# New National Women's Health Policy

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Women's Health In The North
680 High Street
Thornbury VIC 3071
Ph: 03 9484 1666
Fax: 03 9484 1844
E: info@whin.org.au

# 1. INTRODUCTION

Women's Health In the North (WHIN) welcomes the opportunity to make a submission to the new National Women's Health Policy (NWHP) and commends the federal government on its leadership and commitment to the development of new policy directions designed to improve the health and wellbeing of Australian women.

WHIN is a community organisation based in the northern region of Melbourne, an area that has one of the most diverse populations in Victoria as well as high socio-economic disadvantage. WHIN works with all levels of government and other community organisations to promote and improve the health and wellbeing of women by:

- Influencing policy makers, organisations and communities to recognise and respond to women's experience and concerns.
- Providing information and sharing knowledge that empowers women to know about and act on issues affecting their health.
- Advocating on behalf of women to drive social change and remove barriers.
- Providing leadership and innovation in the delivery of women's health programs and services across the northern region.

WHIN works within a framework that recognises that the health and wellbeing of each woman is determined not just by her state of physical health but by the social, cultural and economic factors that govern her life; these include poverty, childcare and carer responsibilities, single parenthood, low wages, intimate partner violence and sexual assault.

WHIN has 17 years experience in providing services to women in the region, with particular expertise in meeting the needs of women most marginalised by the health system who might generally be referred to as 'hard to reach' or 'at risk'.

WHIN is one of nine Women's Health Services that work to support women in urban and regional areas across Victoria. While Women's Health Services share a common philosophy – to reduce health inequities and produce the best possible outcomes for women's health – each health service tailors its work to the diverse needs of the women who live in their communities.

WHIN's work is focused in four areas: violence against women; sexual and reproductive health; economic participation; capacity building.

## 1.1 VIOLENCE AGAINST WOMEN

WHIN has two important roles to play in the reform of family violence services in the northern sub region. WHIN is responsible for leadership and service integration and the regional planning role. The key leadership role is to promote, develop and enhance integrated approaches to Family Violence service provision and establish and work with the Northern Regional Family Violence Strategic Network.

In addition, WHIN is currently initiating the development of a regional prevention of violence against women strategy for Melbourne's North which will include consideration of state and federal action on preventing violence against women.

A recent example of a WHIN project designed to address violence against women is *Modern Media Messages* (Triple Ms). The project examines ways new technologies and new media can be used to disseminate information about intimate partner violence to young women who may not be reached by more traditional forms of media.

## 1.2 Sexual and Reproductive Health

WHIN also works to promote women's sexual and reproductive rights with a recent example being the collaboration with other Victorian women's health services to achieve abortion law reform so that women can legally access safe, affordable abortion.

WHIN is part of the Family and Reproductive Rights Education Program (FARREP) which aims to improve the physical and mental health and wellbeing of women and girls from communities which may practice Female Genital Mutilation (FGM). WHIN works through FARREP to provide community education to women and girls from affected communities, as well as offers professional training to local providers to enhance awareness and understanding of the specific health needs of women and girls from these communities.

WHIN also works with lesbians in Melbourne's north facilitating opportunities for them to come together and develop their own supportive networks. WHIN is currently conducting consultations with lesbians asking them what they expect and need from their community. This information will be fed back to local government and other key stakeholders, and should be of interest to local government more generally, and to federal and state governments.

## 1.3 Economic participation

> Sixty years have passed since the founders of the United Nations inscribed, on the first page of our Charter, the equal rights of men and women. Since then, study after study has taught us that there is no tool for development more effective than the empowerment of women.[1]

WHIN agrees that women's economic participation is necessary if women are to achieve equality, yet has concerns that women are often exploited or not fairly rewarded for the work they do. To promote women's positive economic participation, WHIN has conducted research that examines women in paid work, women in unpaid work, women as consumers and women as consumed by the economy, and climate change and women's health. This research has been compiled into a soon-to-be-released report: *Women and economic participation: the labour market and* beyond. Data emerging from this report is being gathered and tailored to meet different audience needs, presented in fact sheets and will be disseminated to key stakeholders.

Further to its work on economic participation, WHIN is currently conducting research on barriers to finding employment for newly arrived women with overseas qualifications living in a specific local government area in our region. The resulting research will provide an evidence base for partner organisations advocating for recognition of overseas qualifications and other steps that address barriers to paid work for overseas qualified professionals in Melbourne's North.

### 1.3.1 Climate change

The work of the environment has many parallels to the work of women: it is life giving, undervalued, unseen and unmeasured. Marilyn Waring, a feminist economist, argues that economists have traditionally viewed the environment in the way women, and women's unpaid work, is viewed: an inexhaustible resource, ready, at all times, for consumption.[2] The greatest impacts of climate change on women's (as well as men's) health and wellbeing, relate to food, transportation costs and an increase in the cost of energy and water.

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[1] Annan, K (Secretary General) 2005, *Empowerment of women the most effective development tool*, press release, SG/SM/9738, available http://www.un.org/News/Press/docs/2005/sgsm9738.doc.htm,viewed 15 June 2009.

[2] Waring, Marilyn 1999, *Counting for Nothing: What Men Value and What Women are Worth, 2nd Ed.*, University of Toronto Press, Toronto.

#### 1.3.2 Urban planning

The role of urban planning, which includes housing mix and housing affordability can have a significant impact on women's health. Housing estates on outer suburban fringes are also at greater risk from the economic downturn than more established suburbs raising concerns for the communities and for women in particular. Women are more likely to bear the brunt of unemployment, lack of transport, poor infrastructure, isolation and increased violence and homelessness.

Recommendation

Include the impact on women's health of environmental factors, including climate change, in the National Women's Health Policy.

### 1.4 Capacity Building

Prior to local government elections held in 2008, WHIN worked in collaboration with other women's health organisations across Victoria, asking Council candidates to commit to the *Safe, Well and Connected: Victorian Local Government Action Plan for Women's Health 2008-2012*.

The action plan outlines nine actions for local councils to improve women's health in their community. The plan sought commitment from councils to develop a women's health and wellbeing strategy for women within their municipality; be involved in a violence against women prevention strategy for the northern region; consider mental illness, psychiatric and intellectual disability in council disability strategies; and support of family friendly workplace practices.

A total of 93 candidates running in the 2008 Council elections in the northern metropolitan region of Melbourne declared their commitment to the action plan in their respective communities. Twenty-two of these candidates were elected.

## 2. PRINCIPLES TO UNDERPIN THE NEW POLICY

In a report into the social determinants of health, Michael Marmot states that while it is generally recognised that health is sensitive to economic and social factors it is time to look beyond determinants to the "causes of the causes" of determinants to show how the social environment can have a powerful influence on health.[3]

WHIN therefore endorses the New National Women's Health Policy Consultation Discussion Paper's (now to be referred to as the Discussion Paper) recognition of the social determinants of health and inclusion of a social model of health while stressing that gender must feature as a major determinant of health. WHIN also supports the five principles emerging from the Discussion Paper that together provide a framework that seeks more equitable health outcomes for women.

However, while WHIN is in support of the overall policy direction of the Discussion Paper and acknowledges the challenges of a difficult economic environment, this submission will discuss and provide suggestions to further strengthen the NWHP. These will include a greater emphasis on a social model of health that recognises the intersection between social determinants and the social, economic, political and cultural contexts, a shift from the present focus on individual behavioural change to institutional change that identifies the structural responses necessary to improve women's health outcomes, a health prevention framework that considers the broader environment of women's lives and a reduced emphasis on burden of disease.

WHIN's submission will comment on each of the five principles proposed in the Discussion Paper.

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[3] Marmot, M & Wilkinson, R (eds) 2003, *Social Determinants of Health*, 2nd edn, viewed 25 June 2009, http://books.google.com.au/books?hl=en&lr=&id=x23fpBPC3_gC&oi=fnd&pg=PP11&dq=%22Marmot%22+%22Social+determinants+of+health%22+&ots=9eamEpFhQe&sig=r8XkCJaz-rT2y6fKCUVW1xUdTxo

## 2.1 Gender Equity

The Gender Equity Knowledge Network in its report to the WHO Commission on Social Determinants, states that the construction of gender roles has impacts at every life stage and across all areas of women's lives and is a significant determinant of women's health and wellbeing:

> Gender inequality damages the physical and mental health of millions of girls and women across the globe, and also of boys and men despite the many tangible benefits it gives men through resources, power, authority and control … taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources.[4]

Women's lack of social, economic and political empowerment, the demands of providing care for children and extended families and the expectation that women perform most unpaid work, discriminate against women achieving a work life balance and put women's health at risk. Tax arrangements such as Family Tax Benefit B privileges families based on one full-time earner, most often male, and one full-time carer, most often female, encouraging women with partners to stay home rather than enter the workforce. Conversely, single mothers are required to return to the workforce and work a minimum of 15 hours per week once their youngest child reaches 8 years of age in order to qualify for welfare support. If women are to achieve pay equity, systemic barriers must be removed and women supported into the workforce, and as importantly, into 'non-traditional jobs and industries, with strategies to encourage and support women into management and executive roles within their organisations'.[5]

WHIN notes however, that the Discussion Paper does not include gender as a determinant of health at Section 5, nor does it include gender in its discussion of social determinants. It is also of concern that gender does not appear in the *Conceptual Framework for the Determinants of Health* diagram illustrated at page 8, and that the Discussion Paper does not make links between a number of the health issues it highlights and the social determinants that often underpin them. For example:

- Anxiety and depression is identified as the leading contributor to burden of disease in the 15-44 age group but is not linked to gendered roles.
- Violence is listed as a women's *behavioural risk factor* rather than a social determinant.
- High rates of depression and anxiety are not linked to violence against women although high rates of violence against women in the 15-44 age group correlate with high rates of depression in the same age group.
- Homelessness is not linked to violence against women.
- Obesity is listed as of considerable concern but a link between anxiety and depression and weight gain is not made.
- A link between weight gain and high use of anti-depressants in the 30-35 years cohort is not made, though the accelerated weight increase in this age group is highlighted as of considerable concern.

The World Health Organization (WHO) states that the social determinants of health are the conditions in which people are born, grow, live, work and age and are mostly responsible for health inequities …[6] Gender as a determinant of health, must therefore be recognised not only in the health system but at the structural level across all sectors of government and in the design and implementation of all public policy, services and programs.

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[4] Sen, G & Ostlin, P 2007, 'Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it', *Final Report to the WHO Commission on Social Determinants of Health*, Women and Gender Equity Knowledge Network, Karolinska Institutet, p.xii, viewed 19 May 2009, http://www2.ids.ac.uk/ghen/resources/papers/wgekn_final_report.pdf.

[5] National Pay Equity Coalition &Women's Electoral Lobby Inc 2008, Submission 'Inquiry into Pay Equity', House of Representatives Employment & Workplace Relations Committee.

[6] WHO, *Social Determinants of Health*, World Health Organization, viewed 20 May 2009, http://www.who.int/social_determinants/en/

The government's recent introduction of paid maternity leave, while still needing to be expanded, is an excellent example of structural change, that on implementation, will have positive financial impacts and flow-on affects into many areas of women's lives. Another, the Victorian government's reform of abortion law and its removal from the criminal code that now gives Victorian women the right to reproductive choice and therefore increased control over their lives. Similar reform is needed in all Australian States and Territories.

RECOMMENDATIONS

- Recognise gender as a major social determinant of health and as the root cause of avoidable health inequalities.
- Ensure that women's health is not a stand alone policy but that gender and women's health is considered in all policy and program areas.
- Introduce legislation that firstly requires the removal of structural barriers that prevent women's full economic participation, and secondly, provides supports such as paid maternity leave to encourage women into the workforce.

### 2. 2 HEALTH EQUITY BETWEEN WOMEN

The government is to be congratulated on its commitment to promoting health equity between women. WHIN supports the inclusion in the Discussion Paper of:

- Aboriginal and Torres Strait Island women
- Immigrant and refugee women
- Women from disadvantaged backgrounds, including women experiencing homelessness
- Women living in rural or remote areas
- Women who have a disability including mental illness.

However, in order to be fully inclusive, a NWHP cannot overlook older or ageing women, lesbians, young women and carers. Women in these groups are subject to a range of health inequities that may not otherwise be recognised or considered. It follows then, that unless these groups are included in the NWHP, their health needs and the barriers they experience, may be missed from the national health agenda.

RECOMMENDATION

- Expand the NWHP to include, and specifically consider and address, the social determinants of health of older women, younger women, lesbians and carers.

#### 2.2.1 OLDER WOMEN

The Discussion Paper states that much of the increased life expectancy for women is spent with profound or severe limitation, and that women over 80 are twice as likely to experience severe or profound disability. The paper also lists a number of health risks more likely to apply to older women. They include that women are 10 per cent more likely to suffer cardiovascular disease than men (including coronary heart disease and stroke), contributing to over 50 per cent of all female deaths and the leading cause of death for women aged over 85, and that the risk of dying of a heart attack for women who smoke, is three times higher than for an ex smoker.

It has been well documented that an ageing baby boomer generation will see an escalation of women aged over 65 from the next decade onwards. It seems timely then, that the NWHP include older women as a vulnerable population group.

Finally, while heart disease is a significant health issue, the application of a social model of health makes clear that social determinants such as the demands on women of care-giving, experience of poverty and a greater

acceptance of violence perpetrated by an intimate partner, can have negative and far-reaching impacts on the health and wellbeing of older women and that may lead to cardiovascular, coronary heart disease and stroke.

### 2.2.2 Lesbians

Lesbians also have specific health concerns that are often not addressed or understood in a predominantly heterosexist society. Health professionals are often poorly trained and seldom have access to the training and resources they need to ensure that their service is not heterosexist and provides equity in health care to lesbian women. [7] Significant, when heterosexist attitudes have been found to lead to avoidance of routine healthcare including screening.[8]

In addition, lesbians often have poorer mental health as a result of discrimination and homophobia at all levels of society and a lack of social connectedness, all of which can result in increased use of illegal drugs and alcohol.[9]

Lesbians are also part of all other populations of women, including young and older women, Aboriginal & Torres Strait Islander women, CALD women, women with disabilities and women living in rural and isolated areas.[10]

WHIN supports the following recommendation contained in the Gay and Lesbian Health Victoria submission to the National Women's Health Policy:

> Victoria is the only state/territory to have a specific gay, lesbian, bisexual, transgender and intersex (GLBTI) health policy (DHS, 2003). The research paper which informed the development of this strategy argued in fact that there is now sufficient evidence to suggest sexual orientation and gender identity should themselves be regarded as key social determinants of health (Leonard, 2002). However, as information on sexual orientation or transgender identity is not collected in the large population-based studies of the health of Australians, it is not common to see it included in deliberations around policy development and service planning. *The Development of a New national Women's Health Policy Counsultation Discussion Paper 2009* is not unusual in completely overlooking this aspect of health inequality. Nevertheless there is now a sufficiently robust body of research in Australia to make the case that the needs of lesbian, bisexual and trans women should be specifically incorporated into the social inclusion agenda. We would therefore propose their proper inclusion in chapter 5 of this consultation paper as a separate group under 5.2.2. This submission presents the evidence for this argument and seeks to promote Principle 6.2 Health equity between women.[11]

### 2.2.3 Young women

While the Discussion Paper identifies a number of health risks for young women, between 12 – 19 years, the paper does not list these women as a group vulnerable to increased health inequalities. The paper tends to more focus on risk behaviours and individual change rather than social determinants that include gender, education, unemployment and low income.

Recent and alarming increases in sexually transmitted infection (STI) in young women must be urgently addressed by a national sexual and reproductive health strategy that includes education programs that recognise the links between stereotyping, poor mental health, exposure to sexual violence and vulnerability to STIs, and the long-term impacts of STIs on women's sexual and reproductive health.

The health effects of sex role stereotyping on young women are discussed in the1989 National Women's Health Policy. The 1989 NWHP raised concerns, which resonate today, that the health of many women is adversely affected by social pressures to conform to images fostered by a number of factors that include, most pertinently, the media. The 1989 policy also stated that strategies are urgently needed to assist women to resist these images through education and awareness-raising. The figures cited in the Discussion Paper that hospitalisation of

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[7] Mitchell, A 2009, 'Submission to National Women's Health Policy Consultation Discussion Paper', Gay and Lesbian Health Victoria.
[8] McNair, R 2003, 'Lesbian health inequalities: a cultural minority issue for health professionals', *eMJa The Medical Journal of Australia*, http://www.mja.com.au/public/issues/178_12_160603/mcn10852_fm.html, viewed 24 June 2009.
[9] Ibid.
[10] Mitchell, A 2009, 'Submission to National Women's Health Policy Consultation Discussion Paper', Gay and Lesbian Health, Victoria.
[11] Ibid.

young women who self-harm has increased in the last 10 years by 51 per cent, support the need for urgent action.

Government regulation of advertising in particular, is necessary if we are to protect the next generation of young women from an increasingly pervasive and influential media that depends to a great extent on the exploitation of young women's bodies.

WHIN notes that the Office for Youth has identified body image as a key area of concern and commends the government for signposting policy initiatives that encourage healthy body image. The health issues associated with body image confirm the need for inter-departmental collaboration to ensure that policy is developed and coordinated so that women's health issues are addressed effectively.

### 2.2.4 Carers

In 2007, a report found that more than a third of carers reported feeling severely depressed. The study concluded that 'carers have the lowest collective wellbeing of any group.'[12] The emotional, social and economic demands of informal care are recognised in the 1989 NWHP though carers are not listed as a priority group in the Discussion Paper. It is hoped that a new NWHP will give consideration to the gendered nature of caring, its demands on women of all age groups, the barriers it creates to employment and therefore economic independence, and the negative impacts it can have on the physical and mental wellbeing of women.

It is important to note here, that women do not sit exclusively in one group or another but may appear in or across a number of groups during their lifetime. It should also be stressed that women, once affected by violence or disability or poverty, are likely be more vulnerable to a range of health inequities at different times of their lives or as they age.

### 2.2.5 Women with disabilities

While the Discussion Paper does include women with disabilities as a priority group, their experience of disadvantage, discrimination and exclusion cannot be too highly stressed. It is expected that a NWHP will work to ensure women with disabilities are given access to adequate health care and that their major health inequities be addressed. As such, WHIN expresses strong support for the Women With Disabilities Australia's (VWDA) submission to the NWHP.

### Recommendation

- Give urgent attention to the health inequities experienced by women with disabilities.

## 2.3 A Focus on prevention

WHIN welcomes the Discussion Paper's focus on prevention but would like to see less of a focus on illness and disease prevention and an increase in focus on primary prevention that is more in keeping with a social model of health.

A spotlight on prevention would lessen the focus on individual behavioural change and increase the focus on structural change. Prevention frameworks can identify and be tailored to target vulnerable and diverse populations of women rather than take a one-size-fits-all-approach. Prevention also considers the 'causes of the causes', that when applied to women can identify the social determinants that make some women more vulnerable to, for example, poor mental health or obesity. A prevention approach does not look at illness and/or risk factors in isolation and recognises that the social environment often outside an individual's control is often responsible for poor physical or mental health.

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[12] Carers Australia, Australian Unity and Deakin University 2007, 'The Wellbeing of Australians: Carers Health and Wellbeing', www.deakin.edu.au/research/acqol/index_wellbeing/Survey_17.1pdf viewed 29 June 2009.

To consider how a focus on prevention might work, violence against women and sexual and reproductive health provide useful exemplars:

### 2.3.1 Violence against women

In a primary prevention approach, violence against women by their intimate partner, would be addressed through legislative responses, provision of safe and adequate shelter for women at threat of violence, a supportive welfare system, well-funded services and programs that support women leaving violence, and education that raises awareness of the nature of violence and the impact of it on women, children and communities. Women's wider experience of violence in their community and the violence experienced by many newly arrived women, particularly Moslem women, would be similarly addressed through legislative frameworks and education programs aimed at changing community attitudes to make violence against women unacceptable and perpetrators accountable.

#### Recommendations

- Prioritise the elimination of violence against women
- Ensure that all national policies consider how individual policy can address violence against women or the impacts of violence on women's lives i.e. homelessness
- Include elimination of violence against women as a priority in the National Men's Health Policy

### 2.3.2 Sexual and reproductive health

A Sexual and Reproductive Health Strategy is crucial to a prevention approach. A strategy should consider: education of young women (and men) about use and availability of contraception including restrictions imposed by Medicare and PBS; emergency contraception; education programs to raise awareness of sexually transmitted infections such as HIV and Chlamydia and how to avoid and/or limit their spread; sexual violence; links between alcohol use and abuse and sexual activity; ways to reduce the number of unwanted pregnancies; equal access to termination services that provide independent advice as well as access for all women to immediate, safe and affordable abortion; women's health across the lifespan; screening and treatment for ovarian, breast and cervical cancers; the safety and efficacy of Hormone Replacement Therapy (HRT), and impacts of menopause on health and wellbeing.

Women's control over their sexual and reproductive health must also include a woman's right to childbirth choice; that is, that women can decide where and how they give birth and be assured they have access to midwives and appropriately trained staff.

WHIN's submission supports the recommendations of the Maternity Review, which include in that consideration be given to a range of models of care including birthing centres.[13] Such models 'should be integrated family centred models of health care that are patient not provider driven … with a focus on prevention, wellness and the care needs of the women and their families'.[14]

#### Recommendation

- Prioritise the development of a National Sexual and Reproductive Health Strategy.

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[13]Improving Maternity Services in Australia : The Report of the Maternity Services Review 2009, Commonwealth of Australia, p.57, date viewed 30 June 2009, http://www.health.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf

[14] Royal College of Nursing Australia 2009,'RCNA Submission on Improving Maternity Services in Australia, a Discussion Paper from the Australian Government', viewed 30 June 2009, *http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-335/$FILE/335_Royal%20College%20of%20Nursing%20Australia.doc*

## 2.4 A STRONG AND EMERGING EVIDENCE BASE

It is crucial that a NWHP links to other policies that impact on women and that gender be mainstreamed into legislation, policy and across all levels and in all sectors of government. Equally important is the need for links between national and state policies so that the issues of women's health are addressed and integrated at state and federal levels.

In order to address women's health needs now and in the future, the collection and dissemination of disaggregated data is urgently required to provide an evidence base for policy development as well as identify gender disparities. However, it is important that data not only focus on illness and disease but be relevant to prevention, for instance the prevention of violence against women, and an understanding of the social determinants including gender, that underpin, women's lives. WHO states that to respond adequately to gender inequality:

> …it is not enough simply to "add in" a gender component late in a given project's development. Research, interventions, health system reforms, health education, health outreach, and health policies and programs must consider gender from the beginning.[15]

The Victorian Index of Women's Health and Wellbeing Data developed by Women's Health Victoria, is a resource that facilitates access to women's health data and as such provides a model for the development of a national database.

The application of a gender based analysis tool to legislation, policy, and programs and services can further ensure policy is sensitive and responsive to gender. The Canadian Government has mandated the use of such a tool, and the Victorian Government Department of Human Services has developed a gender and diversity lens to identify:

- Hidden assumptions and values which may sustain inequality and contribute to discrimination.
- The possible consequences and impact of initiatives.
- Service gaps and research in areas which require further work.[16]

The application of a gender and diversity lens can also help to ensure that policies and programs are responsive to the needs of CALD women.

### RECOMMENDATIONS

- Collect disaggregated data to inform planning, policy development, changes to legislation, programs and services.
- Mandate a gender and diversity lens to the development and application of legislation, policy, programs and services at all levels of government and in public institutions, organisations and bodies.

## 2.5 A LIFE COURSE APPROACH

WHIN does not strongly support a life course approach as concerns exist that it does not recognise that gender equity in health can change over time. For instance, the longer lifespan of women can contribute to social isolation later in life, often going hand in hand with higher rates of poor long term health and disability. It is therefore recommended that a diversity approach be adopted to encompass Aboriginality, cultural and linguistic diversity, sexual identity, geographic location and socioeconomic status.

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[15] WHO, *"What is gender mainstreaming"?,* World Health Organization, viewed 20 May 2009, http://www.who.int/gender/mainstreaming/en/index.html

[16] Victorian Women's Health and Wellbeing Strategy Diversity Unit, 'Gender and Diversity Lens', Victorian Government Department of Human Services, viewed 20 May 2009, http://www.health.vic.gov.au/vwhp/downloads/gender_diversity_lens.pdf

## 3. Conclusion

WHIN congratulates the government on its commitment to the development of a new National Women's Health Policy and fully endorses the social model of health and social determinants approach taken in the Discussion Paper. However, gender as a significant social determinant of women's health cannot be stressed too strongly, as only when the social determinants of poverty, education, adequate housing, the demands of women's lives such as the disproportionate contribution women make to nurture of family and community, income, sexual and reproductive rights, to name but a few, are considered in health and all other policy, as well as in the design and implementation of programs and service delivery, can women's health inequalities be addressed and avoided.

WHIN also supports the focus on prevention, particularly primary prevention, which takes into account social determinants to enable a shift from the focus on individual behaviour change to institutional change and a removal of structures that have prevented women achieving equitable health outcomes. If prevention is to be successful a strong evidence base informed by sex-disaggregated data is essential as is a gender and diversity lens mandated to all legislation, policy, programs and service delivery, to ensure each are responsive and sensitive to gender and culture.

WHIN welcomes the new NWHP and looks forward to seeing the voices of women reflected in policies that address the broader context of women's lives.