WOMEN'S HEALTHWORKS – HEALTH, EDUCATION AND RESOURCE CENTRE

SUBMISSION TO
THE COMMONWEALTH GOVERNMENT ON
THE NEW NATIONAL WOMEN'S HEALTH POLICY

1 July 2009

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Executive Summary

WOMEN'S Healthworks (WHW) strongly endorses a social model of health as adopted in the Commonwealth's consultation discussion paper, Development of a New National Women's Health Policy (NWHP) 2009. Our experience tells us that for this policy to be effective, Government must take a whole of Government approach to health delivery, thus going beyond the traditional health portfolio. The policy must foster strong inter-sectoral collaboration at all levels of government.

WHW strongly recommends that our health system needs to incorporate well-being into its definition of health with an emphasis on wellness and prevention. The principles that underpin the Ottawa Charter for Health Promotion (1986): building healthy public policy; creating supportive environments for health; strengthening community action; and developing personal skills and reorienting health services must be embraced under the policy.

WHW recommends that the policy and strategies developed as a result of the consultations have a stronger focus on primary care and preventive services to complement secondary services provided by our hospitals.

With appropriate levels of resources community based women's health centres, are well placed, to provide good health outcomes for women of all ages based on sound evidence. Women's health centres importantly provide anonymity to those women who use the centres, therefore women are more likely to avail themselves to services that they might otherwise not because of the stigma attached to doing so. Also women at large have trust in 'women only services' that are community based within their local area. Of significant benefit to government is the cost effectiveness of such services, a strong investment in non-government services means that there is a greater amount of money available to Government to invest in the health system overall. Community based services are also able to be innovative in their response to the community's needs and can quickly put in place services to new and emerging social health issues in a way that Government agencies cannot.

WHW believes it is fundamental that the health system should be more responsive to broader social issues and to addressing barriers which can affect the health of women and communities. WHW strongly supports a focus on gender and diversity analysis, on the needs of marginalised women, and on promoting gender equity in health. The needs for marginalised women must be prioritised. Social inclusion should the cornerstone to any women's health service.

WHW believes that new National Women's Health Policy must recognise and respond to gender as one of the fundamental social determinants. WHW strongly believes action needs to be directed towards achieving positive change with regard to the five women's health priorities identified by the Australian Women's Health Network: economic health and wellbeing; mental health and wellbeing; preventing violence against women; sexual and reproductive health; and improving access to publicly-funded and financially-accessible health services.

Investment in women's health is an investment in the community.

WOMEN'S Healthworks supports the recommendations submitted by the Australian Women's Health Network and Women's Health Victoria and submits in its own right the following recommendations;

WHW Recommendations

1. That the government apply a gender and diversity lens to all public policy with measurable outcomes that demonstrate a change to women's health and wellbeing.

2. That program funding for evidence based preventative/early treatment programs for co-existing, mental health, drug and alcohol, and domestic violence services become a priority under the new NWHP.

3. That a re-current programme be developed to provide funding for women's health centres so they can address barriers and encourage sustainable physical activity.

4. That the Commonwealth take urgent action to address pay equity for women, and that the NWHP recognise the relationship between women's economic security and their health and well being.

5. That the Commonwealth provide sufficient funding in all of its grants to Non Government Agencies to ensure that they are able to pay their workforce commensurate with pay levels equal to the public sector for similar job classifications.

6. That the Commonwealth Government institutes a whole of government approach when addressing the structural barriers that negatively impact on women's health. This includes Housing Policy, Child Protection Policy, Education Policy, National Men's Health Policy, National Mental Health Policy, and Sexual and Reproductive Health Policy.

7. That the NWHP investigate how information and awareness on positive body image can be facilitated through positive community education and social marketing and incorporated in the National Schools Curriculum.

8. That the NWHP is implemented with a whole of government approach to ensure the safety of women and their children.

9. The Shared Parental Responsibility Legislation is reviewed.

10. That education on interpersonal violence is mandatory for all legal professionals involved in the Family Law Courts.

11. That mediation not be endorsed or promoted when there is a history of domestic violence – the case to proceed directly to court.

12. That where there is domestic violence, shared care is not an option.

13. That the issue of the Family Law Court overriding violence restraining orders to be open to vigorous discussion and review.

14. That safety and protection of the child be paramount when dealing with allegations of sexual assault and treatment by experts in child psychology becomes available as soon as an allegation is made.

15. That where termination of pregnancy (abortion) remains in the Crimes Act in any state /territory it should be removed as in Victoria.

16. That the government reviews the current Medicare guidelines to enable appropriately qualified overseas trained doctors to access a Medicare provider number to enable their employment in areas of workforce shortage and unmet need.

17. That funding is made available to women's health centres to expand the provision of services to women whose needs are currently not being met because of the current low level of funding.

18. That all future planning for all women's health ensures the provision of new and emerging technologies, including training for staff in application of these technologies.

19. That any funding given to the States and Territories from the Commonwealth for women's health be tied to the National Women's Health Policy.

Introduction

WOMEN'S Healthworks commends the Commonwealth Government for taking leadership and giving a commitment to a New National Women's Health Policy NWHP, (hereafter referred to as Consultation Discussion Paper). We welcome the opportunity to respond to the *Consultation Discussion Paper 2009*.

Women's health centres, of which WOMEN'S Healthworks is one of twelve situated throughout Western Australia, are well placed with appropriate resourcing, to provide good health outcomes for women of all ages based on sound evidence. WHW believes it is fundamental that the health system should be more responsive in responding to broader social issues and addressing barriers which can affect the health of women and communities. The needs for marginalised women must be prioritised. Social inclusion should be a cornerstone to any women's health service however adequate resources must be provided for services.

The philosophy of women's health services is based on an understanding of health within a social context recognising that;

- Differences in health status and health outcomes are linked to a range of factors including gender, sexual orientation, socio-economic status, Aboriginality, age, disability, cultural and linguistic diversity and geographic location.
- Health promotion, prevention, equity of access and strengthening the community and home based/outreach health system are necessary along with quality treatment services.

In July 2004, three specific health issues of high importance to Western Australia's long-term population health goals were identified and introduced by the State's Department of Health into women's health centres' planning agendas over the next five years:

- The health and wellbeing of women in motherhood
- Women's participation in beneficial physical activity
- Maintaining women's health and wellbeing as they age.

Each of these three issues is of growing critical significance to the health and wellbeing of the Western Australian population and women in particular. Evidence suggests that, when addressed on a population basis within a lifecourse framework, addressing these issues through social models of health, can deliver real and lasting population health benefits.

These reflect State priorities and whilst they are issues which are addressed in aspects of many women's health centres' current programs, increased understanding of the evidence and state health goals will enhance women's health centres' capacity to achieve and measure real health benefits for local women. Women's health centres are to include these issues in all future planning, and must identify and develop strategies relevant to their own community and target groups, to promote the health of women in these priority areas.

Women's Healthworks

Women's Healthworks (WHW) was established in 1989 following the recommendations of the 1986 National Women's Health Policy. We are a community based, not-for-profit, charitable organisation, and are one of 12 independent women's health centres across metropolitan and regional Western Australia. WHW today is a dynamic and innovative health, education and referral service for women who live in the northern suburbs of Perth. WHW provides services to women in the Cities of Wanneroo and Joondalup and parts of the City of Stirling. These are among the fastest growing regions in Australia with an expected combined population of over half a million people over the next 15 years.

Our overall vision is building healthy communities by offering integrated, high quality health and wellbeing opportunities, which are accessible to all women and responsive to local needs. We aim to provide a range of affordable services in a comfortable, confidential, safe, caring and supportive environment. Working collaboratively and developing partnerships has been an important mechanism for building and sustaining capacity in the delivery of our services. WHW aims to empower women, enabling them to make informed decisions about their health and well-being, by providing information, education, support and social groups, counselling and medical clinics, in an environment which values and believes in the capacity of each individual.

WHW services are:

- Accessible, appropriate, affordable and acceptable to women and their families.
- Holistic in approach that ensures linkages with related services.
- Recognises the rights of women and their families as health care consumers who are treated confidentially and with dignity and respect.
- Recognising that informed decisions about health and health care require accessible and appropriately targeted health information.

The northern suburbs of Perth have been experiencing rapid population growth. The Australian Bureau of Statistics reported that in outer suburban areas, the largest population

increase was recorded in Western Australia, with Wanneroo increasing by 9,809 residents in 2007[1].

With this growth have emerged social fissures that have resulted in social isolation and exclusion, particularly in the region of the City of Wanneroo. This has been identified as a key population health issue within the Health Department. The challenges faced by those living in the upper northern suburbs of Perth are exacerbated by the difficulties in accessing transport, financial restraints and a lack of social infrastructure. For already vulnerable families, these additional factors increase the likelihood of dysfunctional coping strategies such as problematic illicit drug and alcohol misuse.

The services we currently offer include:

- well women's health clinics relating to a range of women's health issues;
- counseling on emotional/mental health issues;
- health promotion and education - talks, courses, workshops and forums;
- women's social and support groups eg: craft group, volunteer group, pain management group;
- walking groups - indoors and outdoors;
- Body Esteem Program: self help groups for women with eating disorders and parent education and support groups;
- Village Project: supporting women with drug and alcohol issues who have children under the age of 18 years;
- complementary health: naturopathy and reflexology;
- telephone and information referral;
- Satellite services offered through the Sexual Assault Resource Centre.
- Website www.womenshealthworks.org.au;

[1] Australian Bureau of Statistics, Cat. No 3235.0- Population by Age and Sex, Regions of Austrlai,2007

Progressing women's health in Australia

The demise of the National Women's Policy in 1997 has resulted in lack of any national leadership on women's health. At a State level, women's health has been neglected even further. There is very little initiated, strategic planning, gendered policy development, or evidence which informs the women's health centres in Western Australia.

WHW is a member of the Australian Women's Health Network and Women's Health Victoria and we strongly endorse and support both of their submissions for the new National Women's Health Policy. Both submissions reaffirm that better health outcomes can only be reached by having a health policy that is approached from a gendered and whole of government perspective – one which responds to the broad economic, social and cultural factors that impact on health outcomes for women.

WHW strongly believes that the new Australian Women's Health Policy must;

- Be based on a social model of health;
- Address the social determinants of a health framework articulated and endorsed by the World Health Organization;
- Recognise and respond to gender as a fundamental social determinant;
- Recognise diversity amongst women;
- Endorse the important role of women's and community health services in promoting positive women's health outcomes, especially for marginalised women
- Take a preventative and inter-sectoral approach and go beyond the traditional health portfolio through a legislated cross government gender equality scheme.

Women's Health Victoria in their submission have provided a reflection on the history of policy and funding of women's health. Clearly, the Victorian government has shown its support for women's health by funding a Victoria women's health program. Sadly, in WA we have not had the same commitment and this is evidenced by the fact that women's health centres have had no increase in funding in over a decade. WHW endorses all of Women's Health Victoria recommendations, in particular those relating to the funding arrangements;

- The Commonwealth seeks bipartisan support for the new National Women's Health Policy and Program.
- A new National Women's Health Policy secures a commitment from State and Territory governments for a 'joined-up' approach.
- A new National Women's Health Policy applies a 'dual strategy' model to all States and Territories.

WHW supports the five priority areas of the Australian Women's Health Network as outlined in their position paper, *Women's Health: The New National Agenda*[2]. These are:

- Economic health and wellbeing;
- Mental health and wellbeing;
- Preventing violence against women (in all its forms);
- Sexual and reproductive health; and
- Improved access to publically funded health services.

However to be achievable as national priorities they must be tied to any Commonwealth funding given to the States and Territories.

Principles underpinning the new NWHP

Gender equity

WHW commends the NWHP for its commitment to address gender differences in the respective national women's and men's health policies. Better health outcomes can only be reached by having a Women's Health Policy that is approached from a gendered and whole of government perspective – one which responds to the broad economic, social and cultural factors that impact on health outcomes for women. The integration of gender issues in health concerns is much more than the biological differences between males and females. Gender in health acknowledges the social determinants of health on relationships and responsibilities of men and women and how this interaction changes;

- Health risks and protective factors;
- Access to resources to protect health;
- Manifestation, severity, and frequency of disease;
- Health seeking behaviour;
- Social, economic and cultural outcomes of ill health and disease;
- Response of health systems and services; and
- Roles of women and men as formal and informal health care providers.

A multiplicity of factors, biological, social, cultural, environmental and economic, influence women's health status, their need for health services and their ability to access appropriate services. In particular women's health needs stem from the facts that women are more socially disadvantaged than men in terms of income, education and power and socially

[2] The New National Agenda Discussion Paper July 2007, Australian Women's Health Network

disadvantaged people are more likely to become ill. Women are more likely to use health services because of their social role as carers (of children, older people, or people with disabilities) and the extra strain this places on their health. Women have particular sexual and reproductive health needs including pregnancy, childbirth and menopause. Because of gender inequality, women are generally treated differently than men in society, resulting in, for example, violence against women and sexual assault. Women are also treated differently within the health system. For example, women frequently state that health professionals do not treat their problems seriously, or that they are inappropriately prescribed psychoactive drugs.

Gender in health considers the roots of health seeking behaviour and seeks to improve health outcomes for both male and female populations, regardless of age, ability, sexuality, ethnicity, religion, socio-economic status etc. We cannot assume that health programs and policies affect men and women in the same manner because this will unwittingly perpetuate health inequalities. Despite the growing international recognition of gender as a determinant of health, this awareness has yet to be incorporated into mainstream health policy, and in the design and delivery of programs and services.

Better outcomes in women's health have benefits for individuals and their families, and for the broader community. Flow on benefits are extensive and include greater participation and productivity by women in the paid and unpaid workforce, and less demand for high cost health services to be funded by government. There are still many areas where women's social, economic and health outcomes need major improvements. Arguably this requires a new approach to women's health policy – one which is integrated with other areas of government policy in a coordinated way, and that incorporates gender as part of a 'health determinants' approach. This will require a change of thinking for many, and a greater investment of resources in women's health. However it is also arguable that investment in women's health is an investment in the health of all the community, and will have significant benefits for the whole population.

Health equity between women

Currently, the outer northern suburbs of Perth are recognised as the highest growing areas of metropolitan Perth and receive the highest number of migrants in Western Australia. Many new residents are settling in WHW's catchment area and this provides a challenge to the service providers of this area. In particular, the challenges of accessing these new residents due to the large geographical area and speed of growth, to ensure they have adequate and culturally appropriate knowledge of basic health needs and health services. This area

represents a diverse population including many culturally and linguistically diverse families. Figures derived from the DIMA Settlement reports indicate that;

- For the period 2004 - 2006, 4341 migrants settled in the Wanneroo and Joondalup areas.
- Of this population, 46% entered under the family or humanitarian visa arrangements.
- Since 2001, the population of migrants entering on a humanitarian visa to the Wanneroo and Joondalup areas has almost tripled.

The impelling demographics and statistics indicate that a targeted service for new and emerging communities in the catchment area of WHW is vital to ensure responsive service provision in the area of health and wellbeing for this significant population.

The Points of Departure (POD) project

In 2008, the Multicultural Centre for Women's Health (MCWH) received funding from the Federal Office of the Status of Women to undertake advocacy work on immigrant and refugee women's wellbeing. The project, entitled 'Points of Departure' (POD), commenced in September in 2008. The overall aim of the project is to build knowledge and capacity among NGOs and individuals to advocate on key social inclusion issues relevant and specific to immigrant and refugee women. POD is based on the premise that women's lives are marked by constant change. For most immigrant and refugee women, an 'arrival' is also a point of departure for a new phase in their lives; in other words, they are always 'on the move'. Women have to keep pace with these changes: different health care practices, a new language, foreign values and customs, and an expectation by the host country to integrate into mainstream society.

The POD Discussion Paper noted that overall, immigrants and refugees demonstrate better health on arrival and for some years following than does the Australian-born population. This is explained by the health requirements and eligibility criteria ensuring that generally only those in good health migrate to Australia (AIHW 2002). The health status of immigrants and refugees, however, is known to deteriorate after their arrival in Australia (Alcorso and Schofield 1991), and this is mainly due to the health disadvantages experienced in different areas. For instance, immigrant and refugee women are less likely to take the necessary health-related action during an illness due to several barriers. These include lack of information on the health condition, low English language proficiency, and other structural barriers, such as poor access to facilities due to mobility constraints. These challenges, and in addition housing barriers, cultural barriers, unemployment, and discrimination, are the

major challenges experienced by immigrants and refugees, and do not only affect their health, but their general wellbeing.

There is increasing recognition internationally that discrimination affecting people from diverse cultural backgrounds is a common problem, with serious health, social and economic consequences for affected individuals and their families (World Conference Secretariat 2001; World Health Organization 2001). Discrimination is also costly to business and government and undermines the benefit of cultural diversity.

Recommendation 1 : That the government apply a gender and diversity lens to all public policy with measurable outcomes that demonstrate a change to women's health and wellbeing.

A focus on prevention

WHW believes that Intervention and prevention efforts should be informed by evidence. Prevention is a key element in working within a contemporary public health model. This acknowledges the three different levels of prevention:

1. Primary prevention (before a health problem occurs) - focus on prevention altogether
2. Secondary prevention (immediately after a health problem occurs) - focus on short-term intervention in order to prevent long-term negative health outcomes
3. Tertiary prevention (long-term intervention) - focus on care, rehabilitation and reintegration.

There is much focus and comment about Australia's burgeoning 'health' budget. Examination of analysis carried out by the Australian Institute of Health and Welfare demonstrates that 87.5% of the total recurrent expenditure on health is actually disease expenditure. The remaining 12.5% covers not only community and public health activities but also administration, ambulance services and health aids and appliances. While the governments stated intention is to focus "the health and aged care system more on healthy lifestyles, prevention and early intervention" (from the Department of Health and Aging's 2006-2009 Corporate Plan), the reality is that disease treatment remains the prime focus of our health care system. WHW believes that increased funding of health promotion and preventative programs and early intervention programs is essential.

As recognised within Consultation Discussion Paper, productivity and participation of women is crucial to Australia's economy. Primary prevention is the most cost effective. As

highlighted in the case for prevention of interpersonal violence, prevention strategies cannot just focus on illness and disease, but on the broader social determinant of health.

Two examples of preventative programs at Women's Healthworks are the Village Project and Stepping It Out Project.

The Village Project - (State - Proceeds of Crime Funding, 18 months finishing in June 2009 unless ongoing funds are secured).

The Village Project was developed in response to gaps in services. Specific services are negligible for women with children under the age of 18 years, who reside in the northern suburbs of Perth and want to address issues of substance misuse and parenting. The program was developed to reduce the drug taking behaviour of parents and at the same time increase social connectedness and the visibility of the children of mothers who use illicit drugs and or alcohol.

King Edward Memorial Hospital (KEMH), Perth, has recognised an increasing referral rate from the northern suburbs and recommends that services are developed in the area in which these women reside. A significant barrier for women accessing services is lack of transport and child care options. At KEMH in 2005 and 2006, 102 babies were admitted to the Special Care Nursery for management of neonatal drug withdrawal. The notifications by KEMH and involvement of Department Child Protection (DCP) with high-risk infants have increased by more than 100% in the last decade.

The Village Project offers therapeutic intervention and social support for women who use illicit drugs and/or alcohol, who have children under the age of 18 years and their families. This includes grandparents, parenting and raising their grandchildren due to impact of familial drug and /or alcohol use. Additionally, women and their families are provided with information and referral pathways to a range of support services.

Referrals from DCP, the criminal justice system, and hospitals reflect the urgency in supporting women; particularly those who are single, and have young children. Currently, government departments are not adequately responding to crisis cases and it is imperative programs like the Village project continue to be funded and complement the work of government and support families in a timely manner.

A central strategy of the service has been to offer a non-judgemental, safe and inviting space for the community to begin to engage with staff and explore issues relating to harmful and/or

hazardous alcohol and other drug use and parenting within a harm minimisation approach. Staff have maintained a child focus and have worked systemically with families to join with the client(s) to facilitate change and reduce drug use and increase the safety and other outcomes for children and families. This outreach capacity is an integral response to the isolation, be it physical, financial and social of this target population.

The Village Project is assisting in meeting the needs of the families for which illicit drug use is an issue and, furthermore, it has been working collaboratively with these families in a holistic way to promote the wellbeing of both women and their children. It is our experience which is supported in the literature that women with complex needs respond well to services, such as the Village Program that are well tailored to their multiple needs around parenting, that are practical and close to their place of living and that are non-judgmental.

RECOMMENDATION 2 : That program funding for evidence based preventative/early treatment programs for co-existing, mental health, drug and alcohol, and domestic violence services become a priority under the new NWHP.

Physical inactivity

As cited in the Consultation Discussion Paper, about one third of Australian women do not exercise, which is a major contributor to being overweight or obese. A lack of regular physical activity was the third highest risk factor identified as contributing to the total burden of disease in Australian women in 2003. It is a major risk factor for all of the National Health Priority Areas except asthma. Increasing physical activity not only assists with weight loss but also reduces stress, anxiety and depression[3].

WHW has successfully encouraged many women to take up physical activity and has been able to offer numerous educative programs and raise awareness on healthy lifestyle issues. WHW counselling and medical services (where appropriate) can encourage women with depression and anxiety to join these free to attend, friendly social groups. WHW walking groups are established by an employed coordinator. The sustainability of these groups remains because of the friendships and changed lifestyle.

The aim of WHW physical activity programs is for women to feel empowered and motivated to incorporate physical activity into their lives. WHW targets women who are currently not involved in any regular physical activities nor would be found at traditional sport and recreation settings. Through evaluation, research and feedback from clients the following barriers have been identified; cost, childcare, time, having someone to exercise with,

[3] Development of a New National Women's Health Policy Consultation Discussion Paper 2009

motivation, safety, disability, transport, confidence, need instruction, emotional issues, physical health and a lack of awareness of the need to participate in physical activity, (health/social benefits). Time is the most common barrier identified. All of our walking groups encourage participants to socialise leading to sustainability of friendships and physical activity combined.

Stepping It Out Program (Federal Department of Health & Ageing - 18 months)

The Stepping It Out Program has been developed as an outreach model. This program's main aim is to encourage women to take up regular walking as a form of physical activity. We have specifically targeted women who are socially isolated and have developed specific walks with local community health staff targeting women diagnosed with post natal depression.

Weekly led walks accommodating various levels of fitness from locations throughout the Northern Corridor are delivered from five geographical locations (Butler, Heathridge, Duncraig, Girrawheen, and Joondalup) * Duncraig Walking Group specifically takes referrals from the child health clinic for women suffering post natal depression.

Other physical activity programs

- WHW introduced the first mall walking project in WA - Whitford City Mall Walking addresses many issues identified by women that prevent them walking such as - safety and security.
- WHW has recently launched a new program at Lakeside Shopping Centre to introduce mall walking routes in Joondalup.
- Tai Chi is offered at Joondalup - three classes per week at various levels.

WHW's mall walking has assisted numerous women with heart disease, diabetes, and other significant health concerns such as obesity access safer walking routes. Security is provided at shopping centres and they don't have to deal with uneven floor surfaces, for example. There are seats in the malls for them to rest and some women have walked with shopping trolleys for stability.

WHW is innovative in its approach to encouraging women to take up physical activity and are well placed to assist with reducing the burden of disease amongst those in high risk groups. WHW could continue to target our most marginalised women and build on the excellent work we have achieved in assisting women to feel empowered and motivated to incorporate

physical activity into their everyday lives. The encouragement to socialise helps develop friendships within the group thus encouraging physical activity outcomes that are sustainable.

RECOMMENDATION 3: That a re-current programme be developed to provide funding for women's health centres so they can address barriers and encourage sustainable physical activity.

A strong and emerging evidence base

WHW supports an evidence based approach to improving women's health. This we see as important in order to maximise the effectiveness of policies and programs and to facilitate the allocation of cost-effective interventions. The initiation and development of WHW services is based on a combination of community consultation, statistics, research and anecdotal evidence.

Recent research conducted through WHW reinforces the need for services that respond to female mental health and substance use problems.

Women and Drugs: The risk of harm from consuming alcohol (and/or using other psychoactive substances).

Marika Guggisberg, BSc (Psych), MA (Crim Just), PhD C

I had the opportunity to conduct a study among women in the metropolitan area of Perth inquiring about the nature and the scope of alcohol and other drug use in the context of possible relationship problems. The study was approved by the university ethics committee and involved 148 clients of Women's Healthworks. In 2008 women were asked to complete a questionnaire. They also had the opportunity to take part in an in-depth interview. Study participants represented a cross-section of Women's Healthworks service users. They reported the use alcohol and other psychoactive substances posing alarming health risks.

Results of the study suggest that alcohol use in particular may be problematic in terms of having a negative health impact. Nearly half the women in this study, 48% (72/148) consumed alcohol at a level posing risk of harm. Over one in five women (24%) used painkillers, and 14% used tranquillisers for non-medical purposes. A minority, (13%) reported being current smokers, with 5% indicating being heavy or chain smokers. Around 10% of study participants engaged in illicit substance use (11% marijuana; 10% meth/amphetamines; 9% ecstasy and 0.1% heroin). It was found that often study participants use more than one drug concurrently. For example, while the study found that cigarette

smoking did not seem to be a big issue, of the women being current smokers 79% (15/19), also reported to drink alcohol at a harmful level.

The women accessing our services come for a variety of reasons such as appointments for medical consultations or participating in a walking group. They are concerned with their health and wellbeing, but at the same time may engage in health risk behaviours. Findings of this study show that harmful alcohol use is a concerning issue among our clients warranting further attention. We want to assist women in the general community and help them improve their overall health and support efforts that prevent (or at least reduce) risk of drug-related harm.

The study also found that many women suffer from abuse and/or violence at the hands of a current or former partner. Often, this exposure to abuse and/or violence is compounded by battling mental health problems such as anxiety and/or depression. In fact, the research showed that 55% of clients (82/148) showed symptoms of anxiety, and 21% (31/148) showed symptoms of depression. Fourteen percent of participants (20/148) scored on both scales, indicating diagnosable symptoms of anxiety as well depression at the same time.

Women, while being connected to Women's Healthworks, suffer in silence as their problems do not always come to our attention. The results of this study are surprising and alarming. We, as a responsible women's health service, want to assist all women in the Northern suburbs of Perth to improve overall health and wellbeing as well as reduce drug-related harm. The adverse health effects of drinking alcohol (and using other drugs) are well known. Women, as a specific subgroup of the population, are at risk of harm not only from alcohol use but from life stresses exacerbating the likelihood to engage in drinking behaviour. Further analysis of this research is currently being completed.

PhotoSTORIES

PhotoSTORIES is a program that WHW has utilised as a tool to engage grandparents who are caring for their grandchildren as a result of illicit drug and alcohol misuse of the children's parent. Due to changes in family structures and various trends and phenomena in society in recent decades, grandparents' responsibilities and roles have changed significantly. Grandparents are sometimes the invisible casualties of the impact upon their own adult children and/or their partners of mental or physical health issues, alcohol and/or illicit drug misuse, death, child protection issues, divorce or separation, transience, poverty, domestic violence and other factors that contribute to inability to provide adequate care and protection of their grandchildren.

Contemporary research indicates that harmful and/or hazardous parental substance use is increasingly one of the primary reasons that grandparents become full-time carers of their own grandchildren. Although, in the past this may have occurred occasionally for a range of family reasons, it is more common now than the statistics indicate, as some grandparents are 'flying below the radar' and managing without any formal assistance.

This role of unintended parenting can catch grandparents out, as they are often absolutely unprepared for such a situation that they may have been required to step into, in a crisis or emergency. It can be a complex, challenging and diverse experience, as are the reasons grandparents find themselves raising their grandchildren. Common threads throughout the unique lived experiences of participants in the PhotoSTORIES project include:

- They stepped into the role without hesitation;
- There were seen to be no or limited options in terms of who else was able or prepared to care for their grandchildren;
- Other possibilities were not considered to be in the best interests of the child/children i.e. Department for Child Protection;
- Feeling socially isolated from their peers and friends whose parenting days and associated commitments were long gone;
- Feeling alone in their experience until they became aware of other grandparents parenting their grandchildren and the support groups;
- Being financially unprepared for the unplanned parenting role at a time when other plans were envisaged for their future;
- Still in the fulltime paid workforce and negotiating work, parenting and other commitments;
- Experiences of loss and grief for their adult children's choices and life situations and the impact of those on all family members including themselves. Effects on their hopes, dreams aspirations for themselves, their children and grandchildren.
- Even though parenting as a grandparent was challenging, none would hesitate to do the same again.

A lifecourse approach

Good health is fundamental to positive and active ageing, and the foundations of good health must be laid long before retirement, in fact, across the lifecourse. Within twenty years, almost 25% of the Western Australian population will be over 60 years of age, compared to around 15% currently. This unprecedented demographic shift, part of worldwide population ageing, will increase the proportion of older women in the population.

"…rather than simply treating the consequences of decline in old age, promoting health from the beginning of life should improve health and welling being at midlife and in later years, whilst at the same time reducing the cost of treating degenerative diseases."[4]

Initiatives to enhance the functional capacity of women as they age include the promotion of physical activity, and building the capacity of women to protect and maintain their own good health. In addition, opportunities to promote women's continued participation in positive social, community, intergenerational, and interpersonal networks, and/or in paid or voluntary work, contribute significantly to the maintenance of good physical and mental health.

As cited in the Consultation Discussion Paper[5] there are particular lifecourse transitions that can increase vulnerability to poor health. These include pregnancies, childbirth, school entry, puberty, school leaving, workforce entry, partnering, menopause and widowhood.

As previously stated WHW endorses the submissions submitted by the Australian Women's Health Network and Women's Health Victoria and we support their recommendation that a diversity and social determinants lens should be applied across all stages of the life cycle, encouraging and concretely supporting women to be involved in all decisions about their health, their lifestyles and their use of medical and hospital services.

Priorities of the New NWHP

WHW supports the five priority areas of the Australian Women's Health Network as outlined in their position paper, *Women's Health: The New National Agenda*[6]. These are:

- Economic health and wellbeing;
- Mental health and wellbeing;
- Violence against women;
- Sexual and reproductive health; and
- Improved access.

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[4] Halfon,N and Hochstein, M.: Lifecourse Health Development: An Integrated Framework for Developing Health, Policy and Research. The Millbank Quarterly Journal of Public Health and Health Care Policy. No. 3 2002.

[5] Development of a New National Women's Health Policy Consultation Discussion Paper 2009

[6] The New National Agenda Discussion Paper July 2007, Australian Women's Health Network

Priority One: Economic health and wellbeing

As cited in Consultation Discussion Paper[7] Health inequalities are not only shaped by unequal distributions of material resources. Social inclusion and a sense of control over life circumstances are crucially important for the development of human potential and health. People need to feel that they have at least some level of control over their lives, their jobs, their housing and their environments. A person's economic health and wellbeing has a major impact on their life chances, including their health outcomes. Unfortunately, women continue to experience disadvantage on virtually every indicator of economic health and wellbeing, including their ability to financially support themselves through a longer life span than men and more years of disability.

In recognition of International Women's Day 2009, The Western Australian Council of Social Service focused attention on the issue of gender pay inequity. The following information is taken from this research[8]:

Pay equity is a situation in which men and women receive equal remuneration for work of equal or comparable value. The gender pay gap is a key measure of the degree of pay equity. The gender pay gap (GPG) is the difference in average earnings between men and women. In order to accurately measure the gender pay gap, it's often measured using average weekly ordinary time earnings for full time employees. Using this measure means that large, non-salary bonuses and the low total earnings of part time employees are not included in the data. If those things are included, the gap appears larger. The gender pay gaps referred to in this paper are derived using full time ordinary time earnings. The gender pay gap is caused by a multitude of different factors. Individual characteristics of employees (such as educational qualifications and demographic characteristics) are relatively unimportant factors contributing to the gender pay gap Instead, a major factor, possibly the main factor, underpinning the gender pay gap is the undervaluation of women's work.

[7] Development of a New National Women's Health Policy Consultation Discussion Paper 2009

[8] Close the Gender Pay Gap: Value Community Services, Research Paper, The Western Australian Council of Social Service March 2009

The factors underpinning the gender pay gap include:

- A significant degree of gender segregation of the labour market along industry lines, with female-dominated work areas earnings significantly less than male dominated areas;
- Inequality in the division of unpaid caring responsibilities;
- institutionalised undervaluation of skills and qualifications typically identified with women ('women's work');
- Low levels of access to collective bargaining in female-dominated work areas10;
- Low levels of unionisation;
- A lesser propensity for women to engage in individual salary negotiations, and poorer returns to negotiation when it is carried out;
- Overrepresentation of women among industries and occupations in which deregulation of the labour market (for example, the WA *Workplace Agreements Act 1993* and the Commonwealth *Workplace Relations Amendment (WorkChoice) Act 2005*) has undermined wages and conditions of work; and
- Disproportionate employment of women in Government employment or Government-funded positions, which can lead to the exercise of monopsonistic power in the labour market (this concept is discussed further below).

Most of the factors underpinning the gender pay gap are found in the community services sector. The industry:

- is female-dominated;
- has occupations that tend to involve skills regarded as intrinsically 'female';
- has a low level of collective bargaining;
- has a low level of unionisation;
- has funding arrangements mean that the sector's labour market is effectively monopsonistic; and
- is lowly paid.

It is significant to note here that WA has by far the highest gender pay gap in the country (27.4%), much larger than the national average (17%). The Health and Community Services industry is the second largest employer of WA women, and is the most female-dominated industry in WA. Crockett and Preston in their review of the gender pay gap in WA, found that wage structure effects related to differences in such things as occupation and industry of employment were the main discriminatory factors causing the pay gap. There is a high degree of segregation between occupations and industries dominated by men and those dominated by women. Occupations and industries that are disproportionately

female are, on average, less well paid than those dominated by men. The community services sector is disproportionately female, as are key occupations within the sector.

Staff retention and recruitment is problematic for the sector. Salary levels do not reflect the knowledge and skills required of the workforce. Again, women make up most of the health and community industry's workforce which is low paid and undervalued. Inadequate remuneration has forced many community service workers to leave for higher paying positions in the public and private sectors. There is a high level of pay disparity between the community service and public sectors. Pay disparity for similar positions can be up to $22,000.

Economic health and well being is relevant for both the clients and staff at women's health centres.

Both State and Federal government departments play a significant role in maintaining the pay inequity for the Non-Government Sector of the Health and Community Services workforce through the level of funding they provide to them for both core services and specific program and project tenders/submissions. If the Rudd Government is serious about redressing the pay gender inequity it will ensure that all of its funding to NGOs is sufficient for them to remunerate their workforce equal to the public sector workforce in similar positions.

Recommendation 4: That the Commonwealth take urgent action to address pay equity for women and that the NWHP recognise the relationship between women's economic security and their health and well being.

Recommendation 5 : That the Commonwealth provide sufficient funding in all of its grants to Non Government Agencies to ensure that they are able to pay their workforce commensurate with pay levels equal to the public sector for similar job classifictions.

Primary prevention as raised within Consultation Discussion Paper essentially focuses the reduction of illness and disease. Whilst this is appropriate for programs such as increasing physical activity, we must recognise the importance of government working collaboratively in the area of family and domestic violence for example as there are a number of issues to take into account such as:

- Access to affordable accommodation/housing in WA

Many women wishing to leave abusive and/or violent relationships are forced to stay in their existing situation, as they cannot be guaranteed permanent accommodation in public or private housing and this limits their choice. One client of WHW has left her partner several times but has been forced to return. She has stayed in two separate refuges which could not offer her permanent accommodation. In one instance, she was allotted a second storey flat which she had to refuse because of a foot injury. Finally, three years down the track she was placed in public housing. Those three years have been very damaging psychologically for this woman who now will take years to recover.

- Private rental market

In WA there is a lack of affordable private rental accommodation. Rents have risen significantly faster than average wages in recent years. REIWA predicts that the private rental market vacancy rate will rise above three per cent in mid-2009. A three per cent vacancy rate is widely seen as a 'neutral' figure; if the rate is below three per cent then rents are expected to rise, while a vacancy rate above three per cent would see rents fall in real terms. The vacancy rate has not exceeded three per cent in Perth since 2004.

- Social housing

Social housing represents approximately 4% of the total housing stock in WA, lower than any other Australian State, and than most comparable OECD nations. Currently, 20,000 people are waiting for a home in WA, many of whom have been waiting for 5 years or more.

- Homelessness

Despite the economic prosperity of recent years, the number of homeless people in Western Australia has risen. The rate of homelessness in WA is the second highest of any State (64 per 10000 people), and is significantly worse than the national average (53 per 10 000 people).

As cited in the Consultation Discussion Paper; Homelessness has flow on effects to health and welfare and 'adequate housing is essential for decent health, education, employment and community safety outcomes'.

Our recommendation supports the view in the Discussion paper that changes in the adverse conditions of people's lives are necessary to reduce health risks and avoidable health inequalities. It is the adverse social and economic circumstances of people's lives that lead to high levels of stress and unhealthy behaviours that then lead to high rates of disease and injury.106 It is absolutely fundamental to the success of any government policy that a whole

of government approach be taken to influence broad social inter-sectoral policies/action to reduce health inequalities.

Recommendation 6 : That the Commonwealth Government institutes a whole of government approach when addressing the structural barriers that negatively impact on women's health. This includes Housing Policy, Child Protection Policy, Education Policy, National Men's Health Policy, National Mental Health Policy, and Sexual and Reproductive Health Policy.

Priorities of the New NWHP

Priority two: mental health and wellbeing

Mental health represents a significant cost to the Australian economy (about $20 billion for mental health, approx $56.1 billion for licit and illicit drugs (alcohol 27% of that and illicit drugs 15%). Lack of access to supported accommodation and other services mean that many people with a mental illness or with drug and alcohol issues end up being misdiagnosed, homeless or detained.

Only 9.4% of health spending in WA is allocated to mental health, with only 6.6% of that going to NGOs who provide 88.5% of the services[9].

WHW offers a range of services. Our counselling service aims to support women in understanding their problems, to realise their choices and to develop the confidence and power to reach their potential is influenced by a range of economic and social factors. The WOMEN'S Healthworks psychologist offers generalist, individual low cost counselling for women who are at increased risk of poor health outcomes. This service is available three days per week to women in the northern suburbs.

Despite the Medicare mental health plans our low cost counselling services are in high demand. WHW is one of few agencies (including religious based organisations) that are prepared to waive the fee when there are issues of poverty. The current waiting period to see the psychologist is 8 -10 weeks. WHW closes its books when the waiting period advances 3 months. Limited resources prevent us from expanding this service.

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[9] WACOSS PBS 2009/2010

The range of presenting problems is varied and includes high levels of depression, stress and anxiety. WHW counselling service assists in the prevention of mental health problems from escalating to acute care. Through counselling women who suffer from depression, anxiety, self-harm, suicidal thoughts, anorexia and or bulimia nervosa have a reduced chance of presenting or returning to hospital emergency departments.

Ten top reasons presenting issues for women accessing individual counselling last financial year (07-08) were;

Depression	Stress	Marital Issues	Anxiety/Panic	Family/Parenting
Relationships	Carer Issues	Grief	Anger	Post Natal Depression

WHW waived fees for 28% of women attending counselling due to financial stress in the 07-08 financial year. WHO identifies the gap between rich and poor as a key driver that determines the health of individuals. Anecdotally WHW knows that many women would not access support through our counselling service if payment was compulsory.

Health care card holders made up 28% of women attending our well women's health clinics. In addition, all follow up appointments at WHW are bulk billed. Anecdotally WHW knows that many women would not have preventative health checks such as Pap smears if bulk billing was not available.

Based on client outcomes of the Village project, community consultation, client needs, WHW have further developed an outreach model to target our most vulnerable and disadvantaged. The following provides a brief overview;

Pathways to Wellness

Pathways to Wellness is a culturally inclusive, community outreach and clinical counselling service for Aboriginal and non-Aboriginal women who are completing (or have completed) a community justice order or who are on release and/or parole from a correctional facility and/or who identify as using alcohol and/or other psychoactive substances in a harmful or hazardous way, which is/are having a negative impact on their own lives, their families and/or wider community. This project is both preventative and has an early intervention approach – whereby it will assist women to resist further re-offending as well as promote protective factors for children within the family, for those women who access the program who are parents.

This service is signified by a culturally sensitive 'paired up' outreach and home visiting service which will feed into a clinical counseling service which also has outreach capabilities. The aim of this project is to 'bridge the gap' – that is provide an intervention service for women at a vulnerable time in their lives whereby, with in-home support, education and community liaison the client is assisted to maintain commitment to treatment and support services. The outreach service will assist the client to implement learned strategies gained from the clinical counseling and/or other treatment/support services. The service will also provide an advocacy and liaison role, to coordinate service responses and ensure relevant appointments are attended by clients.

WHW is currently seeking funds to implement this service model.

- **Body Esteem Program - BEP** (Department of Health - State Mental Health Funding)

The federal government recently acknowledged that currently, services for people in Australia with anorexia and bulimia are fragmented and disjointed. Research is scarce, and the information available to people and their families is often inconsistent. This means that these vulnerable members of our community often struggle to get the care and advice they need. WHW is delighted therefore that The Hon Nicola Roxon announced in late 2008 that The Rudd Government will invest $500,000 to help develop a comprehensive, coordinated national approach to eating disorders[10].

Eating disorders are often forgotten in conversations about mental health, yet significant numbers of women and children in our community are affected either directly or indirectly. Anorexia nervosa, bulimia nervosa, and binge eating disorder are severe mental illnesses.

The Body Esteem Program (BEP) was developed as a community response, to the lack of services available in WA to support those whose lives are affected by an eating disorder. Originally, the program was adapted from a format that was being delivered overseas (Netherlands) in 2005. It has since been tailored to suit the Australian context and together with a turbulent financial history of short term funding, it has survived and developed into a reputable and unique service.

[10] The Hon Nicola Roxon MP Minister for Health and Ageing. (2008). *Assisting People with Eating Disorders.* Media Release 14 October 2008 retrieved 25/11/08 at http://www.health.gov.au/internet/ministers/publishing.nsf/Content/22EF18308A28F109CA2574E2001DFD9A/$File/nr135.pdf.

The BEP offers a 20 week program which is facilitated by staff who hold professional qualifications and experience - who uniquely - share with the participants, their own lived experience of an eating disorder. An education and support group (for parents, partners and family members) has also been developed to meet additional needs of people in the caring role. Whilst sufferers of an eating disorder are attending the 20 week program, family members will often elect to attend the education and support group concurrently.

The BEP complements medical and psychological treatment options for eating disorders. Overwhelmingly, our evaluation data tells us that participation has been beneficial to women, assisting them to develop insight into eating behaviours and associated difficulties, and to make positive changes in a range of life domains.

The BEP can accept women who are at least 18 years of age. This program has proven very effective in assisting the recovery of women who suffer either anorexia nervosa or bulimia nervosa type eating disorders but women need to be highly motivated and largely free of complex comorbid conditions that often accompany eating disorders, to be deemed appropriate for inclusion in the groups.

As a peer-facilitated program we do not offer treatment. When it is identified that self-help is not appropriate, we always attempt to refer to the most appropriate services to assist individuals to access treatment and support. For those ineligible to participate due to the severity of their illness and or comorbid conditions and or suicide ideation there is little community support. It has also been our experience, that for those without private health cover, it can be extremely difficult to access specialised eating disorder in-patient services within Western Australia.

Addressing the treatment needs of persons with eating disorders in Western Australia, along with the equally important public health issues of dangerous dieting and disordered eating, requires a multifaceted and multi disciplined approach. It is encouraging that the National Action Plan on Mental Health includes school based early intervention programs targeting children and young people. WHW and the eating disorder sector in Western Australia are keen to develop and build on the existing prevention and intervention programs. Mission Australia's National Youth Survey revealed that the top concern for all young people aged 11 to 25 years was body image. This was ahead of issues related to family conflict and coping with stress. Our young people are more focused on their outward appearance and how they are judged by others based on their physicality. We are encouraged by the Federal Minister for Youth recognising that body image is a complex issue and we look forward to seeing recommendations from the National Advisory Group on Body Image. Certainly, investing in

the mental health of children and adolescents represents the most cost effective action to prevent the continuous increase of mental health problems in all age groups.

Recommendation 7 : That the NWHP investigate how information and awareness on positive body image can be facilitated through positive community education and social marketing and incorporated in the National Schools Curriculum.

Priorities of the New NWHP ....

Priority Three: Preventing violence against women ....

Interpersonal violence is now recognised as a serious public health issue and a leading cause of poor health outcomes for women and children[11] Whilst it is acknowledged that children witnessing family and domestic violence are negatively affected by the experience, recent research indicates that children living in households where Interpersonal violence is common, are also more likely to be actual victims of abuse themselves. All women's health centres, to a greater or lesser extent, respond to family and domestic violence and its effects on women. They will therefore have significant opportunities, through direct services and through community networks, to contribute to breaking intergenerational cycles of violence.

Accurately targeted preventative strategies in the early years of life are increasingly demonstrated to reduce behaviours, including violence and anti-social activities, which perpetuate cycles of violence across generations:

> *Secure attachments with caregivers play a critical role in helping children develop a capacity to modulate physiological arousal. Loss of ability to regulate the intensity of feelings and impulses is possibly the most far-reaching effect of trauma and neglect…The inability to modulate emotions gives rise to a range of behaviours that are best understood as attempts at self-regulation. These include aggression against others, self-destructive behaviour, eating disorders, and substance abuse."*[12]

By ensuring that knowledge of the destructive effects of interpersonal violence is understood and applied to improving services to women, and by utilising knowledge of how the effects of violence are transmitted to the next generation, women's health centres will contribute to a whole of community approach to reducing and preventing harm from violence.

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[11] World Health Organisation: World Report on Violence and Health. 2004:

[12] van der Kolk B and Fisler R: *Childhood abuse and neglect and loss of self-regulation*. Bulletin of the Menninger Clinic, 58(2), 145-168

We offer the following experiences to reinforce the significance of how health inequalities negatively affect women's health and well being and highlight the importance of an intersectoral approach;

Impact of Shared Care Legislation

Since the Shared Parental Responsibility Legislation was introduced in the last term of the Howard Government, there has been a marked increase in the number of women who find themselves experiencing significant mental health issues as a result of the processes of the Family Court. The new shared care legislation links child support payments to the amount of time spent with the non-custodial parent, although it is acknowledged that mothers will still bear the largest burden in providing essentials for children, such as school uniforms, etc.

When and if the women leave their partners, it is often because they are unable to continue living in abusive and sometimes hostile relationships. However, the abusive partner often responds to the departure of his wife/defacto by using the Family Court to regain a measure of power and control over her and the children, through seeking shared care of the minors involved.

As shared care is the default option in the Family Law Court at present, clients are frequently reporting that they are reluctant to leave violent relationships, because they are afraid that their children will be left unsupervised for up to a week at a time with a person known to them to be abusive and volatile. If they stay in the relationship, they feel that they have some hope of being able to control the other party's access to the children.

Further to this, clients report that with younger children particularly, the frequent movements between the maternal and the paternal home have a range of undesirable outcomes. These include, but are not limited to, disrupted sleep patterns, confusion over expected and acceptable behaviours, the children being more disrespectful of the mother - with older boys particularly; mothers report that they begin to treat her in the same abusive ways that they saw the father treat her. This transgenerational phenomenon is particularly distressing to clients and is regarded by counsellors as a disturbing development, as it indicates that the mother's efforts to 'stop the cycle' are being negated by the opposite influence from their father and somewhat supported by the current shared care arrangement nominated by the family court.

- New 'Relationship Centres'

Anecdotal evidence suggests that staff in the newly established 'Relationship Centres' may not be properly trained to detect domestic violence. Mediation in circumstance of interpersonal violence provides opportunity for the perpetrator to use the system to further control and intimidate the mother.

- Women are struggling financially

The new shared-care arrangements link the child support payments to the amount of time spent with the non-custodial parent. Whilst it is acknowledged that this may be a fairer system in some cases, it becomes ludicrous. As an example, a WHW client saw that she was being paid $12.99 per fortnight by her ex-partner. Under the new shared-care arrangements, she received a letter stating that the child support amount had been changed to $9.74 a fortnight, because of increased time spent with the non-custodial parent. Her ex-partner had thus paid $7.19 too much and she was required to repay him. WHW concerns are who is providing the major sustenance for the child, such as uniforms, clothes, food, etc and who is not being supported systematically to do so? The desire for the non-custodial parent to reduce child support liabilities has been shown to be a major motivational factor[13]

In addition to the above, the high rentals and lack of Homeswest housing in Perth mean that more women are reluctant to leave abusive situations. "Safe, affordable housing is still a largely unresolved need" (Stewart, 2005).

- Pressure on women to agree to contact

  Clients report that they are advised by lawyers and mediators to agree to non-custodial contact even when they are reluctant. They are told that they will be seen as 'hostile' and that it may affect the perception of the Family Court. Women experience great fear at this time.

- The system is used to further abuse women

  In some cases, abusive partners are using the new shared-care arrangements to further harass their ex-partners. There is a disturbing element underpinning these individual cases. Pease (2008)[14] notes that gender mainstreaming have shifted the emphasis from

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[13] Keys Young (1996), "Research evaluation of family mediation practice and the issue of violence", *Legal Aid and Family Services, Commonwealth of Australia.*

[14]

men's violence against women to a more neutral term of domestic violence. Gender mainstreaming not only lessens the perception of a need to address women's issues, but also provides a space for men to claim they are being victimised according to Pease (2008).

- Lack of appropriate legal representation
  Clients are experiencing more difficulty in accessing women friendly lawyers. Often they do not have money to go to private lawyers, and are dependent on Legal Aid or Women's Legal Centres. Lawyers are obviously advising their clients to comply with Family Law shared care arrangements, but women are fearful to speak out if they are not assured of equity under the law.

None of the above phenomena are new developments in the lives of women who have had children with an abusive partner. What is new under the Shared Parental Responsibility legislation is the increased amount of time/greater frequency with which they occur, and the reduced time available to the mother to redress the harm that has been incurred. The literature on the subject of perpetrator-change subsequent to the wife and children having left the abusive relationship, as well as anecdotal evidence in abundance, is that substantive behaviour modification for the better (ie less abusive) is very rare; often indeed, the abuse escalates.

The Shared Parenting Responsibility legislation was not intended to produce the outcomes described above. It seems more a matter of inappropriate implementation; ie Shared Care was perhaps adopted as the most expedient/straight-forward means to achieve Shared Parental Responsibility. On the basis of the feed-back provided by women's health centres, and the local Pat Giles Refuge Centre clients, it is a strategy that needs urgent review, especially in light of the statistics that approximately 30% of women are victims/survivors of interpersonal violence. This translates into a high proportion of Australian children being subjected to unacceptable parenting arrangements.

Pease, B (2008), "Engaging men in men's violence prevention: Exploring the tensions, dilemmas and possibilities", *Australian Domestic and Family Violence Clearing House, Issues Paper 17.* Retrieved 10 August 2008 from www.austdvclearinghouse.unsw.edu.au/publications

Recommendation 8: That the NWHP is implemented with a whole of government approach to ensure the safety of women and their children.

Recommendation 9: The Shared Parental Responsibility Legislation is reviewed.

Recommendation 10: That education on interpersonal violence is mandatory for all legal professionals involved in the Family Law Courts.

Recommendation 11: That mediation not be endorsed or promoted when there is a history of domestic violence – the case to proceed directly to court.

Recommendation 12: That where there is domestic violence, shared care is not an option.

Recommendation 13 : That the issue of the Family Law Court overriding violence restraining orders to be open to vigorous discussion and review.

Recommendation 14: That safety and protection of the child be paramount when dealing with allegations of sexual assault and treatment by experts in child psychology becomes available as soon as an allegation is made.

Priorities of the New NWHP ....

Priority four: sexual and reproductive health..

Sexual and reproductive health is a fundamental issue for all women, affecting them at every life stage. It affects women's control over their own bodies, through access to safe and appropriate health services and information, and remains a central priority of women.

Currently, Australia has unacceptably high levels of sexual and reproductive ill-health, demonstrated by the following statistics compiled by the Public Health Association of Australia:

- higher rates of early sexual activity among young people have increased the risk of unplanned pregnancy and sexually transmissible infections
- high rates of sexual violence (19.1 per cent of women and 5.5 per cent of men have experienced sexual violence of some kind)
- increasing rates of chlamydia and newly acquired HIV infections
- inadequate access to safe and effective contraceptive education and methods
- unacceptably high levels of teenage pregnancy compared to other developed countries (18.4 births per 1000 women aged 15-19 years)

- high estimated abortion rates (19.7 per 1000 females aged 15–44 years in Australia) compared with other countries (eg Germany 7.7, The Netherlands 8.7 and Finland 10.9)
- high rates of infertility (1 in 6 couples).

Chlamydia was the most frequently reported notifiable infection in Australia in 2004 with 35,000 cases identified nationwide (Chlamydia grant program, 2005). The reduction of the spread of this infection and other sexually transmitted infections (STIs) is now a national strategy. Thus, the Health Department must step up to the challenge of facilitating the diagnosis, treatment and reduction of infections.

With the alarming growth of STIs among teens it is imperative that WHW is able to provide a safe non-threatening and non-identifiable service to young people aged between 14-25 years. This particular age-group has been noted to have a dramatically higher incidence of chlamydia than any other group (Chlamydia Campaign, 2005). Although WHW is a women's service we are able to provide service to men in the evenings and would do so if we had funding for a STI clinic.

Medical practitioners at WHW (through the Medicare rebate) offer education, information, support and treatment on a wide range of women's health issues, preventative health checks - pap smears and contraception are the main focus of medical consultations. Gardasil vaccine is offered to younger women. WHW also offers shared ante-natal care.

The National Women's Health Policy consultation paper identifies barriers to women accessing health care services.

- Access to safe, affordable and legal abortion is also fundamental to women's sexual and reproductive health. While Victoria has recently had termination of pregnancy removed from the criminal code, currently doctors in Queensland are at risk of being charged with a criminal activity. Women must have choice and be supported in accessing appropriate services.

Recommendation 15: That where termination of pregnancy (abortion) remains in the Crimes Act in any state /territory it should be removed as in Victoria.

Priorities of the New NWHP ....

Priority five: Improved access

As cited in the Consultation Discussion Paper, non participation generally gives rise to further adverse circumstances, such as low educational achievement and lower level of service use, including health services[15]. WHW strongly believes that aaddressing the social determinants is a fundamental step towards reducing health inequalities.

An example of the challenges that face our most marginalised;

The aim of the WOMEN'S Healthworks Health Education and Promotion Program is to provide information about positive health behaviour, to enable women to increase control over and improve their health and well being. One of the strategies, in providing this service, is the provision of courses, workshops and forums that are responsive to the needs/requests of women in the northern suburbs.

The health education programs are developed and delivered by a range of health professionals incorporating Psychologists, Art Therapists, Doctors, Naturopaths and other qualified facilitators who are specialists in their fields.

An example of groups we target, and access issues....

In 2004, a group of teenage parents expressed their interest in starting a young mum's support group because they felt uncomfortable attending mainstream playgroups. Through meeting with other mums their own age they felt they could help and support each other. The participants of this group had been receiving services provided through a joint initiative between the Health Department and Department of Child Protection - The Best Beginnings Program. This program works with mothers who meet criteria of which there are significant risk factors re: healthy outcomes for their child. These factors include age (young), family of origin issues, domestic violence, past history of abuse, hazardous and/or harmful alcohol and other drug use and mental health issues.

Many clients who require treatment and support services that have children in their care, also frequently fall under the jurisdiction of Department for Child Protection (DCP). Because of the extensive networking that has occurred, strong relationships have also been established with the family support services provided by DCP and affiliated agencies connected to this client group.

By working collaboratively to support enterprises such as the young mums support group we have been able to offer therapeutic services which are delivered in a non-stigmatised way

[15] Development of a New National Women's Health Policy Consultation Discussion Paper 2009

and by an agency that is not viewed as authoritative can provide access to services which can assist in rehabilitation and recovery.

The types of programs we have been able to offer this group include Art Therapy and Photovoice. In assisting this target group to access these services childcare and public transport were fundamental barriers that had to be addressed.

An example of one woman's experiences who was trying to participate in an Art Therapy course which was delivered in a community building (the course was an outcome of the group's members articulating a need for this service) was her three hour round trip journey on public transport so that she could attend. The woman had a young child who she needed to place in child care. The only child care place that could be found for her was in family day care and this was in the same suburb of where she lived. Nevertheless the distance was too far for her to walk to on foot (with child in tow). The suburb of where the group was held was adjacent to her own. She needed to catch a bus to the child care centre, disembark and settle her child. Catch the next bus to the group and then complete the same ritual for her trip home. The total length of the trip was – at maximum 10 km. However, it took this women four separate bus trips and over three hours there and back to attend a therapeutic group. Needless to say, public transport issues for young women in the local area are a huge issue and can be seen to further marginalise an already disempowered group which receives much undue negative media attention. Nevertheless, the determination this woman had in being able to surmount these barriers would not easily transfer to others in similar situations. Many marginalised disadvantaged women would simply find obstacles such as these too great to overcome which results in poorer outcomes for both themselves and their children.

Barriers to women seeking health care

Barriers to health care access are among the issues identified Consultation Discussion[16] Paper in which it cites:

Australian women accounted for 56 per cent of visits to GPs in 2006-07. Many women face significant barriers in accessing health care services and information. These barriers are part of the social and economic conditions of women's lives which lead to health inequalities, and include:

- a lack of affordable health care services;
- a lack of female doctors, including Indigenous service providers;

[16] Development of a New National Women's Health Policy Consultation Discussion Paper 2009

- distance to health care services and lack of affordable transport, particularly in rural and remote areas, but also an issue in the outskirts of cities;
- a lack of culturally appropriate services and information;
- a lack of services and information available in other languages;
- inaccessibility of buildings, services and information for people with disabilities; and
- health services being ill equipped to deal with the complexity of the health and social needs of women from particular groups.

A lack of female doctors is particularly relevant to WHW demographics and other women's health centres throughout Western Australia. .

WHW is well placed to provide an appropriate, women-centred approach to medical services to women with sexual health, and mental and lifestyle health issues. The ability for WHW to offer timely medical appointment is hampered only by our inability, because of workforce shortages, to employ suitably qualified doctors. Our recent experience with trying to employ an overseas highly qualified doctor has embroiled us in red tape and the politics of the medical profession. Reviewing the guidelines for overseas qualified doctors so that those with suitable qualifications could work in designated workforce shortage areas regardless of where those areas were situated, would assist in addressing health inequalities. If WHW was able to provide more medical clinics it could assist with overcoming many other risk factors causing chronic illness, injury and premature death can be addressed through linking women to other programs within WHW. Like all women's health issues, women's sexual and reproductive health is affected by factors both within and outside the health sector, including Medicare. We understand that Medicare is currently being reviewed and therefore make the following recommendation.

RECOMMENDATION 16 : That the government reviews the current Medicare guidelines to enable appropriately qualified overseas trained doctors to access a Medicare provider number to enable their employment in areas of workforce shortage and unmet need.

WHW has developed a proposal to act as the *hub* for delivering and coordinating a range of health and social support service at various locations for women and their families in the northern corridor. The proposal has grown out of the deepening concern about the lack of accessible services for women and their families in one of the fastest growing regions in Australia. The *hub* could provide a wide range of social support services in a variety of locations. The model is based upon outreach services using one administration facility to

manage such services. The use of WHW in this way would reduce the need for duplication of physical and management infrastructure, allowing the funding to go directly to service delivery, thus highly cost effective. There are a number of community centres throughout the electorates within WHW's catchment area, which WHW has the remit to service that could be accessed for the provision of such services. Importantly, the non-identifying nature of WHW means that women and their families would be more likely to access services they might otherwise not, because of the perceived stigma attached to presenting for social welfare/mental health support type services.

WHW has a high level of trust and acceptance in local communities. WHW consistently reports a demand for services well in excess of what can currently be provided. Additionally WHW is uniquely placed to contribute to aspects of learning, and health skills development for women with infants and small children, who invariably seek to do the best they can in ensuring the healthy development of their children, and are thus open to positive, timely support and education. WHW through a holistic approach contributes not just to improving women's health, but to influencing the wider social context in which health is achieved and maintained. This preventative focus includes issues like maternal, physical and mental health to ensure families remain functional, productive and strong.

'The purpose of the new National Women's Health Policy is to improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health; encourage the health system to be more responsive to the needs of women; actively promote the participation of women in health decision making and management; and to promote health equity among women.'

Although, since the first National Women's Health Policy, there has been a concerted effort to fund and support women's health services, as a complementary specialist service system alongside the mainstream health services, funding has not kept pace with the diversity and complexity of the issues coming out of the societal changes. However, a 'dual track' approach has allowed the development of a strong national network of women's health services which have contributing to improved primary health care and health education for women.

It is critical that this dual track approach is maintained and funded appropriately. The knowledge and expertise of the women's health service system needs to be incorporated into future strategies to achieve better health outcomes for Australian women, their families and communities.

Responsibility for women's health was handed back to the States and Territories in 1997 and, since then, Commonwealth money has been channelled through the Public Health Outcomes Funding Agreements (PHOFAs).

Funding – Non Government Sector

As can be seen WHW funding comes from a variety of sources. This patchwork approach to funding has often left women and their communities in a void once a program has ceased. Appropriated evaluation tools can be developed to ensure that funding is meeting it stated outcomes. Importantly any funding has to be ongoing and not just one of grants.

In the year 2000, nine out of ten health and community services in WA were operated by the non-government sector.

If the non-government community and health services sector was taken out of the equation in the provision of health and community services, there would be substantial costs both financially and socially for the state and federal governments.

The capacity of the non-government community and health service sector to generate income adds further value to cost effective service provision. The results of the Australian Community Sector Survey 2007 found that for 2004-06 the sources of income for not-for-profit non-government agencies were on average, 26% Federal funding, 45% State funding, 9% client fee income and 20% own source income (including donations, sponsorship, membership fees, sale of goods and services to the public.)

Recommendation 17 : That funding is made available to women's health centres to expand the provision of services to women whose needs are currently not being met because of the current low level of funding.

New and emerging technologies

WHW would encourage all future planning for women's health to ensure provision for use of new and emerging technologies. The increasing prevalence of internet based communities, treatment and therapy options will necessitate technological capacity within the sector. Current social networking trends need to be considered as possible mechanisms to address the fundamental challenge of social isolation emerging as one of the key issues for women in Australia in the 21st century. Young women most often use communication technologies such as mobile phones and the internet as the primary form of interaction with a wide network of friends and associates. As this cohort ages, they are likely to continue this practice, with future generations optimising communication via innovations yet to be determined.

RECOMMENDATION 18 : That all future planning for all women's health ensures the provision of new and emerging technologies, including training for staff in application of these technologies.

Conclusion

In conclusion, WOMEN'S Healthworks congratulates the Government on the development of a National Women's Health Policy.

WOMEN'S Healthworks looks forward to working with the Government to implement the New Women's Health Policy with the knowledge that community based women's health centres are closest to women in their communities, are trusted by women and have a proven track record of delivering quality health and wellbeing services.

Paramount to the effectiveness of any new policy must be a whole of government approach. Policy initiatives must go beyond the medical model and embrace the social model of health and wellbeing with a strong preventative approach to health care. The cost to the economy in not doing so is too high a price to pay.

Finally, we encourage the Commonwealth to seek a bipartisan approach to implementing the New Women's Health Policy and that any funding given to the States and Territories from the Commonwealth be tired to the National Women's Health Policy.

Investment in women's health is an investment in the community.

RECOMMENDATION 19: That any funding given to the States and Territories from the Commonwealth for women's health be tied to the National Women's Health Policy