The Women's Community Health Network's response to the WA Women's Health and Wellbeing Policy draft

Context and background

The Women's Community Health Network (WCHN) supports the priority issues and population groups outlined in the Policy draft. We understands the importance of making the Policy as concise, succinct and accessible as possible. However, it is important that the main policy document provide context and background that clearly conveys the rationale for a health and wellbeing policy with a focus on women. The evidence strongly supports violence against women, gender inequity and the social determinants of health being the headline items (or overarching principles) from which the policy flows.

The reader needs to be provided with sufficient information at the outset of the Policy to develop an understanding of the differences between men and women and the complexity of gender and the way in which it influences health and wellbeing. Gender differences encompass biology, the roles and responsibilities that society assigns to men and women and their position in the family and community. Evidence confirms that these factors all have a great influence on the causes, consequences and management of diseases and ill-health and on the efficacy of health promotion policies and programmes. Women and men have marked variations in patterns of health/mental health and in service utilisation.

The Women's Community Health Network recommends that the Policy be strengthened by positioning the social determinants of health as an organising principle of the Policy and using these determinants to guide the development of actions. Many of the Policy's actions focus on service provision without accompanying actions that are designed to redress structural drivers of poor health. A social determinant approach best ensures effective, sustainable and equitable outcomes for all women, their families and communities. It recognises that the conditions in which people are born, grow, live, work, play and age directly affects their health outcomes (CSDH, 2008).

We also recommend that the Policy gives gender inequity a more prominent focus. Gender inequity combined with intersecting forms of disadvantage directly affect health outcomes for individuals, families, communities and our wider society. WCHN strongly suggests a greater engagement with primary prevention and universal strategies to address gender inequality as a driver of health outcomes for women (in addition to early intervention). Structural gender inequality continues to impact health outcomes for women. We see an opportunity to more clearly articulate gender inequality as a driver of poor or uneven health outcomes, and to integrate primary prevention efforts into the Policy.

Primary prevention would leverage universal strategies to address gender inequality as a driver of poor or unfair health outcomes for women. Improving gender equity (including support for specialist and gender sensitive services) will improve women's physical and mental health outcomes. Improving gender equity is our best overarching primary prevention strategy for violence against women

WCHN recommends the Policy also has more of a focus on the prevention of violence against women. It needs to be clear that a primary prevention focus is fundamental to

improving women's health and wellbeing outcomes and highlight it as an unparalleled public health problem. In other words, rather than just a focus on the heath and wellbeing impacts of violence against women also include a focus on preventing violence against women.

The lesser consideration in the Policy on addressing contributors to women's ill health would also extend to issues such as poor body image and sexualisation/objectification.

Also, the lack of the gendering of health issue policy, health system policy, programs and service delivery will result in this Policy operating at the margins. The problem arising from the absence of recognition of the impact of this is then found through the document.

WCHN strongly supports the need to allocate specific, sustainable funding for women's health programs and services at the State level, including those which focus on knowledge translation, policy and legislative change advocacy and advocates for specific groups of women such as the Women's Community Health Network WA and Women with Disabilities WA.

Perhaps the Policy could begin with 'Women's Health in social context'? Australian Governments have committed to the United Nations (UN) Beijing Platform for Action (1995), the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and the International Covenant on Economic, Social and Cultural Rights (UNHCR 1966). These commitments affirmed women's inalienable rights and fundamental freedoms, including their rights to health, rights to control over their own bodies, and freedom from violence and discrimination. They are intended to guarantee women "the possibility of realizing their full potential in society and shaping their lives in accordance with their own aspirations" (UN 1995, p. 1). These UN instruments provide the global context for action on women's health. They are powerful mechanisms for mobilising action on women's health and well being, but they need to be consistently applied and implemented.

Again, health involves emotional, social, physical and spiritual well-being which, in turn, is dependent on the social, economic, political and cultural conditions of communities and wider society. Specific characteristics of these social conditions affect health pathways and translate into health impacts: for this reason, it is impossible to understand women's health without also understanding the social context of women's lives and the determinants of their health.

Guiding Principles

The social determinants of health - the intermediary and structural factors impacting on health and wellbeing - does not feature strongly enough in the 'principles' to allow it to serve as a foundation of the Policy. This means that when the Policy outlines action under the priority areas the focus for action is significantly on the health sector and individual level determinants (Please see endnote i for a definition of the social determinants of health).

In light of this, WCHN recommends that the Policy include the social model of health as an overarching principle. This model acknowledges the effect of social, economic, cultural and political factors on the health and wellbeing of women and girls and recognises health as 'a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity' (World Health Organisation, 1986). It is not sufficient for the social model of health

to appear in the Policy's companion document. In such a context it appears as 'background information' when in fact it should feature in the foreground of the Policy itself.

WCHN also recommends the Policy include human rights as an additional guiding policy principle. This will ensure that the Policy supports the fundamental freedoms and entitlements as defined in the 'right to health' by the United Nations Universal Declaration of Human Rights. Specifically, this will ensure the Policy supports the right to control one's health and body, the right to participate in decisions about one's health, and the right to freedom from violence. It is important that the Policy supports these rights being protected and fulfilled. WCHN believes that they should be referenced in the Policy and it should be acknowledged that these rights have been systematically denied to women.

WCHN recommends a clearer focus, in the 'guiding principles', on primary prevention and health promotion. Holistic care (a principle in the draft policy) is appropriate for intervention or treatment, not prevention. The Policy also needs to take a primary prevention approach to improving health outcomes for women and girls. A primary prevention approach works across the whole population to redress the attitudes, practices and power differentials that drive poor health outcomes.

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

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

Primary prevention refers to universal strategies (tailored to meet the specific needs of different audiences) to address the underlying drivers (gendered norms, practices and structures) that lead to poor health outcomes for women and girls. It is important that the Policy acknowledges the many structural levers that exist at the state and national level and includes (or links to) initiatives that address these. It is anticipated, for example, that the WA Family and Domestic Violence Strategy will link to the WA Women's Plan, which has a focus on gender equality; recognising that it is a key driver of family and domestic violence. In other words, both nationally and in WA, addressing gender inequality is a primary prevention strategy to reduce violence against women and their children. Similarly the Policy could clearly articulate the same as a means of improving health and wellbeing outcomes for women in Western Australia.

WCHN believes that the following guiding principles need to be more gender specific:

Continuous improvement, research, and innovation

WCHN supports increased research capacity and capability in women's health and diversification of research and data collection across all the priority areas. We recommend that the Policy explicitly refer to:

- Participatory social research methods to ensure that women from diverse backgrounds are represented.
- Research partnerships between universities and women's health services.
- Research on health issues that affect particularly marginalised women.
- Research into effective prevention of violence measures.
- Research into violence against women and its intersection with other health issues for women.

In addition, WCHN has identified other research priorities for women's health. As the draft Policy suggests, there is a high co-occurrence of mental and physical chronic health conditions for women (for example, depression, diabetes and cardiovascular disease):

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

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

- Body image is often not taken seriously as an indicator of poor mental health. There's a need for up to date research.
- Young women report poor body image at high rates. We need to understand to what extent this is driving anxiety and depression and other health issues in adolescence and later life.
- We know young people with poor body image are also more likely to engage in risky health behaviours (for example, unsafe sex). How can we mitigate these risks?
- Research on best practice for endometriosis, polycystic ovarian syndrome and severe period pain/heavy bleeding. How do women manage this? How does is impact their mental health and participation in school/work?
- Anecdotal evidence suggests that women are still feeling dismissed by health professionals for these common, often long-term conditions. What training do health professionals require in order to assist women more effectively/holistically?
- Research into health promotion strategies for women in larger bodies that take a 'do no harm' approach by not reinforcing poor body image and self-objectification.

<u>Collaboration and partnerships</u>

Specialist women's services in Western Australia practice a social model of health and play a critical role in providing information, advocacy and support for women's health. They have also been at the forefront of efforts to prevent and respond to violence against women and promote gender equity for decades. As such, they are an essential partner to support

governments and health services/professionals to identify and respond to women's needs, experiences and priorities. Funding for the Women's Community Health Network should be on par with funding for peak bodies in other sectors; while additional funding for state-based services would enable them to engage more effectively at a sate-wide level.

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

WCHN recommends that the Policy refer to place-based, local and tailored health service delivery. This is the most effective way to respond to diverse needs and inequities. Health initiatives and programs must respond to the local community context and be designed in collaboration with women.

We encourage the Policy to highlight the importance of partnering with organisations and sectors that have strong links with community. The Policy should support a community development framework that enables women – collectively and individually – to design and develop their own programs and to advocate for systemic change. These sorts of government-resourced, community-led initiatives will lead to improved health, social and economic outcomes for women and their communities.

The success of this Policy depends upon strong, coordinated action across federal, state and local government and the non-government sector. We suggest the Policy supports cross-sectoral regional partnerships to achieve sustainable, effective outcomes for women and girls.

Priority areas

WCHN supports the priority areas identified in the policy. However, a high priority – not sufficiently grappled with in the Policy – is investing in translating gender into all health policy and practice. The health sector in Western Australia exhibits neither a cohesive nor a proficient understanding of how gender impacts on health outcomes. WA state health priority areas are remarkable in their lack of gender analysis. Generally, other health policies fail to demonstrate a sound understanding of how gender and other social determinants are related to health outcomes. There is also a need for gender sensitive resources and support services, including training for service providers on how sex and gender impact the health/mental health of women and girls.

Also, all priority areas would benefit from making it explicit that health promotion activities in each area must be aligned with a gender-transformative health promotion framework. This framework informed the development of national health promotion initiatives such as Our Watch's 'Change the Story'. As a field of practice, policy, and research, health promotion is dedicated to "enabling people to increase control over, and to improve, their health."

Health promotion operates across multiple domains. Broadly speaking, it includes:

- Frameworks, such as the Ottawa Charter, that define key principles and areas of action;
- Local, regional, and state-wide polices that direct action;

- On-the-ground programs and projects in a variety of substantive areas, including physical activity, substance use, housing, and chronic-disease management; and
- Professional practices by health care providers such a physicians and nurses

It is internationally recognised that gender is among the most influential of the determinants of health, and that gender roles can affect health. Evidence increasingly demonstrates that health care interventions—including health promotion—are more effective if they are designed with gender in mind.

International development organisations such as the United Nations Population Fund, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Health Organization (WHO) and organisations such as the Victorian Health Promotion Foundation, CARE, EngenderHealth, International Planned Parenthood and the Population Council have taken the lead in implementing "gender transformative" initiatives that address gender norms and inequalities. In Western Australia the health promotion field has lagged in integrating gender into its vision and practice.

Gelb, Pederson and Greaves (2011) provide an historical analysis on the inclusion/exclusion of gender from health promotion frameworks. Overall, there has been limited inclusion or action on gender. Mostly, "considerations of sex and gender and their relationship to health promotion have been taken up in the fields of reproductive and sexual health, particularly within the fields of maternal-child health and HIV/AIDS." However, they point out that "[t]here are several who have, and continue to critically examine, discuss and promote gender in health promotion work….looking to the broader social structures and contexts that influence health to draw from in developing more effective health promotion particularly for women." Health promotion can either improve or exacerbate health outcomes and gender equality.

Gender transformative health promotion focuses on the dual goals of improving health as well as gender equity. There are several key aspects of gender transformative health promotion. These include:

- While recognising sex and gender as fundamental determinants of health, gender transformative health promotion also encourages examining the links between sex, gender and other determinants such as race-ethnicity, income, education, occupation and the social and built environments and processes such as marginalization, discrimination, homophobia, racism and sexism (intersectional analysis)
- Gender transformative health promotion works to overcome the tendency in health promotion to focus on women largely in their reproductive and care-giving roles
- It pays critical attention to the tone and nature of health messages and campaigns and supports messaging that engages and informs women without deliberately or inadvertently playing to women's fears, sexualizing women, or treating women as a homogeneous group (e.g., encouraging women to quit smoking to preserve their looks)

Rather than solely providing information, gender transformative health promotion seeks to place power — as knowledge, as choice, and as opportunity—into women's hands.

Gender transformative health promotion encourages a shift from health promotion activities at the individual level which exhort women to change their behaviours or to adopt particular 'lifestyles' in order to be healthy, to generating a shared, social responsibility for women's health.

Gender transformative health promotion recognises the relevance of addressing men's and boys' influence on women's health and how gendered assumptions may be hindering or helping men and boys achieve health as well. Gender transformative health promotion is interested in improving outcomes for all: women, men, girls and boys.

Health and wellbeing impacts of gender-based violence

This Policy is an important opportunity to use the significant evidence base and existing policy frameworks to prevent, intervene and respond to violence against women and girls. We recommend the Policy commit to actions articulated in Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia (Our Watch et al. 2015) WA is now a signatory to Our Watch).

WCHN specifically recommends the Policy:

- Support partnerships with organisations with gender equity expertise (such as women's health services) to provide violence against women education, training and capacity building in service and community settings.
- Emphasise the importance of safe and responsive services for women who have current or historical experiences of sexual violence. The Policy should clearly identify the services and environments required to ensure they are safe, coordinated and responsive.
- Focus efforts on cultural, behavioural and attitudinal change by partnering with specialist organisations to develop and deliver:
    - evidence-based activities that prevent men's violence against women
    - initiatives to build the knowledge, skills and capacity of individuals, communities and organisations to challenge sexism and the condoning of violence against women.
    - Add definitions of family, domestic, intimate partner and sexual violence and gender based violence.

The Policy should identify the need for statewide infrastructure for the prevention of violence against women to implement Change the Story across all settings (following the example of Victoria). In Victoria the health funded community based women's health services are funded to deliver primary prevention of violence against women in their local communities.

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

Mental health and wellbeing

WCHN recommends that the Policy supports actions that address the social determinants and specific intersectional, gendered drivers of mental ill-health. For example, efforts to support women's mental health need to acknowledge the link between violence against women and poor mental health. Other significant impacts on women's mental health are:

- Intersecting forms of discrimination
- A lack of preventative, intervention and treatment programs co-designed in collaboration with women and communities.
- Access to financial resources and employment.
- Poverty, insecure housing and homelessness.
- Poor social connections.
- Specific vulnerabilities associated with being an older woman.

We also recommend that the Policy has a focus on the necessity of:

- Services to improve access to low cost counselling.
- Strength-based women only programs that enable women to build skills, confidence and social networks.
- Measures to support unpaid carers' mental health and wellbeing.
- Screening and support services for perinatal anxiety and depression.
- Making specific reference to the need for primary prevention (as well as education and awareness for consumers and health professionals)
- Including poor body image and anxiety as specific areas requiring attention
- Highlighting the need for gender sensitive resources and support services, including training for service providers on how sex and gender impact mental and health and wellbeing for women and girls.

Maternal and Sexual and reproductive health

Sexual and reproductive health plays an important role as a determinant of women's health and wellbeing. Thus WCHN also recommends:

- A WA sexual and reproductive health strategy to lift the profile of SRH at the state level. An ongoing state-wide policy is important to set goals and priorities at the state level and to coordinate efforts and funding. It will also create an authorising environment to strengthen existing work and identify opportunities for innovative responses and partnerships. This strategy could then be linked to other relevant polices/strategies at the state-wide level (for example, STIs but also violence against women and gender equity). This would raise the profile of SRH and break down silos in the service system. Prevention and response efforts are linked across a diversity of issues. A strategy could also help focus our attention on building an integrated SRH service 'system'. This includes normalising provision of the full suite of reproductive services, and funding and support for partnership/linking activities.
- A strong commitment to increasing the availability of both medical and surgical abortion, particularly for women in regional and rural Western Australia.
- A stronger role for hospitals in providing access to termination of pregnancy services.
- 'System enablers' such as workforce development, improved health literacy and innovative models of care.

- State-wide sexual and reproductive health phone line to improve the information available to women and health professionals. This will also make the SRH service system more transparent and easier to navigate. It will also help to identify gaps where services are needed.
- Workforce development with a particular focus on building the supply of health professionals trained to provide medical termination and long-acting reversible contraception.
- The establishment of Safe Access Zones to help remove barriers to access, de-stigmatise abortion and end a longstanding public form of gender-based discrimination.
- An ongoing focus on building and sustaining a skilled workforce, supported by ongoing funding, is critical.
- An intersectional approach to all aspects of policy, workforce development and service provision is essential. This includes ensuring that, at a minimum, all services are able to provide supportive and appropriate response (and referral to specialist service as necessary/appropriate) to all groups including young people, international students, people from migrant and refugee backgrounds, sex workers, incarcerated/recently released women, gender diverse people and older women.
- Mainstream and de-stigmatise SRH within the health sector and across the wider community.
- Better integrated primary and tertiary services to strengthen cross-sector partnerships (e.g. between the family and domestic violence and SRH sectors).
- Resource rigorous evaluation and collect and share local and state-wide data, and health promotion interventions to contribute to the evidence base.
- Improve availability and quality of multilingual resources
- More information for primary health providers about LARC including efficacy, how to address public misconceptions and how to have more productive/supportive conversations with women.
- Greater confidence for health professionals and those making referrals for SRH services that they are referring patients/women to supportive local pharmacies for emergency contraception and LARC. More consistent provision of emergency contraception by pharmacies, and transparent and equitable pharmacy processes around age limits.
- 'No wrong door' for SRH information and care. All services should be able to provide a supportive response to all consumers/patients (e.g. women with disabilities and LGBITQ young people), even if patients are then referred to specialist services.
- Centre consumer voices to reduce stigma and improve service delivery and experience.
- Recognise and address additional costs associated with abortion beyond the procedure itself e.g. non-bulk billed ultrasound. Make funding available for travel and accommodation to support rural women's access.
- Increased local government engagement
- Greater recognition of and investment in sexual health across the life span including postnatal sexual health and menopausal sexual health, including defining and implementing sexual health policy and practice for women post menopause .
- Improve the availability of accessible and easy to understand education programs for primary and secondary schools on common and uncommon reproductive health conditions and issues (such endometriosis and PCOS) and fertility.

- Greater understanding across the community that reproductive health is not just a women's issue or responsibility. Work with men, boys, trans and gender non-conforming people is also critical.
- Information and communication access for women with a disability so that they are empowered to access SRH care without depending on family, partners or carers.
- Training for health professionals that challenges gender and disability stereotypes that limit the reproductive autonomy of women with disabilities.
- Put strategies in place that recognise and respond to the fact that equitable access is reliant on the additional things that women need in order to access SRH e.g. transport, childcare, etc.
- Greater availability of easy English SRH resources in easy English and community languages on a range of topics, including information about healthcare rights, advocacy and complaints processes.
- Develop better research questions that go beyond SRH basics (STIs) to include content on consent, pleasure and communication.
- There is demand for more community education sessions with refugees, migrants and international students around SRH (including STIs, contraceptive options, abortion, etc) as well as healthy and respectful relationships education. Education must be culturally sensitive and delivered by or in partnership with community members. This includes attention to FGC response and eradication, refugee health, general health promotion, family and domestic violence prevention.
- Changing the culture of schools in relation to how they deal with SRH. Not just providing SRH curriculum but a broader approach to deal with how SRH is stigmatised in the culture of the school, including engaging non-health teachers and counsellors and other support staff.
- Make SRH education be more widely available to women with disabilities. Peer-led capacity building is one important way of doing this so women with a disability feel confident, informed and empowered around SRH and relationships.
- Research around reproductive coercion – this is an emerging issue that remains hidden despite its likely prevalence and impact on women's SRH and wellbeing.

WCHN supports recognition of the need to tailor service delivery and information to ensure cultural safety in maternal and perinatal care for women. We also recognise and support the importance of bilingual peer education and peer support models for women from culturally and linguistically diverse backgrounds. Further recommendations include:

- Workforce capacity building strategies to increase health workers' ability to provide culturally appropriate and safe services to all women
- Promote awareness of preconception and perinatal health through a range of settings, not only health care settings, and tailor health promotion to young people and other priority cohorts.
- Increase support for women who have experienced female genital cutting including access to timely de-infibulation and culturally-informed and -appropriate care.
- Workforce capacity building to ensure health providers and settings are culturally informed and competent.
- Sexual and reproductive health education for children and young people that is culturally appropriate, inclusive of sex, gender and sexual diversity and is sex positive.

- Ensure that the self-education and self-management tools are co-designed with communities and are accessible and culturally appropriate. These tools should be promoted to communities as well as health professionals.
- Work with specialist services to increase access to cervical screening for under-screened populations.

WCHN also suggests the inclusion of actions related to ensuring equity for women with disabilities in relation to sexual and reproductive health, reflecting that women with disabilities have been (and continue to be) subjected to specific forms of discrimination in relation to contraception and pregnancy.

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

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

A sensitive, strengths-based approach should guide work with these women, which recognises that mothers are often expected to make rapid changes in their health behaviour when they become pregnant in a way that non-birth partners are not. The PEPISU programme at WHFS and WANDAS at Women and Newborn Health Service are tailored to ensure engagement in health services during and after pregnancy for mothers who are alcohol and/ or other drug users.

Healthy Ageing and chronic conditions

WCHN is pleased with the Policy focus on closing the gap in life expectancy and achieving health equity for Aboriginal women. We also support services and programs for ageing women experiencing socio-demographic inequalities, and specifically those on low incomes, at risk of homelessness and living in remote areas.

Actions in this Policy must recognise the effect of gender on ageing and subsequent health priorities. The socio-economic status of women is profoundly affected by a lifetime of gender inequality. Pay disparity, a systemic lack of power, the increasing casualisation of the workforce, underpayment and undervaluing of caring roles, an inequitable superannuation system, and experiences of family and domestic violence leave women at risk of poorer health outcomes. Recent research has highlighted that 34 per cent of single women over 60 live in permanent income poverty, compared to 27 per cent of single older men and 24 per cent of couples (Feldman and Radermacher, 2016).

As noted in the draft Policy, loneliness is a significant concern for older women. WCHN recommends the Policy further elaborates the need for innovative ways to redress isolation and support social inclusion and (importantly) acknowledge the gender inequities that contribute to social exclusion.

Also, WCHN recommends the Policy identify the prevalence of elder abuse and support actions to prevent and intervene in abuse. Older women are significantly more likely to be victims of elder abuse than older men, and most abuse is intergenerational, with sons being perpetrators to a greater extent than daughters (AIFS 2016). Elder abuse includes intimate partner and family violence, as well as violence and abuse experienced in institutional care facilities.

We recommend the Policy include actions that promote and support the sexual and reproductive health of older women and refer to older women in the sexual and reproductive health priority area.

Women's longevity is increasing, but there is a need for actions to support women to have the best possible quality of life as they age. As noted in the draft Policy, with increasing age women are likely to experience multiple chronic conditions simultaneously.

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

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

Monitoring the Policy

WCHN recommends the creation of a steering committee to design and oversee a comprehensive evaluation of the Policy. We recommend that the committee (which should include a diverse range of members) create a theory of change framework to guide the development of measures. The theory of change should identify gender inequity as a key determinant of women's poor health and show the complex, interrelated ways that gender inequity influences health outcomes.

WCHN recommends investment in collective impact evaluation measures, based on the theory of change. Collective impact evaluation is a useful approach to measure lasting social change and especially appropriate when many different stakeholders are working toward shared or similar outcomes.

We recommend that accountability and transparency is ensured by regularly publicly reporting on progress against the Policy. We suggest the Minister table a report to Parliament annually and provide detailed reports and evidence for the health sector and wider community to use.

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

There should be an Implementation Steering Group that includes cross sector gender equity experts. The Implementation Steering Group must also include strong and equitable representation of women from different groups including women with disabilities and Aboriginal women.

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

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

Infographics

The infographics – while referring to the statistics of violence against women – do not highlight the impact of domestic and sexual violence on women's health and the burden of disease. This serves to hide from view the impact of gender based violence on women's lifestyle 'choices' (such as smoking and alcohol and/or other drug use). Intimate partner violence is the greatest contributor to the overall disease burden in Australia for women aged 18-44 years, contributing more to the burden than any other risk factor for this group, including well known risk factors like tobacco use, high cholesterol or use of illicit drugs (ANROWS 2016). We refer you to the ANROWS infographic on the burden of disease of intimate partner violence (https://www.anrows.org.au/resources/). Things like nutrition, alcohol consumption, smoking or participation in physical activity (highlighted in the infographics) are affected by a range of factors, many of them gendered. Income, care responsibilities, cost, location, trauma, education and access to services all have a profound influence in shaping and limiting women's 'choices'.

Reference list

Australian Bureau of Statistics (2012a) Gender Indicators, Australia, 4125.0 - Gender Indicators, Australia, Australian Bureau of Statistics: Canberra.

Australian Institute of Family Studies (2016) Elder Abuse, accessed on 2 November at: https://aifs.gov.au/publications/elder-abuse/export.

Commission on the Social Determinants of Health (2008) Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health, World Health Organisation: Geneva.

Feldman and Radermacher (2016) The Time of Our Lives Report? Monash University, Melbourne.

Gelb, K., Pederson, A., & Greaves, L. (2011). How have health promotion frameworks considered gender? *Health Promotion International*.

Our Watch, VicHealth and ANROWS (2015) Change the Story: A shared framework for the primary prevention of violence against women and their children, Our Watch: Melbourne.

World Health Organisation (1986) Ottawa Charter for Health Promotion: First International Conference on Health Promotion, WHO Press: Geneva.

[i] **The determinants of health**
The determinants of health are the social, economic and political conditions in which people grow, live, work and age, and the structural drivers of those conditions (Baum, Begin, Houwerling, Taylor 2011). The structures of social hierarchy are fundamental because they produce, reproduce, undermine and threaten health. The determinants of poor health can be changed. Actions for change can be conceptualised at three broad levels: individual, intermediary and structural levels (Keleher and MacDougall 2011), as illustrated below. Levels of determinants that affect health outcomes.

Individual level:
lifestyle factors, particularly diet, physical activity, smoking, alcohol, drugs, genetics, social connection, freedom from violence and discrimination, and access to income, opportunities for social participation and citizenship.

Intermediary factors:
Social and community factors, including the influence of neighbourhoods, criminal incidents, unemployment levels, discrimination and racism, social exclusion and cultural influences; living and working conditions including educational attainment, access to health services, housing, employment conditions, unemployment, sanitation, air and water quality.

Structural factors:
General socio-economic factors impacting on health and well-being, including levels of poverty and wealth, how income is distributed, i.e., the social gradient, cultural richness, educational opportunities, legal and political environments, policies, and infrastructure (Keleher & MacDougall 2011, p. 35).

The WHO Commission on the Social Determinants of Health (Irwin and Scali 2007; CSDH 2008) and Dahlgren and Whitehead (1991) have provided useful models/frameworks for making sense of the levels and the range of determinants and their inter-relationships. The range of determinants are recognised by leading agencies (e.g. WHO 2012; Public Health Agency of Canada 2012) as:
• the social gradient;
• early years of life/childhood;
• environments for health, including healthy living conditions, i.e., access to food, water and sanitation;
• education and literacy;
• employment, unemployment and working conditions;
• stress;
• gender;

- social support;
- social exclusion;
- age, sex and heredity factors;
- culture, racism & discrimination;
- accessible, appropriate health care;
- affordable, accessible transport.