Public Health Association of Australia submission on draft National Women’s Health Strategy 2020-2030

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia.

The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Introduction

PHAA welcomes the opportunity to provide input to the development of the National Women’s Health Strategy 2020-2030. The overarching aim of the Strategy is to continue to improve the health and wellbeing of all women and girls in Australia, providing appropriate, accessible and equitable care, especially for those at greatest risk of poor health.

The Strategy is guided by five principles: gender equity, health equity, equity between women, a life course approach to health, a focus on prevention, and a strong and emerging evidence base. Sustainability should also be considered as a principle because for the Strategy to translate into measurable outcomes, plans and actions, strong government funding needs to be allocated for the duration of the Strategy. The five priority areas identified in the Strategy are: mental health and wellbeing, chronic disease and preventive health, sexual and reproductive health, conditions where women are overrepresented, and healthy ageing. PHAA proposes including violence against women as another priority area.

PHAA Response to the consultation paper

1. Overall structure of the Strategy

Is the overall structure of the Strategy easy to follow? YES/NO

Yes

2. Adequate context and background for the Strategy

Do the sections: About the Strategy, The Strategy in context, Women’s health at a glance, Priority populations, Life course approach and What we want to achieve provide adequate context and background for the Strategy? YES/NO

No

Figure 1 should include reference to several other global and national strategies:

Global Strategies:

- Universal Declaration of Human Rights 1948 which includes the fundamental right to health
- Beijing Platform for Action 1995 which calls for equality of men and women
- Convention on the Elimination of all Forms of Discrimination Against Women 1979
- World Health Organization’s Global Strategy for Women’s, Children’s and Adolescent Health 2016-2030

National Strategies:

- Third National Sexually Transmissible Infections Strategy 2014-2017 - Chlamydia and gonorrhoea rates are increasing and women 15-25 years are more likely to be diagnosed than any other age group.
- Fourth National Hepatitis C Virus (NCV) Strategy 2014-2017; Second National Hepatitis B Strategy 2014-2017 - Women with Hep. C and B may experience complications related to their reproductive and sexual health. Hep C and B can be transmitted from mother to child particularly during birth if they have high levels of the virus. Women on pegylated interferon and ribavirin treatment for Hep
C require contraception counselling and access to effective methods as these treatments are teratogenic.

- National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss⁹ - There is gender disparity in eye health for indigenous women.
- Australian National Breastfeeding Strategy 2018 and beyond
- National Strategic Approach to Maternity Services (NSAMS) that is currently in development

The sentence “Overall the health and wellbeing of women in Australia is good” is poor because it provides no comparison point. PHAA suggests that it should be rephrased in terms of women’s health outcomes in comparison with other high-income OECD countries or with similar gross national income and other immigrant nations such as Canada, New Zealand, United Kingdom and Ireland.

The sentence “An emerging potential priority group are women veterans of Australia’s armed services (army, navy, air force and police).” Should be strengthened with some qualification and referencing.

At the August 2018 Forum, the social and other determinants of health featured as a key approach to understanding and addressing women’s health. However, they are not mentioned in this draft Strategy until page 10. PHAA suggests that social and other determinants of health should be clearly and prominently stated as being key, early in and throughout the document.

The Strategy should acknowledge that the life course approach is in line with the WHO’s Global Strategy, as taking a life-course approach highlights the implications of interlinks among all stages of life.

3. Strategy blueprint, Policy principles and Strategy objectives

Do the sections: Strategy blueprint, Policy principles, and Strategy objectives adequately frame the approach for, and intent of, the Strategy? YES/NO

No

The Strategy can be further improved and enhanced to include:

- Poverty and implications on women’s health reflecting the gendered dimensions of poverty in Australia
- Gendered dimensions of ageing including growing homelessness and vulnerability among older women
- Violence against women – with an average of 1 women dying in Australia each week due to violence, this should be added as an additional priority area

The policy principles and objectives should include an objective on health financing and sustainability.

Under principle 1 “Gender equity”, the objectives should include primary prevention strategies to address gender inequality as a driver of health outcomes for women.

Under principle 2 “Health equity between women”, the objectives should specify strategies for improving accessible care. PHAA believes the references to and strategies for accessible care should be strengthened. Accessible care is highlighted in the purpose (p9) and throughout the document and later in the priorities this is noted in relation to the term universal for example: “Deliver a system that provides universal access to people in mental” p 17 “Deliver a system that provides universal access to rapid response high quality services for women with eating disorders” p. 23

A key component of access is affordable services that is central to universal care coverage for all citizens including adolescent girls and women - a key goal of the WHO. The average per capita out-of-pocket health spending in Australia was US$ 802 which is one of the highest compared in high income countries.
compared with Europe and Northern America (US$ 517).\textsuperscript{10} This strategy makes no mention of how services will be made more affordable particularly to those highly underserved women in the priority groups.

Under principle 3 “A life course approach to health”, the objective should be re-worded to acknowledge that the determinants of health (factors including finances, access to services, caring responsibilities, trauma and education) influence women’s choices. The term ‘healthy lifestyles’ does not clearly acknowledge this influence over decisions taken regarding nutrition, physical activity, alcohol or tobacco consumption.

4. Priority areas

Do you agree with the priority areas for the Strategy? YES/NO

No

Violence against women and eating disorders should be additional priority areas. The current draft of the Strategy includes them under Priority 4 “Conditions where women are overrepresented”. This is inappropriate since violence against women is not a condition. A more appropriate listing under a priority area with this title would be, for example, in differential outcomes from certain chronic conditions.\textsuperscript{11} As acknowledged in the statistics provided in the draft Strategy, violence against women is a significant issue for women in Australia, and should be addressed in the Strategy accordingly.\textsuperscript{12} A major health and welfare issue, violence occurs across all ages, and all socioeconomic and demographic groups, but predominately affects women and children. Family and domestic violence is a leading cause of homelessness for women with children. Intimate partner violence also has serious impacts on women’s health – it contributes more to the burden of disease than any other risk factor for women aged 25-44.\textsuperscript{12}

Similarly, eating disorders and poor body image are issues contributing significantly to women’s ill health, especially in adolescent and young women, and should be given higher priority and recognition in the Strategy. This could be achieved either through upgrading to a separate priority, or being more appropriately listed under Priority 1 “Mental Health”.

Priority area 1: Mental health and wellbeing – do the priorities and actions specified adequately address the specific health needs of women and girls in Australia? YES/NO

No

PHAA believes there are several areas in this section that should be strengthened.

There is little reference to social determinants of health in prevention efforts, such as housing and social support across age groups. Whilst there is reference to prevention, there is little said about ‘whole of population initiatives e.g. to address body image through media strategies, improve the health of Aboriginal and Torres Strait Islander women and other vulnerable groups.

The links between family violence, intimate partner violence and sexual assault and violence should be referred to in this section, unless violence against women is a standalone Priority area. There is also evidence to show the linkages between the experience of intimate partner violence, mental health disorders, perinatal mental health disorders and suicidality.\textsuperscript{13-16}

There is no mention of self-harm in this section – this is a major issue for young girls and women, particularly young Aboriginal and Torres Strait Islander women e.g. The rate of hospitalisation for females due to self-harm was 40% higher than for males from 1999–00 to 2011–12.\textsuperscript{17}

Eating disorders and body image would be more suitably addressed under the mental health Priority area.

The Strategy currently does not adhere to appropriate definitions, leading to confusion with the terms used. On page 12 it refers to ‘mental health’ as a ‘chronic condition’ – but this is not always the case,
especially if there is the right early support e.g. in adolescence/young adulthood – there may be no ongoing/chronic conditions. On page 31 it states that 43% of women experience ‘mental illness’, but without a definition - a diagnosed mental health disorder or mental health condition (e.g. anxiety and depression) or a ‘chronic mental health condition’? Many advocacy groups are moving away from the ‘mental illness/mentally ill’ language. In some sections, it appears that ‘person with a psychiatric disability’ may also be appropriate (e.g. for those with a low prevalence disorder/chronic mental health condition).

The link between mental health and early childhood development could also be better highlighted in the prevention section. A gap appears to be parenting support for parents/mothers (e.g. in home parent support and education, comprehensive primary health care services) – there is evidence on child development/early social support being linked to mental health. Birth cohort studies and life course epidemiological studies will provide the needed evidence to address this gap.

**Priority area 2: Chronic disease and preventive health – do the priorities and actions specified adequately address the specific health needs of women and girls in Australia? YES/NO**

No

This Priority area should acknowledge and incorporate breastfeeding as a preventive strategy for chronic diseases and cancers. There is good evidence that breastfeeding protects against infectious mortality and morbidity and dental malocclusions, and growing evidence that it also protects against overweight and diabetes in children and breast cancer, diabetes and ovarian cancer in mothers. Suggested priorities and actions for breastfeeding include:

- Education across the lifespan issues surrounding infant feeding to normalise breastfeeding
- Increase information and access to support for breastfeeding
- Increase availability of unbiased and consistent information across Australia which is not influenced by industry.

The Strategy should clearly incorporate the known differential impacts of and risk factors for various chronic conditions, for women than for men. For example:

- rising mortality rates from lung cancer among women but not men,
- lower tobacco exposure levels for chronic obstructive pulmonary disease for women than men,
- higher risk of stroke and poorer survival rates after stroke, for women with diabetes than men with diabetes

Prevention strategies should focus on primary prevention, and recognise gendered aspects of the modifiable determinants of health, to avoid reinforcing disadvantage. This requires a review of how various factors impact women and chronic disease.

**Priority area 3: Sexual and reproductive health - do the priorities and actions specified adequately address the specific health needs of women and girls in Australia? YES/NO**

No

This section should be articulating a comprehensive approach to sexual and reproductive health service provision in line with evidence put forward in the WHO’s 2017 report: Sexual health and its linkages to reproductive health: an operational approach, and the 2012 Melbourne proclamation. This requires greater consideration of sexual and reproductive health beyond fertility, pregnancy and maternal health, including, for example, reproductive coercion, contraception, and abortion, knowledge about fertility, breastfeeding, menopause, and polycystic ovarian syndrome.
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Priority 1
Reference must be made to the need for preconception information for women older than 36 years; women with chronic disease such as cardiac disease which is the leading cause of maternal mortality; and women with reproductive risk factors (endometriosis; polycystic ovary syndrome; menstrual cycle irregularities (<21 days, >35 days); pelvic inflammatory disease; sexually transmitted diseases (e.g. chlamydia, gonorrhoea); severe menstrual pain; pelvic surgery).

Adolescent sexual and reproductive health should be prioritised given the increased risk for this age group.

Priority 2
Reference should be made for the need to better link maternal and early child services. To foster collaboration, services need to better integrated across public, NGO and private workforce as well as home visiting (universal, indicative and selective).

The Strategy should mention the forthcoming National Strategic Approach to Maternity Services, and also highlight a commitment to breastfeeding.

Priority 3
In line with the focus on prevention and universal access there should be a commitment to provide universal coverage for all forms of contraception for all women particularly LARC that are more effective at preventing unintended pregnancies and will deliver substantial savings to the health system and beyond. Adequate Medicare rebates and pharmaceutical benefits are therefore required for contraceptive consultations, prescriptions, insertion and removal of LARC that do not lead to financial disincentives for health professionals or those seeking contraception.

There should be a commitment to ensuring that women have access to all effective methods available in other countries, such as the combined hormonal contraceptive patch and the Desogestrel progestogen only pill that are not available in Australia.

There should be commitment to public provision of abortion services in all states and territories and there should be public investment in the use of technology to deliver medical abortion and nurse practitioner led services.

Education on contraception (including LARC) and abortion should be provided in all schools in Australia.

Gender inclusive approaches (incorporating trans specific health needs) should be included in the training of medical and allied health professionals and in public health courses.

Priority area 4: Conditions where women are overrepresented - do the priorities and actions specified adequately address the specific health needs of women and girls in Australia? YES/NO
No

PHAA strongly recommends that the Strategy should have a stand-alone Priority area for violence against women. This issue is too important to be subsumed under the somewhat innocuous title ‘conditions where women are over-represented’. Violence against women in Australia is a national crisis, not a condition.

Several strategies are required for the Priority area of violence against women. There needs to be a rebate for GPs to conduct a longer consult to identify, take a detailed history and document findings when they suspect domestic violence. Currently, they can only claim a mental health rebate.

Training should be a mandatory part of GP and hospital accreditation, so that the practice or hospital is accredited for family violence. This should include training for nurses and reception staff to increase safety and confidentiality.
Routine data collection in primary care is required to monitor trends in identification, safety planning and referral.

Most importantly, there should be a commitment to fully implement and resource the National Plan to Reduce Violence against Women and their Children 2010-2022.

The goals towards addressing eating disorders in women should be included under Mental health priority 1.

**Priority area 5: Healthy ageing - do the priorities and actions specified adequately address the specific health needs of women and girls in Australia? YES/NO**

**Commentary (400 word limit)**

Women tend to live longer than men, which is reflected in the differences in life expectancy and is particularly apparent in the older age groups. In 2017, almost two thirds (63%) of all people aged 85 years and over were women.27

Most older Australians are living longer. Some groups, however, continue to face disadvantage affecting their mental and physical health, and their opportunities for social and economic engagement within their communities. For example, the Aged Care Act 1997 defines some populations as ‘people with special needs’- people with particular care needs that should be taken into consideration. Currently, there is no systematic capacity to identify and report on the wellbeing of people from most of these population groups including:

- Aboriginal and Torres Strait Islander communities
- Culturally and linguistically diverse backgrounds
- Veterans of the Australian Defence Force or an allied defence force (or the spouse, widow or widower of a veteran)
- Rural and remote communities
- Homeless people or those at risk of becoming homeless
- Lesbian, gay, bisexual, transgender or intersex people

5. Research, partnerships and progress

**Investing in research: do the priorities and actions specified adequately address the specific health needs of women and girls in Australia? YES/NO**

No

Government funding for research on breastfeeding is required – a 2007 Parliamentary Best Start Inquiry recommended research on breastfeeding, which has not been enacted. Much that is currently labelled as ‘breastfeeding research’ is actually research on how to imitate breastmilk in commercial formulas. There is an urgent need for costing studies and up to date economic evaluations of interventions and strategies to support breastfeeding, including health system cost savings. There is a need to evaluate the time cost to women, and the amount of paid maternity leave that is needed to make exclusive breastfeeding a reality for lower income families. There is also a need for large epidemiological studies using appropriate definitions and measurement of the impact on women’s and children’s health of continued breastfeeding to 2 years and beyond. The effects of the Baby Friendly Health Initiative implementation on breastfeeding rates also requires research.

Priority 2:

PHAA suggests that social scientists be added under “Increase the number of research-focused clinicians”
The strategy needs to address the significant gaps in routinely collected national data. For example, there are no contraception usage or abortion data (including strategy for MTOP data, such as PBS listing) that are reliable and comprehensive in Australia. This must be made a priority.

Action-orientated and community and participatory research should be undertaken into the nexus between gender and social determinants of health. Women should be provided with the chance to have a voice in the research that is being undertaken on them. There should be an increased research and policy focus on how determinants of health and social and behavioural aspects of gender NOT just sex affect risk of chronic conditions such as obesity, diabetes, cancer and heart disease.

Better cross-fertilisation of routine and federally funded longitudinal cohort data – eg high quality consistent measures of family violence must be included in mental health, alcohol and other drugs, GP and maternal and child health data etc, or in LSAC, HILDA, etc so that trends can be appreciated without great additional cost.

Implementation research should be undertaken to establish the best approaches for delivering services to hard to reach women particularly targeted primary health care that is tailored to the needs of specific populations.

**Strengthening partnerships: does the section adequately outline that strong partnerships between government, patients, advocates, healthcare professionals and industry are necessary to implement the actions identified in the Strategy? YES/NO**

Yes

There is no coordinated approach to sexual and reproductive health. This requires a strategic alliance of NGOs, primary, secondary and tertiary care organisations with government. Strong partnerships between government, patients, advocates, healthcare professionals, and industry needs to be clearly articulated in the Strategy with clear implementation and enabling frameworks.

**Achieving progress: What specific targets and measures should be used in the Strategy to determine progress towards achieving the overall purpose of the Strategy to: ‘improve the health and wellbeing of all women and girls in Australia, providing appropriate, accessible and equitable care, especially for those at greatest risk of poor health?’**

Concerted efforts are needed to increase effective routine data collection in primary care (GPs, maternal and child health, and hospitals. This should include gender diversity, migrant, refugee status, disability, Aboriginal and Torres Strait Islander women, cultural and linguistic diversity, rural and remote areas, and homelessness.

6. **Overall comments**

The PHAA supports the overall structure of the Strategy, with the policy principles and identified priority areas. These provide a strong foundation to the Strategy. The focus on priority populations and a life course approach are appropriate, and recognise the importance of health inequities and the modifiable determinants of health.

This strong foundation would be better supported through the changes suggested throughout this submission.
Conclusion

PHAA supports the broad directions of the draft National Women’s Health Strategy. However, we are keen to ensure that the Strategy is clear, comprehensive and actionable in line with this submission. We are particularly keen that the following points are highlighted:

- There are important elements missing from the draft, including reference to other relevant Strategies, and the clear inclusion of determinants of health and primary prevention
- Actions for mental health and also family violence need to be strengthened with family violence as a separate priority area
- Actions relating to conception and contraception need to be strengthened

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to the National Women’s Health Strategy.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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