

To: Consultation on the National Women's Health Strategy
Commonwealth Department of Health
By online survey
5 November 2018

Australian Women Against Violence Alliance Submission on the National Women's Health Strategy 2020-2030

Thank-you for the opportunity to make a submission to inform the development of the National Women's Health Strategy 2020-2030.

About the Australian Women Against Violence Alliance (AWAVA)

Australian Women Against Violence Alliance (AWAVA) is one of the six National Women's Alliances funded by the Australian Government to bring together women's organisations and individuals across Australia to share information, identify issues and contribute to solutions. AWAVA's focus is on responding to and preventing violence against women and their children. AWAVA's role is to ensure that women's voices and particularly marginalised women's voices are heard by Government, and to amplify the work of its member organisations and Friends and Supporters. AWAVA's members include organisations from every State and Territory in Australia, representing domestic and family violence services, sexual assault services, and women's legal services, as well as organisations representing Aboriginal and Torres Strait Islander women, young women, women educators, women in the sex industry and other groups. AWAVA's lead agency is the Women's Services Network (WESNET).

The following is text that was submitted by online survey. The answers refer to sections of the National Women's Health Strategy 2020-2030 Consultation Draft.¹

Some answers required by the survey (e.g. on demographic characteristics such as country of birth) have been omitted. Reference material has been added which was not possible to include in the online survey.

Comments on the overall structure of the strategy

Intimate partner violence is the leading contributor to death, illness and injury among women aged 18 to 44, as documented by the 2016 ANROWS report, 'A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women'.² Mental health conditions were the largest contributor to the burden

¹ <https://consultations.health.gov.au/population-health-and-sport-division-1/establishing-a-national-womens-health-strategy/>

² <http://media.aomx.com/anrows.org.au/s3fs-public/28%2010%2016%20BOD%20Compass.pdf>

due to physical/sexual intimate partner violence, with anxiety disorders making up the greatest proportion (35%), followed by depressive disorders (32%).³ Other diseases linked to physical/sexual intimate partner violence are early pregnancy loss, homicide and violence, suicide and self-inflicted injuries, pre-term and low birth weight, and alcohol use disorders.

It is good to see domestic and family violence addressed directly (albeit briefly) in the draft strategy, and some references to violence against women at other points. However, given the large and complex impacts of this violence on women's health – as well as the key role of the health system in responding to and preventing it – violence against women should be a key priority in itself.

Some specific health dimensions of violence against women need to be drawn out in more detail, including:

- sexual violence including sexual harassment
- reproductive coercion and access to reproductive healthcare options, including abortion, and
- the need for comprehensive sexuality education and respectful relationships programs
- the strong links between violence against women and mental health
- brain injury resulting from violence
- access to sexual and reproductive health services for international students (insurance prevents them, 1 year waiting period)
- forced sterilisation and involuntary contraception of women with disability
- unnecessary medical procedures on intersex infants

Comments on the context and background

Given the pervasiveness of violence against women (VAW) and the need for whole-of-society approaches to preventing and responding to it, there is a need to integrate VAW prevention and response capacity throughout the health system. For example, in relation to palliative care, the services delivering and supporting such care could be improved by integrating the awareness that people in need of palliative care include victims/survivors and perpetrators of various forms of violence against women, as do family members and other informal carers.

The AIHW 2018 report on domestic and family violence and sexual assault found that victims/survivors were most likely to seek advice or support from GPs or other health professionals – after family and friends and before specialist services including help-lines in terms of likelihood. Yet the health system is not yet well-equipped to respond adequately to such disclosures in terms of professionals' own knowledge and capacity, and in terms of systemic supports (such as having enough time to engage with patients sensitively and the existence of referral pathways and an adequately resourced and coordinated VAW service sector).

³ Julie Ayre, Miriam Lum On, Kim Webster, Michelle Gourley and Lynelle Moon (2016) Examination of the burden of disease of intimate partner violence against women in 2011: Final report, Sydney: ANROWS
<https://dh2wpaq0gtxwe.cloudfront.net/s3fs-public/BoD%20Horizons.pdf>

Finding feasible mechanisms to achieve this integration will be a task for those working in the VAW and health sectors over the coming years. The role of the Women’s Health Strategy should be to prioritise and create a platform for this joint work.

In terms of conceptualising the role of the health system in relation to VAW, we refer you to:

- WHO (2013) ‘Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines’⁴
- WHO (2012) Health consequences of intimate partner violence⁵
- García-Moreno et al (2015), ‘The health-systems response to violence against women’, *Lancet*, Vol 385 April 18, pp. 1567–1579.
- Victoria’s 10-Year Industry Plan for Family Violence Prevention and Response and associated capabilities frameworks⁶

We note that the women’s health strategy is being developed in conjunction with a men’s health strategy. While we welcome the approach of addressing health needs in a gender-responsive way, we emphasise the importance of both plans being guided by a structural view of gender inequality, as well as noting the need to be responsive to the experiences and health issues of gender-diverse and transgender people.

On p7, Figure 3, the reference to “women inexperienced in relationships” being at greater risk of violence could be taken to imply that the onus is on women to behave in certain ways in relationships to avoid the risk of violence, whereas in fact violence is the responsibility of those who use it.

Comments on the strategy blueprint, policy principles and objectives

We welcome the inclusion of gender equity as the first principle. It would be good if the strategy could identify the links to gender equity across social policy areas including but not limited to health, e.g. “work with other areas of policy to promote gender equality.” For example, see comments in a later question on older women and poverty.

Under principle 2. Health equity between women, it is good to have the diversity of women recognised and equity between them articulated as principle. It would be good to have a deeper analysis of the intersecting and interacting forms of discrimination/oppression and advantage/privilege rather than thinking of these as separate single blocks of ‘priority populations’. Targeting particular ‘at-risk’ populations sometimes works against more equitable universal forms of access and support overall. The strategy needs to consider and challenge presumptions about who are the ‘normal’ or ‘main’ people being addressed, and not just focus on measures to address the groups of people experiencing the worst outcomes.

Under principle 4. – A focus on prevention, it would be good for the strategy to integrate a gender equality perspective through the focus on prevention, acknowledging that improving gender equality overall is important for women’s health, in part because it is the key measure for preventing violence against women.

⁴ <https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

⁵ http://apps.who.int/iris/bitstream/handle/10665/77431/WHO_RHR_12.43_eng.pdf?sequence=1

⁶ <https://www.vic.gov.au/familyviolence/family-safety-victoria/industry-plan.html>

Comments on the priority areas

Given the importance of VAW as a contributor to ill health, particularly mental illness, it does not seem adequate to have the section on domestic and family violence as the only identified section in the strategy on VAW and for it to be situated in the 'overrepresented conditions' section. VAW needs to be identified as a priority area in its own right as well as included under each priority area.

Priority area 1: Mental health

Under the first set of priorities and actions, and throughout this section, violence needs to be identified as a key contributor to mental illness. For example, the "resources, guidance and support [provided] to women, healthcare professionals and education providers" needs to include material on various forms of violence and equip people to elicit (where appropriate) and respond appropriately to indications that individuals have experienced or are experiencing violence. More importantly, as in the health system generally, the capacity to prevent and respond to VAW needs to be addressed at the whole-of-organisation level, incorporating "champions", measures to respond to practitioners' own experiences of violence through employee support, and proper referral pathways and choices for individuals (García-Moreno et al 2015).

In relation to the second set of priorities and actions:

- Training for GPs should be included as a point of intervention, as GPs sometimes lack knowledge about mental health care plans and their negative responses to women presenting for plans can be big barriers to access.
- The limit of 10 sessions is also a problem, including for young women and women from lower socio-economic positions who may not be able to afford private health care, and can result in intermittent or lapsed care.
- It should also be acknowledged that a diagnosis is required to get a mental health plan and some women experiencing violence are reluctant to pursue that avenue in light of the possibility that records of their counselling may be subpoenaed for use against them in family court cases.

Under the third set of priorities and actions:

- In terms of building engagement with young women, this must be strengths-based and treat young women as experts in their own health, including both face-to-face and online forums.

Under the fourth set of priorities and actions

- We suggest considering the need for adequate support services when promoting models of peer advocacy and 'end-user voice'. The health system needs to bear the primary responsibility for providing adequate services, instead of relying on the advocacy of people with lived experience. This is particularly important in light of the prevalence of violence as a factor in mental health issues.
- The strategy should note that the mental health needs of lesbian people, transgender people, non-binary people and people with intersex variations are likely to be different among each other, and require different responses. This needs to be better understood.

Priority area 2: Chronic disease and preventative health

The concept of preventative health should include measures to promote gender equality and prevent violence against women, given the role of gender inequality in driving this violence, and the fact that violence against women is a leading preventable contributor to illness, injury and early death.

Violence prevention needs to be undertaken through an intersectional approach, with increased funding and support for community-led and culturally-sensitive prevention and early intervention initiatives in diverse communities including Aboriginal and Torres Strait Islander, LGBTIQ+, culturally and linguistically diverse, migrant and refugee communities and at-risk cohorts including women with disability, women in the sex industry, women in rural and regional areas, older women and young women.

- On page 16 in section 2, the reference to “female role models”, should be replaced with “celebrate healthy and diverse women and girls as role models” as a better use of sex/gender language.

Priority area: 3 Sexual and reproductive health

This section should include direct references to sexual assault, reproductive coercion and technology-facilitated sexual violence, to make it clear that these forms of violence are among the main factors influencing women’s sexual and reproductive health. Improvements to sexual and reproductive health, and health overall, will be gained by increasing women’s autonomy and control over their sexual and reproductive lives. For women experiencing violence, it is particularly important that legal and health systems support their autonomy rather than undermining it.

Abolishing forced sterilisation, non-consensual abortion and involuntary administration of contraceptives to women and girls with disability should be considered in the scope of the strategy. Likewise, the strategy should also commit to ending the practice of unnecessary medical procedures on people with intersex variations.

In relation to the second set of priorities and actions:

- Increased support for women in the perinatal period should include a VAW lens, and screening for violence during this period needs to be conducted in a skilled and sensitive way.

Under the third set of priorities and actions:

- Comprehensive sexuality and relationships education needs to be delivered in all Australian schools with a whole of school approach.
- Sexuality and relationships education must be inclusive for people of diverse genders, sexualities and with intersex variations, young people from Aboriginal and Torres Strait Islander backgrounds, and people from culturally and linguistically diverse backgrounds.
- Given that abortion is now decriminalised (up to varying periods of gestation) in every Australian state and territory except New South Wales, it is imperative that abortion be made readily accessible as a health procedure for women and pregnant people.

This process could include training programs for doctors, as well as a public health campaign to destigmatise abortion.

- Birth control should be made more accessible by availability over the counter rather than through a doctor's prescription.

Priority area 4: Conditions where women are overrepresented

As mentioned above, while it is good to see domestic and family violence addressed directly, given the large and complex impacts of violence on women's health – as well as the key role of the health system in responding to and preventing it – violence against women should be a key priority in itself. We therefore question the inclusion of domestic and family violence primarily as a “condition where women are overrepresented”.

In relation to the first set of priorities and actions:

- Inclusive practices should include access to health services including abortion and contraception for women experiencing reproductive coercion and domestic violence.
- Comprehensive sexuality and relationships education is needed, including about respectful relationships.
- It needs to be acknowledged that family violence disproportionately affects young people who are transgender, lesbian, bisexual, gay or gender diverse (ACON 2010, Writing Themselves In 3).
- Specific actions to reduce harm should include screening for reproductive coercion as a way of educating health system professionals on domestic/sexual violence (Children By Choice, 'Reproductive Coercion'⁷)

Under the second set of priorities and actions:

- As noted above, it is highly problematic to call for 'empowering' victims of violence to speak out and be advocates for their peers before sensitive and responsive systems are in place, and when funding for shelters, and access to mental health and other support services are inadequate.
- The strategy needs to recognise that coordination with other systems including legal systems, justice systems and health care professionals must be appropriate and sensitive for women to be 'empowered' to report and speak, including coordination with mental health care services.

Priority area 5: Healthy aging

This section needs to acknowledge the feminisation of poverty, the high risk of poverty for older women, and the fact that these dynamics compound the impacts of violence. Single elderly women – aged over 60 – living in Australia belong to the lowest income earning family group in the 2017 HILDA survey.⁸ This family subset, according to the survey, earns on average less than \$30,000 a year. This group is the most likely household type to live in poverty. Older women are one of the fastest growing groups experiencing homelessness. AIHW data shows that from 2014/15 to 2015/16 there was a 17.5% increase in the number of women 55+

⁷ <https://www.childrenbychoice.org.au/factsandfigures/reproductivecoercion>

⁸ Melbourne Institute (2017), *The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 15* https://melbourneinstitute.unimelb.edu.au/_data/assets/pdf_file/0010/2437426/HILDA-SR-med-res.pdf

seeking out specialist homelessness services (SHS).⁹ This is twice the rate of growth for the generalist SHS population.

Improving women's economic well-being across the life course creates options for building lives free of violence and improves prospects for healthy aging. In contrast, violence itself undermines women's economic well-being which undermines access to preventive health services. The health impacts of both poverty and violence on an individual and population level become acute for older women and need to be addressed in the strategy.

Comments on strengthening partnerships

As mentioned above, integration of a VAW lens throughout the women's health strategy will create a platform for better partnerships between those working in the health system and those working to prevent and respond to violence against women.

Additional comments

We encourage you to use the terminology of domestic and family violence instead of intimate partner violence.

We also encourage you to use the terminology of women from culturally and linguistically diverse backgrounds consistently across the strategy. Currently, while we welcome the intention to use the term CALD women to be inclusive of migrant, asylum-seeking and refugee women, this is not used consistently. We also note the importance of identifying refugee women specifically when it comes to mental health for instance. We advise against the use of the 'non-English speaking background' terminology use.

If you would like to discuss the contents of this AWAVA submission further, please contact Merrindahl Andrew, AWAVA Program Manager, using the details below.

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⁹ Equality Rights Alliance (2017) 'Pre-Budget Submission', <http://www.equalityrightsalliance.org.au/wp-content/uploads/2017/02/ERA-Pre-Budget-Submission-17-18-Final.pdf> p4.