Women's Health VICTORIA

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30 October 2015

RE: Health 2040

Women's Health Victoria (WHV) is a statewide women's health promotion, information and advocacy service. We work collaboratively with health professionals, policy makers and community organisations to influence and inform health policy and service delivery for women.

Our work is underpinned by a social model of health and a commitment to reducing poor health outcomes which arise from social, economic and environmental determinants. By incorporating a gendered approach to health promotion we aim to reduce inequality and improve health outcomes for women. Our goal is an integrated social care and health system that prioritises prevention as well as universal access to high quality and appropriate health services, and gender equity.

Our goal is not only to achieve equity in health outcomes for women and men, but also to achieve equity in outcomes for all groups of women. This means balancing universal strategies with specialist, tailored approaches for women who experience intersectional disadvantage including Aboriginal and culturally and linguistically diverse women, women with disabilities and women living in rural areas.

As a statewide body, WHV works with the nine regional and two other statewide services that make up the Women's Health Association of Victoria (WHAV).[1] The women's health services network offers a unique approach to women's health across the state by providing an infrastructure which focuses solely on gender equity, health promotion and improving women's health outcomes. The women's health services network infrastructure enables us to work flexibly at the regional level, while simultaneously coordinating and effecting structural and policy change at a state level. Together we fulfil a vital role in supporting women's health and wellbeing across the state by building the capacity of our partners and the broader health sector. Our research and advocacy is critical to the development of sound women's health policy and the implementation of initiatives arising from it.

WHV is pleased to contribute this submission in response to the Victorian Government's Health 2040 discussion paper on the future of healthcare in Victoria. The submission has been developed in collaboration with, and with contributions from, the other members of WHAV.

We would welcome the opportunity to provide any further information that may be useful in the shaping the future of the Victorian health system and look forward to working with the government to support better health outcomes for the Victorian community.

Yours sincerely,

Rita Butera
Executive Director

[1] The three statewide services are Women's Health Victoria, the Multicultural Centre for Women's Health and the Royal Women's Hospital. The nine regional services are Women's Health and Wellbeing Barwon South West, Women's Health Grampians, Women's Health Loddon Mallee, Women's Health Goulburn North East, Gippsland Women's Health Service, Women's Health West, Women's Health in the North, Women's Health East and Women's Health in the South East.

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Submission in response to the Health 2040 Discussion Paper

30 October 2015

This submission is endorsed by:

gippsland women's health

Multicultural Centre for Women's Health

Women's Health East

WOMEN'S HEALTH GOULBURN NORTH EAST
Challenging inequity, embracing diversity.

WHG women's health GRAMPIANS

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WOMEN'S HEALTH AND WELLBEING Barwon South West Inc.

Health 2040: Submission from Women's Health Victoria

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Introduction

The Health 2040 discussion paper provides a welcome opportunity to consider and set a clear vision and goals for the health of the Victorian community into the future. We congratulate the government on important steps taken recently, including the Royal Commission into Family Violence, the commitment to gender equity in all public board appointments, and the commitment to introduce safe access legislation to ensure women can access health services without obstruction and intimidation. We are confident that each of these important initiatives will contribute to better health outcomes for women.

However, foreseeable challenges, including an ageing population, mean that our health system as a whole will be under enormous pressure by 2040 unless we set and achieve a better vision for the future. Health 2040 provides the opportunity to create a vision for a more equitable, responsive and financially sustainable health care system able to meet the needs of the future. By investing in health promotion and prevention strategies that address the social determinants of health, including gender inequality, we can create a more cost-effective health care system that reduces disparities in outcomes for vulnerable and disadvantaged groups and delivers better outcomes for all Victorians.

Health 2040 provides us with an opportunity to set a clear vision supported by ambitious goals, and to provide a road map to achieving these over the next 25 years. In our submission, WHV sets out our vision for the Victorian health system in 2040, as well as clear goals and principles that can help us work together to achieve the improved outcomes we seek.

Our vision for 2040: All Victorians are living well – healthy, empowered and equal

Our goals for 2040:

1. **Universal access to health services has been achieved.**
2. **The social determinants that we know lead to poor and unequal health outcomes have been addressed through increased investment in universal and targeted health promotion and prevention strategies.**
3. **Gender equity is recognised as a key driver of better health outcomes for women, the gendered norms that contribute to poor health outcomes for men and women have shifted, and the experiences and wellbeing of women has become central to the design and operation of the health system.**
4. **The essential role played by specialist women's health services in identifying and responding to the specific health risks experienced by women has been recognised, strengthened and embedded as a core feature of the primary preventive health system.**
5. **Strategic investment in innovation including technological solutions has been targeted to meet the specific health needs of the most vulnerable and hard to reach groups.**

Our vision for 2040: All Victorians are living well – healthy, empowered and equal

By addressing the social determinants that lead to poor and unequal health outcomes, including gender inequity, we can work towards a vision of all Victorians living well: healthy, empowered and equal.

Our goals for 2040

We believe that achieving our vision for a healthier and more equal Victoria will require whole of community work and commitment so that, by 2040, the following five goals have been reached:

1. **Universal access** to health services has been achieved, meaning that all Victorians can obtain high quality and appropriate health care when they need to, regardless of wealth or postcode. This includes access to preventive health measures and health promotion opportunities, through to acute care, rehabilitation and recovery. A key priority for women's health services is to ensure that all Victorian women have access to integrated sexual and reproductive health services, including free contraception and termination of pregnancy.
2. The **social determinants that we know lead to poor and unequal health outcomes have been addressed creating a more equal and healthier community**. This has been achieved through increased investment (now) in **universal health promotion and prevention strategies, in conjunction with specialist, tailored strategies for priority (and hard to reach) population groups.** As a result, the incidence of preventable health problems including chronic diseases and violence against women has been significantly reduced and has resulted in better health outcomes and significant savings to the overall health budget enabling funding to be re-directed to meet the challenges of the future, including an ageing population.
3. **Recognising that gender equity is a key driver of better health outcomes for women, by 2040 the gendered norms that contribute to poor health outcomes for men and women have shifted and the experiences and wellbeing of women have become central to the design and operation of the health system, rather than a secondary consideration.** Evidence shows that gender-based inequities are both the underlying cause of poor health outcomes for Victorian women and the barriers to achieving improvements in Victorian women's health.[2] Our goal is that improved gender equity by 2040 has supported women's increased participation in work and community life, and has reduced the incidence of violence against women, and associated chronic health problems such as depression.
4. **The essential role played by specialist women's health services in identifying and responding to the specific health risks experienced by women has been recognised and strengthened**. As a result, the impact of gender on women's health is recognised by policy makers and health professionals and has become central to their work. Generalist services are equipped by specialist women's health services to provide the best possible health promotion, prevention, early intervention and care to women. Major health issues affecting women which have otherwise been neglected or ignored by policy makers and generalist health services have been addressed through the shared expertise of specialist women's services.
5. **Strategic investment in innovation and technological solutions, including e-health options for health literacy, health promotion and health care, has contributed to better health outcomes and experience for all Victorians**, particularly the most vulnerable and hard to reach groups, such as women in rural and regional areas, Aboriginal women, women from immigrant and refugee backgrounds, and women with disabilities. Collaboration with these groups undertaken by specialist women's organisations has enabled innovative solutions to be co-designed and tailored to their needs.

[2] Women's Health Association of Victoria, 2015, *Priorities for Women's Health 2015-2019, Women's Health Association of Victoria*, Melbourne, p. 9.

What principles should guide healthcare reform?

WHV believes that three key principles should underpin Victoria's future health system:

1. **Investment in universal and tailored health promotion and prevention strategies that support equitable outcomes across the population as a whole**
2. **A gendered approach to healthcare and health promotion, promotion of gender equity and empowerment of women**
3. **Valuing and resourcing of specialist women's health services so they can continue to provide expertise in primary prevention and health promotion, and strengthen the capacity of the health system to identify and respond to the needs of women**

PRINCIPLE 1: Investment in universal and tailored health promotion and prevention strategies that support equitable outcomes across the population as a whole

We welcome the discussion paper's focus on reducing the health burden of chronic disease. To achieve this will require sustained investment in preventive health strategies starting now. While the discussion paper focuses on the role of primary health care in prevention, WHV believes that directing prevention and health promotion efforts at addressing the social determinants or root causes of ill health is critical to improving health outcomes and creating a more equitable, inclusive and productive society.

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.[3] Structural barriers including access to political power and resources, social isolation, economic participation, cultural beliefs and stereotypes, freedom from discrimination based on gender, race or experience of disability are all important social determinants which play a key role in predicting and affecting the health outcomes of individuals or groups.

The *Victorian Public Health and Wellbeing Plan 2015–2019* sets out the current Government's priorities and vision to improve the health and wellbeing of Victorians over the long term, and particularly over the next four years. The Plan confirms the importance of addressing the social determinants of health in preventing chronic disease.

> "The differences in health status do not happen by chance, nor, in most cases, are they the result of natural biological variation between individuals. They are socially patterned, and generally follow a social gradient in which a person's overall health tends to improve at each step up the economic and social hierarchy,"[4]

Our shared vision for Victoria's health system in 2040 needs to recognise that health does not begin with an individual's first visit to the doctor. Ensuring preventive strategies effectively address the social determinants of health will require innovative cross-sector partnerships spanning multiple settings including early childhood, schools, workplaces, community organisations and media, in addition to primary health settings. We need an integrated health system that promotes a seamless approach to prevention, primary, secondary and tertiary health care.

Investing in prevention now will lead to healthier, happier communities and reduce the burden of chronic disease on the Victorian health system. Creating tailored prevention strategies for groups at increased risk of poor health outcomes due to marginalisation and disadvantage will improve health outcomes for these populations and reduce existing inequalities.

[3] World Health Organization, 'Social determinants of health' on *World Health Organization website*, Geneva, updated 2015.
[4] Department of Health and Human Services, 2015, *Victorian Public Health and Wellbeing Plan 2015-2019*, Victorian Government, Melbourne, p. 19.

PRINCIPLE 2: A gendered approach to healthcare and health promotion, promotion of gender equity and empowerment of women

As recognised in the discussion paper, disparities in health outcomes are determined by the social, cultural and economic factors that influence peoples' lives. Gender and gender-related inequity play a profound role in shaping women's lives and health outcomes across the lifespan.

In thinking about the health system of the future, there is an opportunity to pay greater attention to the different health needs of women and men, reflecting the evidence that women experience different health risks, needs, treatments and outcomes over the course of their lives. A 'gender-blind' approach that fails to consider the differing needs of women will reinforce gender-based inequities and disparities in health outcomes.

All health policy and services should consider the different needs and life experiences of men and women and the way that gender norms and stereotypes impact the way women and men encounter/interact with the health system. Structural barriers such as poverty, childcare responsibilities, single parenthood, low wages, domestic violence and sexual assault are just some of the factors that disproportionately impact women's health outcomes.

While Victorian women are more likely to live longer than Victorian men, the higher prevalence and incidence of non-fatal health problems among women results in more years lived with ill health and disability. For Victorian women aged 15 to 44 years, for instance, intimate partner violence is the leading contributor to disability, illness and, tragically, death.[5]

A gendered approach is important because it makes visible:

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

Incorporating a gendered approach to healthcare, we will improve health outcomes for women and support more effective policy development to achieve better outcomes across the community as a whole. The benefits of taking a gendered approach are demonstrated in our case studies throughout this submission.

Importantly, gender-based discrimination interacts with other types of lived experiences of inequality. This interaction, in which one experience impacts on another, is termed 'intersectionality'. Social and structural inequalities, such as class, race, sexuality, disability and residency status may act to increase women's vulnerability to negative and compounding health outcomes. In order to be effective and to avoid reinforcing existing disparities, healthcare interventions in Victoria (spanning prevention, acute care and recovery) must take this into account, and be tailored accordingly.

PRINCIPLE 3: Valuing and resourcing of specialist women's health services so they can continue to provide expertise in primary prevention and health promotion, and strengthen the capacity of the health system to identify and respond to the needs of women

> "Providing services for vulnerable women through mainstream organisations presupposes that services can achieve the same outcomes for women without applying gender-informed practice. The history of social policy

[5] VicHealth, 2004, *The health costs of violence: measuring the burden of disease caused by domestic violence*; Melbourne, p. 10.

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> and our knowledge of best practice in achieving outcomes for vulnerable women does not support this assumption." (Women's Services Network (WESNET) 2015)

It is easy to take for granted the strides made by specialist women's health services in identifying and responding to the health needs of women including in relation to prevention of violence against women, sexual assault, and sexual and reproductive health, including access to contraception, unplanned pregnancy support and abortion. These typically very small, under-resourced organisations have, with sustained effort and in partnership with government and community, identified numerous serious health issues for women that have otherwise been overlooked by generalist services and policy makers despite their prevalence, seriousness and preventability. Specialist women's health services have worked tirelessly to undertake research, collect evidence, and design policy and health promotion programs and services, in order to render the health concerns and life experiences of women visible and important. By sharing this knowledge, specialist women's health services build the capacity of an entire region or network of service providers to ask the right questions, collect the right data, inform policy development, design best practice interventions, and support appropriate and effective engagement with men and communities.

It is essential that the design of Victoria's future health care system recognises and enhances the value added by specialist statewide and regional women's health services. Without continued investment in specialist women's health services, we may see a further reduction of women's access to specialist support, increased risk to women and children affected by gender-based crimes such as violence against women and sexual assault, and further increases in structural and systemic gender inequality.

What should be the priorities for reform?

This section of the submission applies the three principles outlined above to the six priorities outlined in the Health 2040 discussion paper.

1. A person-centred view of healthcare

The best health outcomes for individuals will be achieved when healthcare is tailored to meet their individual needs and priorities. Navigating a complex health system can be expensive, time-consuming and disorienting and the impacts of this will be felt most by people with multiple and complex health needs, fewer financial resources, low health literacy and/or those who experience geographical and language barriers to access services.

Universal access to essential health services is the first step towards person-centred care. While WHV supports initiatives aimed at increasing choice, personalisation and patient participation in health care, we believe that much work remains to be done to ensure all women are able to access all the basic health services they require over the course of their lives at all, let alone in a person-centred way.

For women, being able to request female health professionals, feeling secure and safe, and feeling that their confidentiality will be respected is particularly important, especially for those women who have experienced physical, emotional and/or sexual violence. Because of the high occurrence of gender-based violence, these considerations are relevant to many women.

However, in striving for a person-centred approach to health care we first need to achieve universal access to essential health services that is responsive to the needs of women. For example, in the absence of any statewide framework for sexual and reproductive health promotion and care, many women are unable to access essential health services including contraception and pregnancy termination. This has lifelong impacts for women's ability to participate equally in work and community life, earn an income and care for their families.

Many publicly funded health services, including hospitals, do not provide the full suite of sexual and reproductive health services, in particular contraception and abortion. There is no transparency about which hospitals are providing which services, making it extremely difficult for women to access timely information, care or essential services. Regions with high rates of unplanned pregnancies also have long waiting lists for accessing the most effective contraceptive methods (long acting reversible contraceptives) and provide little or no access to pregnancy terminations. Some groups of women, such as women with disabilities and immigrant and refugee women, experience additional barriers to service access.

Inability to access sexual and reproductive health services contributes to social and economic disadvantage for women and their communities and further exacerbates health inequalities. Improving sexual and reproductive health is recognised as a health and wellbeing priority in the Victorian Government's *Public Health and Wellbeing Plan 2015-2019*.

Person-centred care for women with unplanned pregnancies would include access to high quality, non-biased options counselling and the opportunity for women to make an informed choice about their options, including whether a medical or surgical termination of pregnancy would be the best option, followed by timely access to their chosen method.

Case Study 1: Access to sexual and reproductive health services

We know that women bear the primary burden of reproductive health and decision making. Access to reproductive health services is essential for every Victorian woman's health and wellbeing, and they must be able to enjoy their legal right to bodily autonomy.

However many hospitals do not provide the full suite of sexual and reproductive health services, in particular contraception and abortion. Those services that do provide abortion cannot keep up with demand for the service.[6] Surgical abortion services are concentrated in metropolitan Melbourne which can negatively impact women in rural and regional Victoria in terms of access, travel and cost.[7]

Some of the barriers to accessing sexual and reproductive health services include:[8]

- **Lack of availability** of local services and specialists, leading to long wait times: *"At the moment it seems that a lot of women are "shipped off" to Melbourne, there is limited amount of local counselling available and they have to find their own way to appointments etc. This is archaic."*
- **Lack of privacy** and anonymity: "*In some towns they are only available at local shops. I had a young person tell me that the shop keeper refused to serve them and threatened to tell their mum (who was a friend)."*
- **Distance** to service and lack of transport: *"Find it very difficult - access is an issue, particularly related to travelling and accessing service in a timely manner."*
- **Cost**, including for contraception, appointments, travel and time off work: "*Cost is a big factor in young people not getting the emergency contraception or getting contraception in general."*
- **Lack of accurate and up to date information** about contraception and abortion services for clients and health professionals, including a lack of comprehensive education for both clients and health professionals around contraceptive options. In addition, women from immigrant and refugee backgrounds, including international students, may lack awareness of family planning services and methods, and there is a lack of interpreting services and in-language print information regarding contraception and abortion.
- **Community attitudes**: *"Lack of support from family/partner is huge, with some women continuing with pregnancies they don't want due to significant pressure from family."*
- **Attitudes of health professionals and health services**: In 2012, a Victorian Women's Health Program survey found that 44.9% of respondents indicated that they were aware of health professionals in regional Victoria who would not refer women for abortion.[9] It is also believed that not all publicly funded hospitals currently provide abortion services.[10] Some women have reported having to arrange their own termination from private providers costing thousands of dollars due to inadequate assistance from health professionals and lack of availability of services.[11] Health professionals may also lack cultural awareness which can impede their ability to provide cultural and linguistically appropriate and responsive services.
- **Restrictions on access to services:** For example, there is generally a 12 month waiting period for international students for pregnancy-related conditions under Overseas Student Health Cover.

WHV's vision is that by 2040:

1. Sexual and reproductive health services are **universally accessible** to all Victorian women. Contraception (including emergency contraception) is widely accessible, pregnancy advice and support is available and

[6] Royal Women's Hospital, 2015 'What if I can't get through to the Unplanned pregnancy support line?', Royal Women's Hospital website, Melbourne.
[7] Better Health Channel, 2014, 'Abortion services in Victoria', Victorian Government, Melbourne; [7]Partland, L, 2013, 'Abortion, contraception still a problem for women in regional Victoria' *ABC Ballarat*, Ballarat.
[8] All quotes in this section sourced from Rural Victorian Women's Health Services, *2012 Victorian Rural Women's Access To family Planning Service Survey Report*, Project of the Rural Services of the Women's Health Association of Victoria.
[9] Rural Victorian Women's Health Services, 2012 *Victorian Rural Women's Access To family Planning Service Survey Report,* Project of the Rural Services of the Women's Health Association of Victoria, p. 16.
[10] Mildew, J, 2015, 'Barriers to abortion remain in Victoria seven years after decriminalisation', *The Age,* Victoria.
[11] Mildew, J, 2015, 'Barriers to abortion remain in Victoria seven years after decriminalisation', *The Age,* Victoria.

accessible statewide, surgical and medical termination services are available at every public hospital and medical terminations are widely available at GP clinics.

2. Women have greater **choice of services, privacy and anonymity**, supported by access to **accurate information to support decision-making**. This would include the provision of education for women (including women from different cultural backgrounds), health professionals and community workers about contraceptive options, as well as increased access to contraception and medical terminations. Education of health professionals and community workers would include cross-cultural training to build their capacity to provide cultural and linguistically appropriate and responsive services.

WHV believes that the development and implementation of a state-wide Sexual and Reproductive Health Framework is essential to the health and wellbeing of Victorian women into the future. Such a framework would provide policy makers and women's health services with an accurate statewide picture of available sexual and reproductive health services and the rates and consequences of unmet need. The development of a Sexual and Reproductive Health Framework, together with implementation of measures to address identified gaps, is critical to ensure that all public health services, including hospitals, provide the full suite of sexual and reproductive health services. This would support a measurable improvement in women's health and socio-economic status by 2040.

There is also a need for a statewide sexual and reproductive health promotion policy, which would form the basis for regional health promotion plans. Women's Health West's health promotion plan, *Action for Equity: A Sexual and Reproductive Health Plan for Melbourne's West 2013-2017*, is currently being used as a model by other regional women's health services.[12]

WHV recommends that a state-wide Sexual and Reproductive Health Framework be implemented that:

- maps the current availability of sexual and reproductive health services across the state, as well as identifying gaps;
- invests in Victorian women's health services to lead the development, implementation and evaluation of regional sexual and reproductive health plans (including health promotion plans) in partnership with others;
- establishes a comprehensive and uniform Victorian sexual and reproductive health data collection system to ensure that prevention (and intervention) efforts are evidence based; and
- addresses the social determinants of sexual and reproductive health with a focus on primary prevention.

Case Study 2: BreaCan and person-centred care

BreaCan is a service of Women's Health Victoria which has been providing an innovative, flexible and high quality community-based peer support service for women with breast or gynaecological cancer and their families in Victoria since 2003.

BreaCan's programs and services have been designed by and for women who have experienced cancer, and include information and support through formal and informal activities. BreaCan hosts information sessions on cancer and wellness topics as well as providing a free and confidential phone line, website and library including the smartphone app, Navigator.[13] BreaCan also provides exercise sessions in the community that are tailored to the physical limitations experienced after surgery.

[12] Women's Health West 2013, *Action for Equity: A Sexual and Reproductive Health Plan for Melbourne's West 2013-2017*, Melbourne.
[13] BreaCan's Navigator app is a stepping stone to finding good quality, current information on a range of breast cancer related topics from reputable sources.

BreaCan differs from other services because:

- it is founded on the diverse experiences of those affected by breast and gynaecological cancer, and arises from direct consultation with women with a lived experience of breast cancer;
- BreaCan collaborates with other health and community services, volunteers and service users to deliver and shape programs;
- it is a peer support model based on a social model of health, which addresses the social, emotional and psychological impacts of cancer diagnosis and treatment as a complement to medical treatment.

One of BreaCan's programs is the Bridge of Support, an outreach program in which trained volunteers and BreaCan staff provide support to women undergoing chemotherapy, surgery or attending the outpatient clinic at the Breast Service of Royal Melbourne Hospital and the Sunshine campus of Western Health. Having experienced breast cancer themselves, the volunteers make a remarkable difference to the health and wellbeing of women with breast cancer by understanding, listening and providing hope and confidence to continue with treatment. A 2012 evaluation of the RMH service reported high levels of satisfaction with the service from women, volunteers and hospital staff.[14] It also found that the Bridge of Support had supported almost 50% of the women seen by the Breast Service at the hospital, including many from CALD backgrounds, of whom 79% went on to have further contact with BreaCan.[15] This partnership demonstrates how medical and social models of health can work together to provide connected and person-centred services for women.

As evidenced by the feedback below, BreaCan has a strong and credible reputation with women, service providers and the broader community. It demonstrates how successful a person-centred approach can be when it is based on a social model of health.

"It is an invaluable level of support and understanding and has been of greatest significance in my recovery."

"It has given me motivation to 'keep on going' and to overcome the hurdles of the physical effects of treatment."

"Meeting other people at BreaCan is a good thing… I feel that I am not the only person getting in this kind of situation in life. Knowing these other people doesn't make me feel so isolated. They are also with me battling this disease."[16]

[14] WHV & Royal Melbourne Hospital, 2012, 'The 'bridge of support', an innovative program bringing peer support to the hospital setting' poster at Clinical Oncology Society of Australia Conference, Brisbane.
[15] WHV & Royal Melbourne Hospital, 2012, 'The 'bridge of support', an innovative program bringing peer support to the hospital setting' poster at Clinical Oncology Society of Australia Conference, Brisbane.
[16] Quotes from BreaCan, 2014, *BreaCan Year In Review 2013-14*, Melbourne.

2. Preventing and treating chronic disease

WHV supports the assertion in the discussion paper that our current health care system does not have a strong enough focus on prevention and early intervention, particularly in relation to chronic disease. In order to prevent and reduce the burden of chronic disease on the health care system in 2040, we must start now. Efforts should be focused on effective prevention strategies which address the social determinants of ill health and engage settings outside the traditional health care system, including schools, workplaces and community settings.

Social determinants that increase the risk of chronic disease risk and which disproportionately impact women include:

- limited access to resources and economic participation (such as employment and educational opportunities as well as superannuation);
- gender norms that contribute to a health system that minimises the mental health concerns of women (by dismissing women's concerns) or fails to recognise the social contributors to poor mental health, including experiences of gender-based violence including family violence, sexual assault and sexual harassment; and
- experiences of gender-based discrimination over the life course, including exposure to gender-based violence and trauma resulting from family violence, sexual assault or sexual harassment.

As noted in the discussion paper, chronic disease has a disproportionate effect on older people, people with a mental illness and Aboriginal people. Women live longer than men and are twice as likely as men to experience depression and anxiety disorders.[17] However, policy and programs relating to mental health, ageing and chronic disease have tended to take a gender-blind approach, assuming that what will work for men will work for women, despite the evidence that symptoms, treatment and care pathways for women with these conditions are very different. As a result, prevention strategies, interventions and services have not been tailored towards women and key opportunities to reduce the incidence of chronic disease have been missed, compounding unequal outcomes for women.

Ensuring prevention strategies and treatments for chronic disease are successful requires a gender-sensitive approach, both in relation to health issues that disproportionately affect women, such as gender-based violence and sexual and reproductive health, and in relation to health conditions which on the surface may appear gender neutral. The requirements of male patients are often generalised to women, despite differences in the way women and men experience symptoms or process medication.

Collection of sex-disaggregated data, including longitudinal data to measure change over time, is key to supporting a gendered approach to prevention. There is also a need to invest in robust evaluation and cost-benefit analysis of preventive strategies to build the evidence base for further investment.

The case studies below demonstrate the shortcomings of a health system based on the assumption that what will work for men in relation to chronic disease will work for women.

Case Study 3: Women and cardiovascular health

A gendered approach is important when identifying and treating a range of cardiovascular diseases (CVD) including coronary heart disease, which can lead to heart attacks, stroke and death. CVD is the leading cause of premature death in Australian women.[18] Women are also more likely to die following a heart attack than men as their

[17] Australian Bureau of Statistics 2007, *National Survey of Mental Health and Wellbeing: Summary of Results*, Canberra.
[18] Australian Institute of Health and Welfare, 2010, *Women and heart disease: Cardiovascular profile of women in Australia*, Canberra, p. 1.

symptoms are less likely to be recognised by both the women themselves and by health professionals, and they are less likely to be given appropriate medical treatment. [19]

Women experience different and less recognised symptoms of coronary heart disease such as fatigue, isolated shortness of breath, nausea and vomiting, pain between the shoulder blades and jaw pain.[20] This is in addition to symptoms commonly suffered by men including chest pain or pressure, irregular heartbeat, feeling of indigestion and sweating.

Women also experience additional risk factors for CVD including:

- Women tend to develop CVD approximately 10 years later than men.[21] This has been attributed to the protective properties of oestrogen being reduced once women reach menopause.[22]
- Menopause compounds other traditional risk factors for developing CVD though changes in body fat distribution and increased blood pressure[23].
- The later presentation of CVD in women contributes to likelihood of co-morbidities influencing their treatment and outcomes.[24]

Risk factors for women are also compounded by disadvantage, environmental and socioeconomic factors:

- Women from the most disadvantaged areas of Australia have CVD death rates 29% higher than those women from the least disadvantaged areas.[25]
- Aboriginal and Torres Strait Islander women commonly have more risk factors for CVD than non- Aboriginal and Torres Strait Islander women including higher rates of smoking, diabetes and obesity. [26]

Under-representation of women in cardiovascular trials and research[27] has also resulted in a gender-blind approach to treatment. For example, in 2008, a drug found to prevent heart attacks in men was marketed to both men and women despite the lack of benefits for women.[28] It has also been found that even when women have established CVD, they receive less aggressive care than men.[29]

The differential experience of CVD for women has significant implications for the delivery of health care services. WHV recommends:

- increased representation of women in cardiovascular trials and research; and

[19] Canto J G, et al, 2012, 'Association of age and sex with myocardial infarction symptom presentation and in-hospital mortality', *Journal of the American Medical Association*, Feb 22 vol. 307 no. 8., pp. 813-22; Turnbull F, et al, 2011, ' Gender disparities in the assessment and management of cardiovascular risk in primary care: the AusHEART study', *European Journal of Preventive Cardiology*, vol. 18 no. 3, pp. 498-503; Gippsland Women's Sexual and Reproductive Health Survey Report, Gippsland Women's Health Service, 2012, Gippsland Women's Sexual and Reproductive Health Survey Report, Gippsland;
Sahil Khera et al, 2015, 'Temporal Trends and Sex Differences in Revascularization and Outcomes of ST-Segment Elevation Myocardial Infarction in Younger Adults in the United States', *Journal of American College of Cardiology,* vol. 66 no. 18. pp. 1961-1972; and Erica C. Leifheit-Limson et al, 2015, Sex Differences in Cardiac Risk Factors, Perceived Risk, and Health Care Provider Discussion of Risk and Risk Modification Among Young Patients With Acute Myocardial Infarction, *Journal of American College of Cardiology,* vol. 66 no. 18, pp. 1949-1957.

[20] Correa-De-Araujo R, 2006, 'Serious Gaps: How the lack of sex/gender based research impairs health', *Journal of Women's Health*, vol. 15 no. 10, pp. 1116-1122.

[21] Hung J, 2006, 'Aspirin for primary prevention of cardiovascular disease in women: does sex matter?' *Medical Journal of Australia,* vol. 184 no. 6, pp. 206-261.

[22] . Mendelsohn M, 2008, 'Hormones and cardiovascular disease', *Gynaecological Endocrinology,* vol. 24 no. 9, pp. 483-484.

[23] Rosano GMC, Vitale C, Marazzi G et al, 2007, 'Menopause and cardiovascular disease: the evidence', *Climacteric* vol. 10 no. 1, pp. 19-24.

[24] Antoniucci D, 2006, 'Acute myocardial infarction: do women benefit from primary angioplasty?', EuroPCR The Paris course on revascularization.

[25] Australian Institute of Health and Welfare, 2006, ' Socioeconomic inequalities in cardiovascular disease in Australia', *Bulletin* Issue 37 August.

[26] Penm E, 2008, 'Cardiovascular disease and its associated risk factors in Aboriginal and Torres Strait Islander peoples 2004–05', *Cardiovascular disease series* no. *29*, Australian Institute of Health and Welfare , Canberra.

[27] Hung J, 2006, ' Aspirin for primary prevention of cardiovascular disease in women: does sex matter?', *Medical Journal of Australia,* vol. 184 no. 6, pp. 206-261.

[28] Dobson R, 2008, ' Atorvastatin advertising misled over benefits for women, study claims,' *British Medical Journal* vol. 337, a2209.

[29] Cho L, et al, 2008, 'Gender Differences in Utilization of Effective Cardiovascular Secondary Prevention: A Cleveland Clinic Prevention Database Study', *Journal of Women's Health* vol. 17 no. 4, pp. 515-521.

- education about the differential risk factors for, and symptoms of, CVD in women, for both health professionals and women, particularly targeting higher risk population groups.[30]

Case Study 4: Women and mental health

Depression is a major health problem for Australian women and is frequently accompanied by other psychological problems such as anxiety disorders and post-traumatic stress disorder.[31] Women are more likely to experience depression and anxiety than men.[32] Violence is linked to increased incidence of depression and women are more likely to be victims of violence than men.[33] One in six women will also experience post-natal depression, which is under-diagnosed and treated.[34]

The nature of suicide and suicide attempts is also gendered. Whilst men commit suicide three times more often, women attempt suicide three times more often than men.[35] Despite this, suicide prevention services are overwhelmingly directed at men.[36]

The World Health Organisation argues that women's higher rate of depression can be linked to the social determinants of health, including the prevalence of men's violence against women, discrimination and higher rates of poverty.[37] It is now also recognised that gender-based expectations about roles, responsibilities and power relations, and gendered divisions of labour in the economy, the home and the community, contribute to women's higher risk of depression.[38]

Gender-based discrimination and stigma (for instance in relation to pregnancy or parenting with a mental health condition) and the experience of gender-based violence (and resultant trauma) both causes and perpetuates women's experience of mental illness over a lifetime.

A gender-sensitive approach to chronic mental health issues would recognise the gendered nature of depression, anxiety and suicidal behaviour, and the social and structural inequities that contribute to poor mental health among women, in order to design policies and programs that better prevent and respond to women's experience of these chronic conditions. Investment in women's only psychiatric wards provides an example of a specific initiative that would lead to improved mental health outcomes and experiences for women.

A gender-sensitive approach would also recognise that by reducing men's violence against women, we would also reduce the incidence of depression and anxiety among women. For example, a 2012 evaluation of the Doncare Angels for Women Network (DAWN) Program showed that rates of depression and anxiety among women recovering from domestic violence who were matched to a DAWN mentor were dramatically reduced. The average depression rating declined from 'Severe' to 'Moderate' by the end of the program and 87% reported feeling happier.[39]

[30] For example, Multicultural Centre for Women's Health has been working collaboratively with other stakeholders, such as the Heart Foundation and Diabetes Victoria, to ensure its Health Education Program is updated and its Bilingual Health Educators are receiving ongoing trainings so they are updated and competent in providing education to women from different cultural backgrounds.
[31] Guggisberg, M, 2006, 'The interconnectedness and causes of female suicidal ideation with domestic violence', *Australian e-Journal for the Advancement of Mental Health*, Vol. 5 no.1.
[32] Beyond Blue, *Depression and Anxiety Disorders in Women*, 2011, p. 1.
[33] WHO, 2005, *Gender in Mental Health Research*. Department of Gender, Women and Health Family and Community Health. Geneva, World Health Organisation.
[34] Suicide Prevention Australia, 2015, *Suicide and Suicidal Behaviour in Women :Issues and Prevention*, p. 20. & Women's Health Victoria, 2011, *Women and suicide*: Gender Impact Assessment 15, Melbourne, p. 7.
[35] Australian Bureau of Statistics., 2010, *Yearbook Australia 2009-10*, Canberra.
[36] Women's Health Victoria, 2007, *Women and depression*: Gender Impact Assessment 1, Melbourne, p. 2.
[37] WHO, 2005, *Gender in Mental Health Research*. Department of Gender, Women and Health Family and Community Health. Geneva, World Health Organisation.
[38] Bishop, A, 2002, 'Depression and gender issues.' In: *A Gender Agenda: Planning for an Inclusive and Diverse Community*. Women's Health West, Footscray.
[39] Doncare, 2013, *DAWN Evaluation Report 2007-2012*, Melbourne, pp. 15. 23.

Gender Impact Assessment: Women and suicide, Women's Health Victoria 2011

As part of our gender advocacy work, WHV produces topic-based Gender Impact Assessments. They highlight policies and practices that are gender-blind, and make recommendations that promote gender sensitivity and improved outcomes for women.

WHV's 2011 Gender Impact Assessment on women and suicide unpacked the complex interplay between gender and other social determinants of suicide among women, and highlighted the need for a gender-sensitive approach when designing programs for women suffering from depression and other mental illnesses.

The research paper highlighted the different risk factors for mental illness and suicide among women, including higher rates of self-harm, body image dissatisfaction and related disorders, sexual abuse and intimate partner violence, and postnatal depression, as well as structural inequalities arising from social isolation, unequal access to economic resources and discrimination.[40]

The paper made a number of recommendations including:

- Increased data accuracy through the establishment of a separate data category for suicide attempts, as distinct from 'intentional self-harm' (currently the number of people who self-harm without the intention of suicide cannot be distinguished)
- Consistent reporting of sex-disaggregated data (including sexual and gender identity demographic categories) on suicide, suicide attempts and mental health
- Well-articulated policies and strategies to promote women's mental health and wellbeing and address women's risk factors for suicide, including strategies on body image, bullying, social inclusion and respectful relationships;
- Gender- and culturally sensitive mental health literacy programs and resources;
- Gender-sensitive service provision to meet the needs of women at risk; and
- Mandatory guidelines for treating those who have attempted suicide.

Women and suicide's recommendations were endorsed and promoted by suicide prevention peak body Suicide Prevention Australia in July 2015 in their landmark discussion paper *Suicide and Suicidal Behaviour in Women: Issues and Prevention*, which noted that a gender lens had not previously been applied to suicide. Suicide Prevention Australia recommended collaboration with women's health organisations to develop sustainable prevention and early intervention strategies for women.[41]

[40] Women's Health Victoria, 2007, *Women and depression*: Gender Impact Assessment 1, Melbourne; Bishop, A, 2002, 'Depression and gender issues, ' in *A Gender Agenda: Planning for an Inclusive andDiverse Community*, Women's Health West, Footscray.
[41] Suicide Prevention Australia, 2015, *Suicide and Suicidal Behaviour in Women :Issues and Prevention*, Sydney, p. 32.

3. Improving people's health outcomes and experience

WHV supports empowering patients to make informed choices regarding their healthcare treatment and service options. For women, meaningful choice includes the ability to access women-centred, specialist services that recognise the way gender impacts heath across the lifespan.

For example, there remains an almost total absence of specialist services for injecting drug users or those with blood borne viruses that are able to contextualise medical care within a framework acknowledging the different experiences, needs and priorities of women. Case Study 5 shows how this has a profound impact on the way women experience the health system and directly impacts their health outcomes.

While the paper highlights that one of the challenges facing our health system is 'lifestyle choices and behaviours that are contributing to higher levels of chronic disease', the paper misses the opportunity to contextualise the 'choices' people make within a broader social context where lack of health literacy and lack of regulation around advertising limits meaningful choice, which negatively affects people's experience of healthcare, as well as their outcomes.

Addressing disparities in health literacy on priority health issues for women and for priority population groups, including Aboriginal people, those in rural areas and socio-economically disadvantaged groups, is critical to improving health outcomes. Technological solutions, including e-Health initiatives, should be developed to improve health literacy, and enhance people's health care experience and outcomes, as well as to enable better care for an ageing population.

Case Study 6 on WHV's *Labia Library* provides an example of how an innovative, technology-facilitated strategy developed by a specialist women's health service can improve health literacy, support improved outcomes and experiences, resource health professionals and reduce costs to the health care system.

The development of gender-disaggregated outcomes measures across all areas of health would demonstrate the need for, and benefits of, gender-sensitive health care, assist in targeting resources and effort, and ultimately improve health outcomes for women. Case Study 7 demonstrates how the Victorian Women's Health Atlas is providing sex-disaggregated data to assist health services, local governments and other organisations to bring a gender lens to health issues. WHV recommends that the Victorian Government mandate that funded organisations provide sex-disaggregated data, research and evaluation.

Case Study 5: Specialised service delivery - a gendered approach to Hepatitis C (HCV)

Drug use and access to drug-related health services are profoundly gendered, for example:

- Most users, dealers and traffickers are men. As a result, policy interventions and services have tended to be aimed at men, and their impact on women is not seriously taken into account.
- Gendered expectations around motherhood and femininity mean that women face additional stigma and more obstacles to accessing testing and treatment services, particularly when accessing health services during pregnancy. For these reasons, women have been found to be less likely to seek medical treatment for Hepatitis C (HCV) than men.[42]

[42] McNally, S. & Temple-Smith, M, 2004, 'Psychological and social factors associated with uptake and maintenance of clinical treatment for hepatitis C', in *Australian Research Centre in Sex, Health and Society,* La Trobe University, Melbourne.

- Experiencing domestic violence not only increases women's risk-taking behaviour, but also creates barriers to women's efforts to access treatment and obtain stable accommodation and reliable income.
- Women have also reported that their ability to engage in treatment for HCV is impacted by their need to care for dependants, indicating a lack of appropriate child care or accommodation in connection with HCV programs.

Responses to women involved with illicit drugs must take gender into account to produce successful outcomes.[43] To be effective, policy relating to prevention, testing and treatment must take a gendered approach which recognises and is responsive to women's experience.

HCV is mainly spread through the sharing of equipment by injecting drug users.[44] Recognising that women face additional stigma and other barriers to accessing drug treatment services, Needle Syringe Programs (or Needle Exchange Programs) should be designed to provide safe access for women. A women-only needle and syringe program could provide testing, treatment and other health services, including those related to pregnancy and parenting. The staff at women-only needle and syringe programs would be trained to work with women to achieve better health outcomes, including through undertaking risk assessments for domestic violence and homelessness. A childcare service would also enable women with dependants to attend the program.

Case Study 6: Improving women's health literacy - the Labia Library

The Labia Library[45] is a web-based health literacy project that was developed by WHV to show women that, just like any other part of the body, labia come in all shapes and sizes.

WHV became aware that genital appearance was becoming a significant contributor to women's poor body image when Victorian health professionals reported a rapid and dramatic increase in requests for purely cosmetic genital surgery between 2001 and 2011.[46] WHV was concerned that many women lack knowledge about what healthy female genitals actually look like and get inaccurate ideas about what's normal from magazines and pornography, resulting in poor body image and impacting on their mental health and wellbeing.[47]

The website is a world-first. It features a photo gallery that shows real, unaltered images of women's genitals. As well as equipping women and girls with information about the natural diversity of female genitals to support positive body image, the website busts myths about how normal genitals look, addresses common concerns around issues like labia size and shape, and equips women with media literacy so they can understand the genital images they see in magazines and pornography.

Due to the unique, innovative and specialist nature of the website, reach has exceeded all expectations. Since its launch in September 2013, the Labia Library has been visited by millions of users from 235 countries around the world. There has been overwhelmingly positive feedback from almost 10,000 voluntary Labia Library user surveys, indicating that the website has not only improved body image perceptions for young women in Victoria, but for women of all ages all around the world:

[43] Stengel, C. & Fleetwood, J, 2014, 'Developing drug policy: Gender Matters', in *GDPO situational analysis, Cardiff: Global Drug Policy Observatory*, Swansea University.
[44] An estimated 80% of existing infections in Australia result from the sharing and re-using of injecting equipment, and around 90% of new infections occur this way, Hepatitis Victoria, 2012, *Impact, Information about Hepatitis C*, Melbourne.
[45] www.labialibrary.com.au
[46] Department of Health and Ageing, 2012, *Medicare Benefits Schedule item statistics report : Item 35533* [Requested Medicare items processed from January 2000 to December 2011]. Canberra.
[47] Braun V, 2010, 'Female genital cosmetic surgery: a critical review of current knowledge and contemporary debates', in *Journal of Women's Health*, vol. 19 no. 7, pp. 1393-407.

"I think its [sic] great to show the differences. I am 38 and I have thought for a long time that I need labia surgery it's a relief to see many like me. Thank you for taking my worst insecurity and making me feel normal."

"Thank you for this site! It's very informative in a way that doesn't bombard me with scientific terms, but in a perfect way that provides good need-to-know information."

"I have always had insecurities about the appearance of my genitalia. Do I look normal? What does the appearance signify? To whom do I ask these questions? Your site has answered them all.... Thank you for creating a change in my self esteem."[48]

As this feedback attests, the Labia Library is a powerful tool that enables women and girls in Victoria and all over the world to access high quality information in a way that empowers them to feel happy and healthy in their bodies.

The Royal Australian College of General Practitioners now recommends doctors refer patients to the Labia Library to help them understand the diversity of genital appearance, thereby reducing demand for unnecessary surgery.[49]

Case Study 7: Using sex-disaggregated data to improve women's health – the Victorian Women's Health Atlas

The Victorian Women's Health Atlas has been developed by WHV, in collaboration with other state-wide and regional women's health services in Victoria. Its purpose is to provide reliable data for evidence-based planning which will contribute to lasting improvements in the health of Victorian women. The Atlas is an interactive resource that shows gender differences covering indicators for Sexual Health & Reproduction, Gendered Demographics, Mental Health and Violence against Women for each local government area in Victoria.

For example, the Victorian Women's Health Atlas can be used to influence urban planning and design to ensure that our built environment can be enjoyed equally by all Victorians. Users of the Atlas can see sex-disaggregated data measuring the proportion of men and women who felt safe walking in their local areas at night. The data reveals significant discrepancies between men and women. In one local government area, for example, 81.7 per cent of men felt safe at night, while only 40.3 per cent of women reported feeling safe.[50]

We know that women's experience of street sexual harassment and assault contributes to poor mental health, limits women's ability to contribute equally in the communities and the ability of women to take exercise and maintain a healthy lifestyle. Understanding the gender differences in perceptions of safety enables local governments to identify and implement measures that will both improve women's health and enhance community safety. For example, the council may decide to install more street lamps to increase visibility in public spaces.

The Victorian Women's Health Atlas demonstrates the way in which sex-disaggregated data can improve policy and program responses to women's health issues.

[48] All quotes from the voluntary *Labia Library User Survey*, Women's Health Victoria, 2014-2015.
[49] Simonis, M, 2015, *Female genital cosmetic surgery – A resource for general practitioners and other health professionals*. Royal Australian College of General Practitioners, Melbourne, p. 9& 13.
[50] Community Indicators Victoria, 2011, in' Violence Against Women: Perceptions of Safety', *Victorian Women's Health Atlas,* Women's Health Victoria, Melbourne.

4. Improving the way the system works together

We agree with the discussion paper's assertion that 'a system that doesn't work together well impacts disproportionately on people who are most vulnerable and most likely to be multiple service users.' We also agree that when the health system does not work well with other services, the impacts are especially felt by those who are most vulnerable, including victims of family violence, who are overwhelmingly women. A robust, well-resourced and specialist women's health service sector is our best asset in ensuring that the broader health and welfare systems provide women with the best, and earliest response.

Efforts to improve the way the system works together should be focused on increasing health literacy and health promotion; integrating prevention, primary and acute care; and integrating pathways between specialist and generalist services to support a person-centred approach so that no matter which service a person first enters, they are supported to receive the most appropriate response.

Victoria's network of specialist women's health services is a key strength of a healthcare system that prioritises better outcomes for women. In Victoria, evidence shows that women achieve better health outcomes where strong and well-resourced women's health services exist.[51] It is in the interests of policy makers and generalist health services to partner with Victorian women's health services to develop strategies and actions to improve the health of Victorian women. This will, in turn, improve the health of the Victorian population and reduce the burden of ill health and disease across the state.[52]

Women's health services have reach into metropolitan and regional areas and are well-positioned to implement government prevention initiatives on women's health. Regionally-located women's health services engage in health and community planning and lead area-based health prevention initiatives in the community, in tandem with local, state and federal governments, and other community organisations.[53]

With their emphasis on, and strong skills in, integrated health promotion, Victorian women's health services straddle the health, human services and community development sectors. Their partnerships with local government, community health, community organisations and peak bodies, as well as with the acute sectors in health, family violence, sexual assault, crime, emergency relief and mental health, result in alliances and expertise that enable effective prevention approaches. Women's health services have the capacity to encourage gender transformative policy and practice by changing the way communities view, value and assign roles to women and men.[54]

Case Study 8: The role of women's health services in regional planning to prevent violence against women

Women's health services provide health promotion, research, advocacy, training, direct services and activities across Victoria designed to promote the health, safety and wellbeing of women.

Primary prevention of violence against women is a growing field of practice that has gained considerable momentum in Victoria over the last decade. Victoria's women's health services have long identified men's violence against women as a priority and are leaders in regional action to address its social determinants, drawing on our expertise in integrated health promotion. We also know that working together produces more powerful results than any single organisation could achieve alone.

[51] Women's Health Association of Victoria , 2015, Priorities for Women's Health 2015-2019, Melbourne, p. 9.
[52] Women's Health Association of Victoria , 2015, Priorities for Women's Health 2015-2019, Melbourne, p. 9.
[53] Women's Health Association of Victoria , 2015, Priorities for Women's Health 2015-2019, Melbourne, p. 5 &30.
[54] Women's Health Association of Victoria , 2015, Priorities for Women's Health 2015-2019, Melbourne, p. 30.

Addressing the social determinants of violence against women is our best evidenced strategy for addressing the attitudes and beliefs that support gender inequality and enable violence against women to continue. Women's health services are leading prevention efforts across the state, with WHV leading and coordinating these efforts through:

- mapping existing activities, avoiding duplication and identifying gaps;
- collecting and analysing data and evidence;
- developing innovative new strategies including fostering partnerships with non-traditional stakeholders such as businesses;
- developing best practice guidelines for regional planning of initiatives to prevent violence against women.

The expertise and credibility of specialist women's services remains the greatest asset our society has in addressing violence against women. Protecting and nurturing these organisations, enabling them to build the capacity of others is the bedrock of effective policy development, system reform and primary prevention strategies.

Preventing Violence Together: Women's Health West

Preventing Violence Together is the regional agreement, partnership and action plan to guide the primary prevention of violence against women in the western region of Melbourne.[55] Launched in 2010 and led by Women's Health West, *Preventing Violence Together* was Victoria's first collaboratively-developed, regional action plan and partnership dedicated specifically to the primary prevention of violence against women. Under the agreement, Women's Health West partners with 18 organisations including local governments, community health, family violence services, sexual assault services, primary care partnerships, Indigenous services, Victoria Police and the Department of Justice & Regulation.

Women's Health West's role as lead agency *for Preventing Violence Together* is to design and deliver prevention of violence against women training packages and manuals and capacity building forums and workshops, write law reform submissions, and develop audit tools and conceptual frameworks to support partners to undertake gender equity work in their organisations. Each partner organisation has committed to a number of actions that it will implement internally. Drawing on the VicHealth evidence-base[56] to respond to the determinants of violence against women – that is, the factors that cause men to commit violence against women – these actions are designed to foster cultures of gender equity, nonviolence, and respect.

Key outcomes to date include:

- all partners have prevention of violence against women embedded in their strategic or operational plans;
- a model Gender Equity policy and Gender Audits Guidelines Tool have been developed;
- a Prevention of Violence against Women training package and Preventing Violence Together resource hub have been developed; and
- various capacity building sessions have been delivered for staff within partner organisations, for example on engaging men in prevention of men's violence against women, conducting gender audits, women's leadership and unconscious gender bias, and working with culturally and linguistically diverse communities.

[55] Women's Health West, 2010, *Preventing Violence Together: The Western Region Action Plan to Prevent Violence Against Women*, Melbourne.
[56] VicHealth, 2009, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*, Melbourne, p. 13.

The Australian Research Centre for Sex, Health, and Society has been engaged to independently evaluate the project, VicHealth's Partnership Survey is conducted annually to determine the partnership's strengths and weaknesses, and evaluations of all capacity-building, training sessions and advocacy campaigns are undertaken.

In seeking to end men's violence against women, the *Preventing Violence Together* regional partnership demonstrates a promising model in which women's health services take the lead in advancing the primary prevention of men's violence against women in Victoria.

5. Better health for people in rural and regional areas

Women in regional and rural locations encounter further barriers to accessing healthcare, including prevention and health promotion activities. These barriers include, but are not limited to, geographic and social isolation, economic disadvantage, challenges with maintaining anonymity and privacy, limited public transport networks, and fewer support and health services than are available in metropolitan areas.[57] This results in healthcare by 'postcode', where access to healthcare, and in particular sexual and reproductive health services such as contraception and pregnancy termination, varies greatly depending on where you live.

Women seeking support in regional and rural areas may also encounter the 'digital divide' when accessing information and assistance (for example limited internet access or computer skills), as well as additional risk factors for domestic violence such as higher levels of perpetrator gun ownership.[58] Services and support for Aboriginal and Torres Strait Islander survivors of family violence, culturally and linguistically diverse survivors and survivors with disabilities are also more limited in rural and regional areas.

Addressing disparities in health for people in rural areas is a clear priority. Investment in innovative and technological solutions should be harnessed to deliver better outcomes for people in regional areas, and must be accompanied by strategies to increase access to electronic and internet-based health services. Examples of technological advances to help reduce healthcare barriers for people in rural areas and other hard-to-reach population groups include: the introduction and roll out of self-administered pap tests and sexually transmitted infection tests, which can be posted to health services for testing; telehealth consultations; and dissemination of culturally appropriate health information via electronic devices.

Victorian women's health services work flexibly at the regional level, responding to specific local priorities and needs, and fostering long-term relationships and engagement with communities, businesses and local government.

Case Study 9: A gendered approach to disaster management in regional and rural Victoria

As a result of climate change, it is expected that rural and regional Victoria will experience more extreme weather events, such as heat waves and bushfires. In planning for extreme events, it is important to consider the differential impact of emergencies and disasters on women and men. For example, women's experience in times of natural disaster includes:

- Increased risk of injury and death – women are 14 times more likely to die in a natural disaster
- Increased violence against women
- Health impacts arising from women caring for others and ignoring their own health
- Bearing the impact of difficulties accessing key resources, including money/ financial benefits, food and water, and safe spaces. [59]

Gender affects how women and men experience and recover from natural disasters, which can both reinforce and subvert gender norms and roles. For example, the aftermath of a natural disaster can severely affect women's return to the workforce. This is compounded by disruption of schools and child care services, because women are expected

[57] Rural Victorian Women's Health Services, 2012, *Victorian Rural Women's Access To family Planning Service Survey Report*, Project of the Rural Services of the Women's Health Association of Victoria, p. 6.
[58] George, Amanda and Harris, Bridget, 2014, Landscapes of Violence: Women Surviving Family Violence in Rural and Regional Victoria, p. 3.
[59] Women's Health Loddon Mallee,2010, *The Health Impacts of Climate Change and Drought on Women in the Loddon Mallee region*, Loddon Mallee, p. 11.

to take primary responsibility for child care.[60] On the other hand, research undertaken by Women's Health Goulburn North East found that, when women's voices were heard and documented, gender stereotypes of men as 'protectors' and women as 'protected' were challenged, with women equally likely to play the role of 'knight in shining armour'.[61]

Consequently, risk management and planning processes around extreme weather events need to include women to ensure their needs are considered in decision-making about resource allocation, services, supports and infrastructure post-crisis. Undertaking a gendered analysis of the roles women are expected to, or do, fulfil also assists in tailoring disaster responses to mitigate specific risks facing women (such as increased violence) and meet their health and support needs.

Women's Health Loddon Mallee, Women's Health Goulburn North-East and Women's Health In the North are playing a leading role in raising awareness of the importance of bringing a gender lens to disaster planning and emergency management.

For example, Women's Health Loddon Mallee has worked with Macedon Ranges Shire in the development of its Prevention of Violence Against Women in Emergencies Action Plan. The Plan utilises a gender lens to assess and respond to women in disaster – as residents, emergency services personnel, community and emergency services leaders, first responders and recovery responders. The Plan's strategies include:

- identifying where different approaches may be needed with men and with women to achieve the desired outcomes;
- developing knowledge and understanding of gender differences in how emergencies are experienced;
- developing knowledge of how to incorporate gender into decision-making, policy development and service delivery;
- creating a better gender balance in the emergency management sector to reduce the historical and cultural domination of the sector by men; and
- encouraging and supporting the collection and use of sex- and age-disaggregated data by agencies following emergencies.[62]

These strategies will help ensure that the relevant authorities can make informed and evidence-driven decisions that are responsive to gender at all stages of disaster response.

Women's Health In the North and Women's Health Goulburn North East resource and convene the Victorian Gender and Disaster (GAD) Taskforce, which is attended by over 20 leaders from emergency service organisations and key community members. The GAD Taskforce is an important forum for supporting the work of organisations in addressing gender as an influential factor in their work.

These two Women's health services have partnered with Monash University's Injury and Research Institute to create the Gender and Disaster (GAD) Pod, a first in Australia. The GAD Pod has been commissioned to undertake training for Emergency Service Organisations about family violence after disaster, gender equity and the disproportionate impacts of disaster on women, to undertake research and to develop National Gender and Emergency Management guidelines.

[60] Women's Health Goulburn North East, 2012 , *The relevance of gender in disaster snapshot 2*, Goulburn North East.
[61] Women's Health Goulburn North East, 2012 , *The relevance of gender in disaster snapshot 2*, Goulburn North East.
[62] Macedon Ranges Shire Council, 2015, *Prevention of Violence Against Women in Emergencies Action Plan 2015-16*,Macedon Ranges, p. 3.

Case Study 10: Regional women's health services working with the community to improve health outcomes

Gippsland Women's Health (GWH) collaborates with partners and stakeholders in order to achieve the best outcomes for women in their region. GWH convenes and facilitates the Sexual and Reproductive Health Reference Group, whose membership includes representatives from the school nursing program, the health and community sector, primary care partnerships, state and local government and Gippsland Primary Health Network. The Reference Group's vision is: *for young people in Gippsland to have a respectful and responsible approach to sexuality and the right to safe, positive sexual experiences.*

Among the Reference Group's objectives has been to increase access to condoms and contraception in Gippsland. ABS data had shown that rates of adolescent pregnancy in the region had more than doubled and the rate of sexually transmitted infections had almost tripled between 2008 and 2011, with both surpassing the Victorian average.[63]

Limited access to sexual health services and contraceptives, including condoms, was identified as a key barrier in the *Victorian Rural Women's Access to Family Planning Services* survey[64] as well as GWH's *Gippsland Women's Sexual and Reproductive Health* survey.[65] GWH also mapped access to condoms in Wellington and Latrobe City local government areas. Based on a project in northern Victoria, Gippsland Women's Health has partnered with local governments to install condom vending machines in public toilets across the region. The condom vending machine project is a way to create a supportive and accessible environment for sexual health which removes some of the barriers to condom purchase (including cost, because they are purchased individually, and anonymity). GWH held funds for the project, developed Memoranda of Understanding and liaised with councils and sporting clubs. Key partners include local councils, Primary Care Partnerships, sporting clubs and GippSport.

Bass Coast Shire Council has now installed six condom vending machines, Morwell Football and Netball Club have installed a machine, and negotiations are continuing with other local councils. Headspace has consulted with young people and found that the majority of young people were 'extremely positive' about the benefits of condom vending machines.[66]

[63] Australian Bureau of Statistics, 2011, *Profile.ID Baw Baw Shire Five Year Age Groups*, Baw Baw Shire Council.
[64] Rural Victorian Women's Health Services, 2012, *Victorian Rural Women's Access To family Planning Service Survey Report*, Project of the Rural Services of the Women's Health Association of Victoria, p. 6.
[65] Gippsland Women's Health Service, 2012, *Gippsland Women's Sexual and Reproductive Health Survey Report*, Gippsland, pp. 12-13.
[66] Headspace Central West Gippsland, 2015, *Sexual Health and Youth (2): A Qualitative Study*, Gippsland, p. 16.

6. Valuing and supporting our workforce

As noted in the discussion paper, our health workforce is vital to the health and wellbeing of Victorians. Each of the opportunities to improve healthcare provision by 2040 outlined in previous sections of this submission is reliant on a highly skilled, motivated and diverse health workforce. Whether in a regional community health service, the emergency department of a major metropolitan hospital or over the phone, every day health professionals make a real and meaningful difference to the lives of their patients.

Health services are also a major employer, and there are many opportunities to build the capacity of the workforce by supporting workers and workplaces to be healthy, inclusive and safe. Achieving this begins with recognising that healthcare professions such as nursing, health promotion, social work and community health are female-dominated. Women are over-represented in casual and shift work, and under-represented at the management and board level. As has come to light recently through the Royal Australasian College of Surgeons' investigation into systemic sexual discrimination, healthcare workplaces (like other workplaces where power is unevenly distributed between men and women) can be discriminative, isolating and even dangerous places for female professionals, significantly impacting on workplace morale and personal wellbeing.

Workplaces have been referred to as the 'next frontier in health promotion'. Many of us spend much of our time in the workplace, meaning that health promotion workers can access a captive audience, and workplaces themselves can offer incentives to improve staff health and wellbeing. Workplaces are also a barometer for acceptable social norms and behaviours that impact on health and productivity (for example, race- or gender-based discrimination) and are therefore an optimal setting for achieving cultural and attitudinal change.

There are opportunities to strengthen our health workforce by investing in programs that address gender equity by identifying harmful cultures, attitudes and behaviours in workplaces, as well as removing structural barriers to gender equality by reviewing formal organisational processes and policies. Policies that promote health and wellbeing for individual workers and address gender equity in the workplace include introducing family violence clauses in enterprise bargaining agreements and/or committing to gender equity in all managerial and board appointments.

WHV congratulates the Victorian Government on its promise to pursue gender equity in all future appointments to Victorian public boards. This commitment represents a significant step towards achieving gender equity in Victoria and will lead to improved results for public organisations, including public health services. Studies suggest that promoting gender equality is associated with better organisational performance, a benefit for staff and patients alike.[67]

Finally, it is also important to recognise the under-recognised and under-supported role that carers play, and have always played, in providing informal and unpaid healthcare support. A significant amount of unpaid healthcare provision occurs outside the formal healthcare system and is undertaken by carers, around two thirds of whom are women.[68] Empirical literature suggests that the self-rated physical health of carers for a person with a disability is worse than the physical health of the general population.[69] Carers, in particular carers who are also employed in paid work, experience higher levels of emotional strain, depression, somatic symptoms, physical exhaustion and burnout,

[67] Workplace Gender Equity Agency, 2013, *The business case for gender equality*, Australian Government.
[68] Australian Bureau of Statistics, 2015, *Gender Indicators: Providing primary care to people with a disability*; Women's Health Victoria, 2015, 'Gendered demographics: Unpaid assistance to a person with a disability', *Victorian Women's Health Atlas,* Melbourne.

[69] Edwards, B, 2008, 'Empirical findings on the physical health of carers', in *The nature and impact of caring for family members with a disability in Australia: research report no. 16*, Australian Institute of Family.

than the general population.[70] Carers also often miss their own health appointments due to their caring responsibilities.[71]

Carers make a significant contribution to the sustainability of the healthcare system. Without carers, the healthcare system would be under further pressure by 2040, especially in relation to the management of chronic disease, mental health and aged care. The disproportionate impact of caring on women needs to be acknowledged, and their critical role supported. It is WHV's vision that, by 2040, progress made towards gender equity will mean that the provision of unpaid care is shared more equally between men and women.

Case Study 11: Workplace-based primary prevention - Take a Stand

Developed by Women's Health Victoria, Take a Stand is a program that strengthens the organisational capacity of workplaces (male-dominated workplaces in particular) to address attitudes and behaviours that enable men's violence against women. Take a Stand works with organisations to implement policies and equip bystanders to challenge violence-supportive attitudes and promote respectful relationships between men and women.

The aims of the *Take a Stand* program are to:

- Prevent violence against women using the workplace as the setting by addressing its causes or determinants, namely:
    - unequal power relations between women and men;
    - adherence to rigid gender stereotypes; and
    - broader cultures of violence.
- Strengthen the organisational capacity of workplaces to promote equal and respectful relationships between women and men; and
- Engage employees in skills development to speak up against attitudes and behaviours that sustain violence in our community.

Take a Stand takes a 'whole-of-workplace' approach to preventing domestic violence. The approach includes the introduction of a workplace domestic violence policy, training for staff, support for trainers, and provision of information about promoting workplace violence prevention initiatives and strategies.

This multiple award winning[72] primary prevention program, originally funded by VicHealth and piloted at Linfox, has been highly successful. The evaluation showed that participants felt they were more likely to challenge violence-supportive attitudes and behaviours as a result of the training, and understood how violence against women occurs on a continuum of sexism:

- 87 % felt that the training helped them understand how things people say or do can support domestic violence.

[70] Skinner, N & Pocock, B, 2008, 'Work–life conflict: Is work time or work overload more important', *Asia Pacific Journal of Human Resources,* vol. 46, no. 3, pp. 303-315.
[71] Essue, B et al, 2011, 'We can't afford my chronic illness! The out-of-pocket burden associated with managing chronic obstructive pulmonary disease in western Sydney, Australia', *Journal of Health Services Research and Policy',* vol. 16, no. 4, pp. 226-231.
[72] Certificate of Merit, Australian Crime and Violence Prevention Awards, 2009,VicHealth Award, 'Organisational Development' Category, 2010, and Victorian Community Sector Awards, 'New approaches to Partnerships with Philanthropy and Business' Category, Runner-up, 2010.

- 89% felt that they were very likely or quite likely to speak out against domestic violence as a result of the training.[73]

Since 2012, WHV, Women's Health Loddon Mallee and Women's Health and Wellbeing Barwon South West have delivered *Take a Stand* using a 'Train the Trainer' model that has reached more than 3000 employees across a range of workplaces around the state.[74]

By addressing gender norms and violence-supportive attitudes, *Take a Stand* also addresses issues such as bullying and harassment, which has been found to be widespread in some health professions, such as surgery, and could be rolled out or used as a model for the development of gender-based violence prevention programs for health services.

[73] Women's Health Victoria, 2012, 'Everyone's business: A guide to developing workplace programs for the primary prevention of violence against women', Melbourne.
[74] A recent article on the implementation of *Take A Stand* in the Barwon South West region can be found online at: http://www.standard.net.au/story/2633422/time-is-right-to-take-a-stand/?cs=75