinatal Mental Health Consortium (2008). *National Action Plan for Perinatal Mental Health 2008-2010*, Summary Document.
[34] The Hon Jenny Macklin MP Minister for Families, Housing, Community Services and Indigenous Affairs, Media Release National Framework for Protecting Australia's Children 30/4/09

Mums for Mums NCJWA

While they may not be at sufficient risk for referral to health professionals, many new mothers feel anxious and isolated. This is exacerbated by issues such as recent migration and lack of family support. The 'Mum for Mum' program was introduced to Australia by the National Council of Jewish Women of Australia. It provides free weekly home visits for the first year of motherhood by trained and supervised volunteers who are matched with new mothers. The aim is to establish a nurturing and supportive relationship, reduce the mother's feelings of isolation and stress, boost her confidence and improve attachment between the mother and her baby. The program has gone from strength to strength and its value is recognised by referring services such as the Royal Hospital for Women in Sydney. The program now has a website of its own: www.mumformum.org.au.

Dalia Sinclair, National Council of Jewish Women of Australia

Supporting breastfeeding is also an important issue for women and their babies. The World Health Organization recommends exclusive breastfeeding for the first six months of life and then continuing for two years or more.[35] Although most mothers in Australia initiate breastfeeding, more than half stop by six months and less than one fifth breastfeed for 12 months.[36] Younger, less educated, and more socioeconomically disadvantaged women are less likely to breastfeed in Australia.[37] There is currently no strategic approach to breastfeeding support, promotion and research in Australia.[38] The Public Health Association of Australia has called for a number of mechanisms to support breastfeeding in Australia, including establishing a peak body, legislative support for combining breastfeeding and work, supporting health professionals to be competent in supporting women to establish and maintain breastfeeding, provision of parenting facilities in public places and implementing international initiatives such as the *Baby Friendly Hospital Initiative* and the *International Code of Marketing of Breastmilk Substitutes*.[39] The AWC welcomes the recommendation of the recent Maternity Services Review to identify health care or community settings in which

[35]World Health Organization (2001). *Expert consultation on the optimal duration of exclusive breastfeeding. Conclusions and recommendations*. http://www.who.int/inf-pr-2001/en/note2001-07.html.
[36]Australian Bureau of Statistics (2003) *Breastfeeding in Australia*, 2001, Cat No 4810.0.55.001
[37]Scott JA & CW Binns (1998). *Factors associated with the initiation and duration of breastfeeding: a review of the literature.* Australian Journal of Nutrition and Dietetics,55(2):51-61.
[38]Public Health Association of Australia (2007) *Breastfeeding Policy*
http://www.phaa.net.au//documents/policy/Breastfeeding.pdf
[39]Ibid

breastfeeding information and support are effectively received, with a focus on women from diverse socioeconomic and cultural backgrounds.[40]

Recommendations

> Recognise the specific needs of women's mental health throughout the lifespan, particularly around the time of childbirth. Culturally appropriate mother and baby residential units should be accessible to all women if they are required. **[Rec 15]**
>
> Support continued upscaling of early intervention approaches for the promotion of maternal health and the prevention of childhood abuse and neglect. **[Rec 16]**

Life transitions

The AWC Preparing for Healthy Ageing report identified key life transitions during which health promotion initiatives could be targeted- reaching middle age; menopause; retirement; widowhood; and coming to need care. The report also identified that comprehensive health checks at each decade of life 40-80 years may be of value as a preventive health initiative, to prepare for healthy ageing.

[40] Commonwealth of Australia (2009). *Improving Maternity Services in Australia: The Report of the Maternity Services Review*, February 2009.

5. Building on the 1989 Women's Health Policy

5.1 Priorities of the 1989 Women's Health Policy

Five priorities of the 1989 Women's Health Policy remain priorities for the Australian Women's Coalition: reproductive health and sexuality; the health of ageing women; emotional and mental health; violence against women; and the health needs of women as carers. New strategies are needed under each of these priority areas in the new National Women's Health Policy. The 'health effects of sex-role stereotyping on women' could be broadened and modernised to discuss 'the health effects of gender inequity and inequality'.

Although we advocate taking a holistic rather than disease centred approach to women's health, given the increasing recognition of the morbidity and mortality associated with cardiovascular disease in women, we believe this should be included as a priority in the new policy. Adding this as a priority will help to address the lack of community, and health professional, awareness of the morbidity and mortality associated with cardiovascular disease in women.

5.1.1. Reproductive health and sexuality, including menopause

The lack of a national strategy on sexual and reproductive health should be noted. The Australian Women's Coalition endorses the approach promoted in the recent *Time for a national Sexual and Reproductive Health Strategy for Australia: Background Paper*[41]. In particular, this document calls for:

- Core teaching competencies and minimum standards for relationship and sexual health education
- Consistent national minimum data collection of key sexual and reproductive health indicators
- Full burden of disease assessment and economic evaluation of a national strategy
- A national research program and national clearinghouse on sexual and reproductive health
- Provision of a full range of contraception and community information strategies
- Sexual and reproductive health services and workforce development
- Legal, safe, accessible and affordable pregnancy termination services.

The discussion paper considered several specific women's reproductive health issues:

[41] Public Health Association of Australia, Sexual Health and Family Planning Association of Australia and the Australian Reproductive Health Alliance (2008). *Time for a National Sexual and Reproductive Health Strategy for Australia.*

- Antenatal and postnatal depression
- Cervical cancer
- Chlamydia
- Endometriosis
- Gestational diabetes
- Menopause symptoms
- Ovarian cancer
- Polycystic ovary syndrome

The AWC supports the inclusion of specific women's reproductive health issues. We believe that the current proposed list of conditions needs to be expanded to be more comprehensive of the main issues affecting women in Australia.

The Discussion Paper failed to mention the policy directions that would be taken on these issues. AWC recommends that the new National Women's Health Policy commits to concrete policy directions in relation to each of the following issues:

(i) Cervical and other cancers of the female reproductive system

Continued research and funding for cervical screening programs that target Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds needs to be made a priority. This could be done through upscaling health promotion programs to these target groups as well as providing culturally appropriate referral and treatment services.

The BRCA1 and 2 mutations greatly increase the risk of ovarian and breast cancer. The senate enquiry looking at the issue of intellectual property and patenting for genes must recognise the importance of women's rights to information about their own genetic makeup, access to which should not be controlled by the private sector.[42]

(ii) Non-malignant Gynaecological Disorders

The AWC supports moves by NASOG[43] to the Medicare Benefits Consultative Committee to ensure equitable rebates for gynaecological surgical procedures commensurate with other surgical disciplines. This is a gender issue in medicine, undervaluing the surgical expertise required to manage these conditions as well as the benefits in quality of life for women and their families gained from these procedures. Failure to rebate these procedures adequately

[42]Parliament of Australia Senate (2009) Inquiry Into Gene Patents http://www.aph.gov.au/Senate/committee/clac_ctte/gene_patents/index.htm.
[43]The National Australian Society of Obstetricians and Gynaecologists www.nasog.org.au

results in greater out of pocket costs for medical services disproportionately affecting women.

(iii) Menopause and other effects of aging on women's health

With an ageing population, access to safe management of menopausal symptoms, including access to mental health services, should be increased.

Incontinence and pelvic organ prolapse are predominantly gender specific conditions affecting older women and should be recognised for the huge morbidity they cause in society.[44] Funding should be increased for specific physiotherapy and bladder retraining which should encompass prevention practices around the time of pregnancy. Funding should also be given for high quality research studies for investigation and treatment of these conditions.

(iv) Infertility

Recent controversy over the reported abuse of the Medicare safety net by infertility specialists highlights the need for increased public funding for these services.[45] The current system restricts infertility services largely to those who can afford to pay for them, discriminating against women who are socioeconomically deprived. AWC believe that all women and their partners should have access to infertility services if they so desire.

Recommendations

Include primary, secondary and tertiary prevention of cardiovascular disease as a priority in the new National Women's Health Policy. **[Rec 17]**

Take account of the rationale for a national Sexual and Reproductive Strategy and the implications of this for a new National Women's Health Policy. **[Rec 18]**

Prioritise research and funding for cervical screening programs that target Aboriginal and Torres Strait Islander women and those from culturally and linguistically diverse backgrounds. **[Rec 19]**

[44]Olsen AL, Smith VJ, Bergstrom JO, Colling JC & Clark AL (1997). *Epidemiology of surgically managed pelvic organ prolapse and urinary incontinence*. Obstetrics & Gynecology, 89:501-6.
[45]The Sydney Morning Herald May 8, 2009 http://www.smh.com.au/lifestyle/wellbeing/budget-removes-safety-net-for-ivf-parents-20090507-awlx.html

Increase funding for specific physiotherapy and bladder retraining, including in pregnancy, to improve prevention and management of incontinence and pelvic organ prolapse. **[Rec 20]**

Increase public funding for infertility services so that access to assisted conception is not dependent on socioeconomic circumstances. **[Rec 21]**

5.1.2 The health of ageing women

The health of ageing women is important to our constituents. Particular groups we believe are at risk of poor health as they age are migrant women and elderly women carers. Specific strategies to improve the health of ageing women are addressed elsewhere in the submission.

5.1.3 Emotional and mental health

Women's emotional and mental health remain key issues in 2009. Emotional and mental health are deeply gendered[46]- the gendered expectations of both women and men in society contribute significantly to their emotional and mental health. However, this understanding of gender is significantly lacking in policies, programs and services that seek to improve mental health.

'... the differences between sex and gender are almost entirely neglected in the mainstream literature on depression. The now routine finding of epidemiological studies is that the incidence of diagnosed depression in women is twice as high as that for men. But the highlighting of apparent sex differences is no guarantee that gender will also be considered. In the vast and growing literature on depression – and in stark contrast to emphasis on a seeming sex disparity – the role of gender is much less discussed. The ways in which attentiveness to gender may challenge existing understanding and treatment of depression – as distinct from why women may seem to be more `prone' to depression– are scarcely considered'.[47]

Stavropoulos, 2003

Women experience a double burden of mental ill health, as patients themselves, and often as carers of others. Many of our members noted in our consultation that stigmatisation of mental illness remains a significant issue in Australian society.

[46] Jack DC (1993). *Silencing the Self: Women and Depression*, Harper Collins, New York.
[47] Stavropoulos P (2003). *Healing Depression: The Holistic Treatment Approach of a Women's Health Centre*, Published Report, Leichhardt Women's Health Centre, Sydney

Professor Carolyn Quadrio is an eminent psychiatrist whose opinion we sought in preparing this submission. Professor Quadrio believes that a major issue for women's health is the biological approach to managing women's predominantly psychosocial problems.

'In spite of an official position that psychiatry espouses a biopsychosocial model, there is little doubt that it is increasingly biological.[484950] *Thus many women whose problems are essentially social – poverty, violence, racial and ethnic issues – will be conceptualised in biological terms when they present with psychological symptoms and are more likely to receive medical type interventions, including ECT.*[51] *This is becoming more of a problem because of the increasing tendency to prescribe potent and even toxic psychotropic drugs. I can provide many examples of women for whom antipsychotic medications have been prescribed for non psychotic problems, leading to serious side effects including diabetes and morbid obesity and, similarly, of mood stabilisers prescribed for unipolar depression also leading to toxic effects.'*[52]

Carolyn Quadrio, 2009

We have identified young women in custody, and leaving custody, as at particular risk for poor emotional and mental health (see Section 6.3).

Emotional and mental health around the time of childbearing are discussed in Section 4.2.5.

Recommendation

Support the recognition of mental ill health in women as arising from a combination of biological, social and psychological factors, and being inherently gendered, necessitating approaches that are broader than the administration of psychotropic medications. **[Rec 22]**

[48] McLaren N (2007).*Humanizing Madness - Psychiatry and the Cognitive Neurosciences*. Future Psychiatry Press
[49] Read J, Bentall R & Mosher L (eds) (2004). *Models of Madness*. Routledge, Hove
[50] Read J (2004*). The bio-bio-bio model of madness*. http://www.critpsynet.freeuk.com/1005read.pdf.
[51] Quadrio C (2001).*Gendered Practices in Women Working and Training in Australian Psychiatry*, Bookhouse. Glebe, NSW: 121-153.
[52] Personal communication, C. Quadrio, June 2009

5.1.4 Violence against women

The AWC understands that violence against women is being addressed though the *National Plan to Reduce Violence against Women and their Children.* However, given that violence is being increasingly recognised as causing a large burden of illness for Australian women and for their children, we believe that policies addressing violence against women should be coordinated across all relevant strategies, including the new National Women's Health Policy. In particular, access to information about violence prevention and services needs to be targeted to women in non-English speaking communities.

It is widely accepted that 'criminalised' women and girls have much higher rates of abuse and neglect in their life histories[53], and they should be included as a priority population group in the *National Plan to Reduce Violence Against Women and their Children*. A number of our organisations are involved in providing services to women who have experienced domestic violence where there are gaps in funded services. It remains an ongoing, nationwide issue that there are inadequate refuges and safe houses for women escaping violence in Australia, particularly in rural and remote areas and for women for whom English is not their first language.

The link between domestic violence and homelessness

Women escaping domestic violence who do not speak English as their first language and who do not hold citizenship or permanent residency are in a particularly difficult situation and are at significant risk of homelessness, or of returning to a violent situation. The AWC has strongly argued that the Federal Minister for Housing acquires some residences that could be used as halfway houses for 6 months where women would be safe, pay minimal rent, acquire permanent residency, learn to speak English, receive some basic training and gain confidence to start their life again.[54]

Australian Women's Coalition, 2008

[53] See Appendix 4 for a discussion of some of the relevant literature.
[54] The Australian Women's Coalition (2008). Report for the Commission on the Status of Women, New York, 2009.

Workplace Violence: The impact on health professionals

In the last 10 years, four Australian general practitioners have been murdered while working. These deaths appear to be at the tip of the iceberg of increasing violence against medical practitioners and the community. The main Australian study on the prevalence of violence in general practice[55], reported that 63% of general practitioners (GPs) experienced some form of violence in the previous year. The majority of affected GPs were **women** working in lower socioeconomic areas[56] and rural areas[57]. There are many anecdotal reports from medical practitioners about the failure of the mental health system, the drug and alcohol services, the legal system and the police to respond to patient violence appropriately. These anecdotal reports require formal study. Better community partnerships between medical practitioners, the mental health system, the drug and alcohol services, the legal system, the police and other community services and stakeholders should be encouraged and supported. Violence in Australia is a major public health issue and increasing violence against women general practitioners and strategies to protect doctors must be considered in the broader context of increasing community violence.

Jan Coles, Australian Federation of Medical Women

Recommendations

Coordinate policies addressing violence against women across all relevant strategies, including the new National Women's Health Policy. **[Rec 23]**

Urgently address the shortage of refuges and safe houses for women escaping violence in Australia, particularly in rural and remote areas and for women for whom English is not their first language. **[Rec 24]**

Recognise the significance of personal histories of abuse and neglect in the profiles of 'criminalised' women and girls by making them a priority population group in the National Plan to Reduce Violence Against Women and their Children. **[Rec 25]**

[55] Magin PJ, Adams J, Sibbit DW, Joy E & Ireland MC. *Experiences of occupational violence in Australian urban general practice: a cross sectional study of GPs*. Medical Journal of Australia, 2005;183:352-356.
[56] National Health and Medical Research Council (2002). *When it's right in front of you: Assisting health care workers to manage the effects of violence in rural and remote Australia*, www.nhmrc.gov.au/publications/synopses/hp16syn.htm
[57] Coles J, Koritsas S, Boyle M and Stanley J (2007). *GPs, violence and work performance. "Just part of the job"*. Australian Family Physician,36189-191.

5.1.5 Health needs of women as carers

One of the key differences between women and men is the role that women often play as informal carers, for children, grandchildren, elderly parents, family members with physical or mental disabilities and others. This has a significant impact on the health of these women: conversely addressing the health needs of women has significant impacts on those for whom they care. Understanding the broad roles of women in society, and the importance of family networks to many women, is important in the provision of health services to women.

As the population continues to age, women take on increasing roles as carers. Given the preventive strategies outlined in the new National Women's Health Strategy, preventive health strategies should be extended to considering preventing poor health specifically in women who are carers.

Recommendation

> Recognise that women who are carers are at particular risk of poor health and consider targeting preventive strategies to these women. **[Rec 26]**

5.2 Key action areas of the 1989 Women's Health Policy

5.2.1 Improvements in health services for women

Specific women's health services provide a unique model of care for women, particularly those who are marginalised or disadvantaged. Women's health centres typically operate on principles of social inclusion, empowerment, multidisciplinary care, networking and referral with other services, preventive approaches to health and understanding women's health in the broad context of their lives. Women's health centres can provide a complementary approach to that provided by primary care, hospital and other services. However, to operate successfully these services need to be sustainably funded not just for primary care services but for outreach, health promotion and community development activities that facilitate access to women who would not otherwise attend health services.

Recommendation

> Support ongoing, sustained funding for specific women's health services and centres in Australia. **[Rec 27]**

5.2.2 Provision of health information

Given the changes in access to information technology in the last 20 years access to high quality health information is much more important than it was in 1989. Our constituents noted that access to high quality information is particularly important for women for whom English is not their first language.

5.2.3 Research and data collection

The establishment of Women's Health Australia has enabled the collection of data and publications on many important issues relevant to women's health. The AWC recommends that Women's Health Australia be strongly supported in the new National Women's Health Policy. The results of this research should be presented from a gendered perspective. We have discussed research and data collection further in Section 4.2.4.

Recommendation

> Support the continuation of Women's Health Australia, the National Longitudinal Study on Women's Health. **[Rec 28]**

5.2.4 Women's participation in decision making in health

We have addressed this in Section 4.1.3

5.2.5 Training of health care providers

We have addressed this in Section 4.1.2.

6. Recent work of the AWC relevant to the new National Women's Health Policy

AWC has worked on a number of specific projects which inform our current submission. Summaries of the following projects are attached:

- Preparing for Healthy Ageing
- The Caring Sandwich- Caring for Young and Old- The Price Women Pay
- Young female offenders- Gender responsive policies and programs for young women and girls
- Gender/cultural competence training for health professionals

In addition, AWC has investigated a number of other issues which are peripherally related to women's health:

- Grandparenting-in particular the impact on grandmothers of leaving the workforce to care for their grandchildren because their own children cannot find or afford child-care.
- Work/Life Balance- in particular the needs of women in relation to the unequal responsibilities of caring and sharing at the household level.
- Post-acute care- in particular strengthening an organised approach that is shared between service providers, patients and their carers from pre-admission to post-discharge care.
- A project in South Australia looked specifically at the training and education needs of Aboriginal women in remote areas.

6.1 Preparing for Healthy Ageing

In 2008 AWC conducted the 'Preparing for Ageing Project', a research project to investigate what women need to do at different life transitions to prepare for healthy ageing and what initiatives are required to enable this. In particular, the project looked at priorities for healthy ageing in the context of developing a new National Women's Health Policy.

The majority of respondents to the project identified the following three health priority areas as central to addressing health over the long term:

- Arthritis and musculoskeletal problems
- Cardiovascular disease
- Cancer

The two broader issues that were identified as high priorities by all respondents were:

- Access to publicly funded health services
- Economic health and well-being

In particular, the importance of preparing for financial security as women aged was emphasised strongly throughout the project.

The project identified five key transitions in preparing for ageing over the decades from 40 to 80[58], at each stage of which adjustments occurred, including attitudes to and awareness of ageing, health concerns, changing family relationships and social networks and financial security. Increased awareness and action at each of these particular points could be used to promote initiatives for healthy ageing.

Important findings from the project include the central role of general practitioners in preparing for ageing; the importance of continued social and recreational contact within local communities as women age; the long term effects of chronic work injury that may not be felt until retirement; the importance of seeing ageing and the role of older women positively; and the difficulty in the lack of public transport that particularly affects women as they get older.

In developing the infrastructure to support healthy ageing, the project recommended boosting current health and community services, particularly health promotion activities such as low cost community based fitness programs and falls prevention programs. In addition, comprehensive health reviews at each decade of ageing could provide preventive health opportunities. The project highlighted the need for gender equity in current preventive programs, such as those addressing cardiovascular disease.

The full report is included as Appendix 2.

6.2 The Caring Sandwich- Caring for Young and Old- The Price Women Pay

The 'Sandwich generation' are women who have dependent children and caring responsibilities for other family and extended family members and older women carers. In 2005, AWC conducted a research project to investigate the needs of these women. The overriding finding of the report was that these women are in need of practical, family based support and care for themselves. The research findings that are particularly relevant to the new women's health policy are:

- The need to provide families with more diverse types of 'time out' options, including appropriate community based activities, on a regular basis

[58] (1) Reaching middle age (2) Menopause (3) Retirement (4) Widowhood (5) Coming to need care

- Providing more services to carers where they are based ie in their homes and immediate neighbourhoods rather than in widespread or distant community centres
- Providing greater assistance with transport

The full report is available as Appendix 3.

6.3 Young female offenders- Gender responsive policies and programs for young women and girls

Every day, approximately 1871 women are in prison, and 60 girls are in juvenile detention in Australia.[59] Aboriginal and Torres Strait Islander women and girls are significantly overrepresented. Whilst this represents a relatively small number of women compared with men in detention, they are a particularly disadvantaged group with very poor physical and mental health outcomes. In addition, incarcerated women are often the primary, sole carers for children, inflating the familial and generational health and welfare costs associated with these poor outcomes.

The Australian Women's Coalition is currently investigating gender responsive policies and programs for young female offenders. Several of AWC's members are involved in providing services to young women and girls at risk in these situations and have grass roots knowledge of the challenges facing them. In particular, members of the AWC network have reported anecdotal evidence of an increase in the number of these young women and girls who are becoming homeless.

The available research evidence points to poorer mental health outcomes for women and girls who are incarcerated. However, a cautionary note is needed in examining mental health statistics in this context. Analysts run the risk of stereotyping individuals and making this an individual-level issue while ignoring the underlying social precursors of mental health and substance abuse problems in this group. Rather, it is imperative to consider the importance of gendered responses to economic disadvantage as well as physical and sexual violence and trauma in the life histories of incarcerated women and girls. For example, these women and girls are much more likely than their male counterparts to have been victims of sexual violence before becoming homeless, turning to drugs, and engaging in crime. They are also much more likely to engage in prostitution than violent robberies. Preventing violence against women and girls in the first place will give them a better chance at staying out of the justice system later.

[59] Australian Government Productivity Commission (2009). Report on Government Services Australian Government Productivity Commission Report on Government Services 2009 http://www.pc.gov.au/gsp/reports/rogs/2009

A recent conference noted that despite national recognition of the complex interaction of issues associated with female offending, 'there is still no national consensus about the need for a gender-specific approach to women's offending'.[60]

The interim report for this project reviews the available evidence regarding gender responsive approaches to young female offenders, and makes a number of recommendations to facilitate an appropriate joined up, governmental response to these issues. The interim report and recommendations are included as Appendix 4.

6.4 Gender/cultural competence training for health professionals

Women from culturally diverse backgrounds in Australia are at particular risk of poor medical care. Peak ethnic community organisations have become alarmed by the inequities in the quality of care available for women because of ethnic, cultural, language, race and other barriers.

In 2005 the Australian Federation of Medical Women (one of the members of AWC), in association with four universities, conducted a research project to investigate how the medical workforce could be equipped with clinical skills to care for women of all cultural backgrounds in Australia, that is, with 'gender/cultural competence'. Australia has both a culturally diverse patient population and a culturally diverse medical workforce. Both doctors and patients are attempting to 'communicate across cultural gaps that can render behaviours and attitudes of either the doctor or the patient as quite mysterious to the other'.[61] In this project focus group discussions were held with women in the community about their preferred ways of receiving care, and with young doctors about their perceived needs in equipping them with gender/cultural competence.

Women who participated in the project wanted doctors to be aware of their family history and cultural background; to not stereotype or make assumptions about them; to be aware of the use of complementary and alternative medicines; to have good listening skills and an awareness of interpreters and their role; to be aware of gender and women's health issues; to create a trusting and safe environment for doctor patient interaction; and to adopt a holistic approach.

[60] Corrective Services Administrators Council (CSAC) (2007). 7th National Women Offenders Conference, Summary of Proceedings, Melbourne, 4-5 December 2007.

[61] Australian Federation of Medical Women, Centre for Culture and Health UNSW and Australian Resource Centre for Healthcare Innovations (2005). *Achieving gender and cultural competence by Australia's medical workforce*, Report to Office for Women, 21 June 2005:39

Young doctors who participated in the project identified the need for teaching about difference where it is clinically important; the impact of gender and culture on illness; effective strategies for communication with opposite sex and culturally diverse patients; and gender differences in the epidemiology and pathophysiology of disease.

The report points to current gaps in training and possible curricula for inclusion in medical schools in Australia.

The full report is available as Appendix 5.