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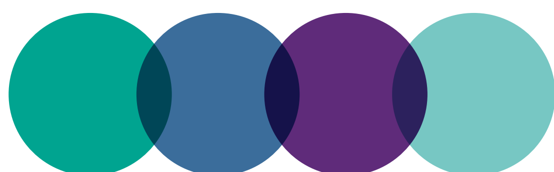

WOMEN AND HEALTH AND WELL-BEING

Position Paper 2012

Australian Women's Health Network

Women and Health and Well-being

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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 (Sen and Ostlin 2007, p. viii).

Table of contents

Executive summary 5

Recommendations 6

Definitions 8

Women's health in social context 9

The determinants of health 9

Indigenous women 10

Refugee women 11

Women with disabilities 11

Why gender matters 12

Smoking 13

Alcohol 13

Violence 13

Weight and nutrition 14

Non-communicable (chronic) diseases and gender 14

Cancer 15

Cardiovascular disease 15

Mental health 17

Diabetes 17

Gender mainstreaming and gender equity 17

Women's health and well-being in relation to work 18

Why citizenship matters for women's health and well-being 21

Summary 22

References 23

Executive summary

Women in Australia have fewer financial resources, less wealth and property, and higher family burdens in the dual economies of paid and unpaid work than their male counterparts. They ensure the reproduction, well-being and survival of others, from newborn to old age, but often lack necessary support and financial independence. There are specific groups of women whose health is significantly compromised by their exposure to risk and social experiences. In particular, the poor standard of health of Indigenous women, refugee women and women with disabilities raises concerns about the capacity of health services to meet their needs. This paper considers the means by which Australian health programs and policy can redress these inequities. It further highlights the inequities for women in relation to non-communicable diseases (chronic diseases). The social gradient, the health sector, and gender are key determinants of health equity for women. The health sector in Australia has a responsibility to improve equity; however, prevailing inconsistencies in its understanding of how gender impacts on women's health outcomes currently inhibit effective action.

The paper argues broadly for recognition of a number of principles essential to establishing a firm basis upon which to redress health inequities for women:

- It is impossible to understand women's health outcomes without also understanding the social context of women's lives;
- International human rights and cultural conventions are a powerful mechanism for mobilising action on women's health and well-being;
- Gender power relations impact on social and health outcomes for women;
- The factor of gender accounts for the fundamental differences between women's and men's experience of health issues. As such, improvement of women's health care necessitates affording high priority to gender issues in all aspects of health care;
- In determining health and illness outcomes, health systems have a responsibility to acknowledge the importance of gendered social relations, social factors, and conditions of living;
- Understanding the ways in which gender impacts on chronic health conditions will be enhanced by explicitly mainstreaming gender in the process of informing gender-specific services;
- It is vital to infuse gender analysis, gender sensitive research, women's perspectives, and gender equity goals into policies, projects and institutional ways of working.

Recommendations

To improve the health and well-being of Australian women, AWHN recommends that:

1. the Australian National Preventive Health Agency provide leadership to health promotion and preventative health programs in gendering action across the social determinants of health; at the individual level, and both intermediary and structural levels. (p.9).
2. the Australian Health Ministers' Advisory Council provide leadership on improving health equity through implementation of action promulgating understanding of how gender impacts on health outcomes across population groups and in all policy areas, e.g., through the inclusion of gender equity as a key performance indicator in all policies, programs and funding agreements. (p.20).
3. the Australian National Preventive Health Agency Expert Committees on Obesity, Tobacco and Alcohol incorporate into their work comprehensive gender and health analysis. (p.13).
4. the Commonwealth Government host a forum of key opinion leaders to explore ways to increase investment in Australian analysis of gender and of non-communicable (chronic) diseases, particularly within those population groups that are marginalised and/or socially excluded, and to outline the application of solutions by funded health and preventative health agencies. (p.14).
5. the Commonwealth Government commission the development of a gender and diversity analysis training package, and fund its delivery to those involved in policy development: this will ensure that state and federal government policies reflect gender equity as well as the diversity of the communities they serve. (p.21).
6. all Federal, state and territory health policies, whether they concern cancer, heart disease, mental health, or ageing women, be revised—after consultation with women's health and NGOs for information regarding best practice—to incorporate a guide for health practice and programs which ensures that:
    - health systems are responsive to women's particular needs;
    - strategies are developed to improve the health status and experiences of all women, but particularly vulnerable and marginalised women;
    - there is a commitment to expanding service, workforce and system capacity for gendering of policies and programs;
    - there is accountability, whereby outcomes for women are measured and transparent;
    - gender mainstreaming is promoted by the health sector in order to embed gender in policies across sectors, e.g., in social inclusion, or disability and employment policies. (p.17).
7. the Commonwealth Government invest in creating healthy workplaces which include a greater workplace health focus on upstream policy and program approaches, thereby ensuring more gender equitable workplaces. (p.18).
8. priority be given to meeting set targets for gender equity in local, state and federal parliaments, and on boards: this is necessary given that the representation of women in politics, positions of leadership, and decision-making in public life, business and industry are critical determinants of the conditions that impact on women's health and well-being. (p.21).
9. the Federal Government explore incentives that reward businesses which actively promote women to executive management levels. (p.21).
10. governments and Industrial Tribunals give priority to addressing the gender pay gap, as highlighted by the Australian Human Rights Commission. (p.19).
11. national, state and territory governments give preference to organisations/businesses that have
    - gender equity as a goal in the organisations strategic plan
    - a high-level of support and direct top-level policies for gender equality and human rights. (p.17).
12. a report is commissioned to examine the extent to which the Australian economy relies on women's unpaid labour. (p.18).

13. national Health and Medical Research Council research priority be given to the effects on the health of individuals who care privately for disabled, elderly, or chronically ill charges: this is necessary as health system reforms are increasingly shifting the care of sick persons from institutional care to home care, yet the effects on health of caring is under-researched and financial or other support for carers is limited. (p.18).

14. the Commonwealth Government commission a report into CVD diagnostic and therapeutic procedures to identify gender bias in their application, and to make recommendations for achieving more equitable outcomes. (p.15).

15. public money should only be provided to public and not-for-profit child-care services that have transparent parent-managed boards, with public agency oversight of services and their placement within communities. (p.20).

16. the entirety of the *National Plan to Reduce Violence Against Women and Their Children* be implemented and adequately funded at both federal and state levels. (p.13).

17. a national health strategy for Australia be developed as a priority which addresses the social determinants of sexual and reproductive ill-health: this will improve the sexual and reproductive health of the community. (p.12).

Definitions

Burden of disease / Burden of poor health:
Disease burden is the impact of a health problem in an area, measured by financial cost, mortality, morbidity, or other indicators. Measures of the burden of disease provide insight into the loss of health and well-being of Australians due to premature mortality, disability and other non-fatal events.

Cardiovascular diseases (CVD): Diseases of the heart (cardio) and blood vessels (vascular). The main cardiovascular diseases, and the focus of this report, are coronary heart disease (CHD, including heart attack and angina), stroke, and heart failure.

Citizenship: access to the civil, political, economic, social and cultural rights of one's country of nationality. This definition is not without complications because women in many countries are often subject to discriminatory laws that deny them the rights accorded to men (UN 2003).

Non-communicable diseases (NCD):
Non-communicable diseases, also known as chronic conditions/diseases, are a group of conditions including cardiovascular diseases, cancer, mental health problems, diabetes mellitus, chronic respiratory disease including asthma, chronic kidney disease, and musculoskeletal conditions. These disorders are largely preventable and are linked by common risk factors, underlying determinants, and opportunities for intervention. Most NCDs require long periods of care and treatment.

Social gradient: In general, the lower an individual's socioeconomic position, the worse their health; a social gradient in health runs from top to bottom of the socioeconomic spectrum.

Well-being: In population health, well-being incorporates measures of self-assessed health status and psychological distress as indicators of overall well-being. Well-being is more broadly connected to citizenship, which is an outcome of human and cultural rights, as well as an outcome of meaningful participation in the social, economic, and political domains of society.

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.

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.

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.

The social gradient is well-established in relation to health and well-being (Kaplan et al 1996; Turrell et al 2006; Marmot and Wilkinson 2003; Wilkinson and Picket 2008) and in relation to specific conditions (Brunner, Marmot et al 1997; Heeley et al 2011). Low educational attainment is a long-established marker of low socio-economic status that has consistently been associated with an increased risk of cardiovascular morbidity and mortality in men, and even more strongly in women (Heller et al 1984), particularly women with disabilities (Salthouse 2005) and women who are sole parents (AIHW 2010a). Women in low status jobs, who also report feeling that they have low control at home and over life circumstances, have an increased risk of depression (Marmot 2001). Australian data shows a clear social gradient in the prevalence of obesity and diabetes among adult women, and similar trends in tobacco use and risk for alcohol misuse (Friel 2009). Generally, however, there is a lack of gendered analysis of the various determinants and their impact on the health of all Australians.

Both gender and the health sector itself are vital determinants of health and therefore, are keys to improving health equity (Baum, Begin, Houwerling, Taylor 2011; CSDH 2008). However, the health sector in Australia exhibits neither a cohesive nor a proficient understanding of how gender impacts on health outcomes (Keleher 2012). The National Health Priority Areas are remarkable in their lack of gender analysis. Some states are able to refer to women's health policies that recognise the determinants of health and the actions that need to be taken to change the determinants that impact negatively on women's lives. Generally, however, health policies fail to demonstrate a sound understanding of how gender and other social determinants are related to health outcomes, particularly for key groups of women. Among women there are groups whose health is of concern: those marginalised by poverty, culture, and discrimination because of race, disability, illness or social stereotyping and difference, work and employment status, experiences of violence, and citizenship. The women most marginalised are Indigenous women; women with disabilities; women living in poverty; refugee and migrant women; women whose work is insecure, marginalised, under-paid or invisible (Keleher 2008, p. 336).

Indigenous women

Indigenous women live on average 17–20 years less than other Australian women. The Indigenous female population is much younger overall than the non-Indigenous female population. Access to formal education tends to be lower for Indigenous women living in rural and remote areas. Indigenous women experience more economic hardship than non-Indigenous women and reduced participation in the mainstream workforce (Burns, Maling, Thomson 2010).

Cardiovascular disease is the leading cause of death for Indigenous females, with almost three times the number of deaths than for non-Indigenous females, followed by deaths from neoplasms (mainly cancers), external causes, diabetes, and respiratory diseases. Indigenous women have more babies, who on average are smaller at birth. The maternal mortality ratio for Indigenous women in 2003–05 (the most recent period for which detailed data are available) was 21.5 deaths per 100,000 confinements, almost three times higher than the ratio of 7.9 per 100,000 for non-Indigenous women.

Indigenous women have 2.3 times the standardised rate of hospital admissions than non-Indigenous women, with higher rates attributed to assault, renal dialysis, childbirth-related issues, respiratory disease, digestive disease, and injury/poisoning. Hospitalisation rates for assaults from family violence were 35 times more common for Indigenous females living in Qld, WA, SA and NT in 2003–04 (the most recent data available) than for their non-Indigenous counterparts (FaHSCIA 2009), and 50% of hospitalisations for assault were a consequence of family violence. Hospitalisation rates for family violence-related assaults were highest among women aged 25–34 years. In 2009, the overall rate of imprisonment for Indigenous females was 360 per 100,000 of population, compared with 18 per 100,000 for non-Indigenous females (Burns, Maling, Thomson 2010). Incarceration is strongly linked to Indigenous women's experiences of family violence, rates of which are estimated to be about five times that of non-Indigenous women (Bartels 2010).

Refugee women

Afghan and Sub-Saharan (Eritrea, Ethiopia and the Sudan) refugees make up the largest refugee groups in the world (UNHCR, 2009). One in four refugees arriving in Australia has experienced torture or severe human rights violations, enduring harsh and lengthy periods of displacement before being accepted for settlement (Rintoul 2010). Almost three in four have been exposed to traumatic events such as forced experiences, such as being subjected to rape and other forms of torture or being forced to witness such violent attacks, and have lost or been separated from family members in violent circumstances.

Refugee women face unique problems adjusting to life in Australia. Many refugee women and their families are being resettled in Australia under the Women at Risk program because of their experiences of traumas and dislocation. The program is aimed at assisting women who are raising children and whose spouses have been killed or have gone missing, and who therefore cannot depend on the protection of a male relative. They have multiple complex health problems, including chronic diseases; reproductive health issues; blood disorders such as anaemia; the physical and mental health consequences of rape and sexual assault; depression; anxiety and grief, all of which require gender-sensitive and culturally specific health system responses (Costa 2007). Refugee women are at greater risk of mental health disorders than the general population, exacerbated by unemployment, lack of English language skills, access to appropriate housing, and discrimination, which creates a sense of hopelessness, low self-esteem, and despair (Costa & Williams, 2002; Gilmore, 2002; DoH 2009). Mental health problems are not resolved by resettlement which, in itself, can be a highly stressful process (Gerritsen, Bramsen et al 2006; Omeri, Lennings et al 2006). Grief is ongoing and associated not only with the loss of family through death and dispersal, but also with the loss of country and a particular way of life (Sampson and Gifford 2010; Rintoul 2010). Refugee women seek to establish identity, belonging and citizenship in their new 'place', all of which are linked to health and well-being, but the challenges are many. The evidence regarding problems of refugees and asylum seekers in Australia is thin due to the lack of research being funded (RACGP 2010).

Women with disabilities

Women with disabilities experience high rates of poverty, are over-represented in institutional care, and experience difficulties in accessing health system services (Salthouse 2005). Women with disabilities face multiple types of discrimination and are often more disadvantaged than men with disabilities in similar circumstances. Women with disabilities are often denied equal enjoyment of their human rights, in particular by virtue of the lesser status ascribed to them by tradition and custom, or as a result of overt or covert discrimination (UN CESCR 2005). "Women with disabilities are often information poor with regard to health, particularly in relation to issues such as: managing menstruation, contraception, exploitative relationships, violence, sexually transmitted diseases, sexual assault, menopause, late onset incontinence, osteoporosis, sexuality, reproductive health, self-management, fatigue, increased dependency, and parenting" (Salthouse 2005, citing Temby 1996 and Cooper & Temby 1995).

Why gender matters

Gender is a system of power relations that permeates the structures, processes and practices of all aspects of life, in the domestic and public spheres, in work, workplaces and employment. Gender shapes the character of institutions and their functions (Doyal 1995; Acker 2006), which demonstrates the need to continually advocate for reforms such as equal pay, increasing the number of women on boards and government committees, and the enactment of laws to protect women from violence. Gender is a key determinant of women's health (Sen and Ostlin 2007; CSDH 2008).

Gender is about social experiences and social relations between men and women. Such relations affect health outcomes: as such, gender refers to interrelated biological, psychological and social dimensions of difference and experience:

- *Biological sex* differences include the better infant survival rates of females, and women's longer life expectancy. By these measures women appear to exhibit biological advantages over men. However, Doyal (1995) reminds us that biological advantages which contribute to women's longer life expectancy in no way compensate for the social disadvantages they experience.
- *Psychological* gender differences and experiences include health practices, coping skills and self-concepts, and the psychological differences between women and men. Women and men have different experiences of health services, programs, interventions and the provision of health care, as well as the uptake of health services, e.g., patterns of use of general practitioners. Personal health practices differ, along with the uptake of health messages.
- *Social* experience is about socially determined differences and experiences. Gendered social relationships and norms are powerful, pervasive, and deeply embedded in social structures. Gendered norms that affect women's health include sex role stereotyping, sexism, and discriminatory attitudes that specifically deny opportunities, privileges, or rewards to women because of their sex. Perhaps the single most important aspect of gender is that it is reflected across the social, economic, cultural and political aspects of women's social experience. In other words, gender and health inequities are fundamentally entwined (Krieger 2000).

Gendered social practices are produced and replicated through interactions in workplaces and wider society. When women are demeaned at work, in their homes, or in social situations, gendered social practices are operating to keep women in subordination. Efforts to change those social practices are frequently met with resistance and ridicule which, in turn, produce and reproduce conditions that create unequal conditions or working relationships for women.

When gender is used in reports and data, it is more likely to be used selectively rather than comprehensively (Keleher 2012). Such selectivity frequently considers biological or psychological differences to the exclusion of gender differences. This occurs when indicators are developed using data that is disaggregated by sex, age and socio-economic and ethnic groups in isolation from social experience.

When gender is used comprehensively, there is recognition of the social experiences of women and how these experiences create pathways to poor health. Indicators guide the collection of data that address gender gaps and inequalities shaped by experiences, including stereotypes; social position/social status; societal expectations; discriminations; power relationships; social and sexual norms; and social, cultural and economic environments that shape women's experience and opportunities.

Comprehensive use and understanding of gender health analysis incorporates analysis of social impacts; differences based on social experience; discrimination and its impact; and the means by which inequities are reflected in health issues (Krieger 2000), such as mental health, violence against women, and chronic diseases. Health systems have a responsibility to adopt a comprehensive approach to gendered concepts, rather than employing selective and narrow understandings. Strategies to advance women's health require continual attention. Women comprise the majority of health consumers, the majority of health service providers, and the majority of carers and managers of family health (AWHN 2007). Women in the formal and informal sectors also maintain many roles in the health of communities. Women are the shock absorbers of social and health systems when reforms are implemented in labour markets, welfare budgets and systems, and health systems (Sen and Ostlin 2007; AWHN 2012).

Broadly, there are five areas in which gendered interventions can influence the determinants of health to produce more equitable health outcomes:

- the values, norms, practices and behaviours across society which are discriminatory towards women;
- the effect on women and men of differential exposures and vulnerabilities to disease, disability and injuries;
- gender analysis in health systems and policy that reveals differential effects of caring between men and women;
- gender in health research; and
- the legal frameworks and social norms that determine women's opportunities to participate equally in the paid economy, and to access needed services that are essential to quality of life.

Addressing these areas is necessary for improvements to women's health and well-being, but inaction will have serious economic, health and social consequences for girls and boys, for women and men, and for their families and communities (Sen and Ostlin 2007).

Women's health in Australia may appear to be paradoxical whereby women, on average, live longer than men, but have poorer health across their lifespan and significantly less access to income throughout their lifetime. Life expectancy is increasing for both women and men as effective treatment options are developed for previously life-limiting illnesses. However, when examined from a women's health perspective, there remain issues of concern. Major risk factors for poor health include smoking, alcohol, violence against women, weight and nutrition; all of which have a causal relationship with poverty. The following section applies a gendered lens to these risk factors.

Smoking

Rates of smoking by women and girls are only marginally behind those of men and boys (Cancer Council NSW 2012). Of lone parents who are smokers, 46% are women (Scollo et al 2008), which is consistent with global and Australian data that regular smoking rates are highest among those with low socio-economic status (Cancer Council Victoria 2008). Most concerning is that close to 50% of Aboriginal and Torres Strait islander women and men are smokers.

Alcohol

For Australian women, the social and personal consequences of drinking are among the worst in the world: Australian women are more likely to suffer social consequences such as harmful effects on work and family relationships than women elsewhere (Graham, Bernards, Knibbe 2011). Young people and women are at greatest risk of harm from others' misuse of alcohol. In Australia every year, 24,000 women are victims of alcohol-related domestic violence assaults, and 20,000 children are victims of alcohol-related child abuse (Laslett, Catalano et al 2010).

Violence

> *The term violence against women means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations 1993).*

Domestic violence and sexual assault are the most pervasive forms of violence experienced by women in Australia (FaCHSIA 2009). Violence against women causes 9.4% of poor health among women and is the leading contributor to death, physical injury and mental health disorders among women 15–44 years of age (VicHealth 2004). Violence and abuse cut across lines of income, class and culture (Commonwealth Secretariat 2000), with long-term effects on women's mental health. Indigenous women and girls are 35 times more likely to be hospitalised due to family violence-related assaults than other Australian women and girls (FaCHSIA 2009). There are enormous economic costs of violence. Domestic violence and sexual assault perpetrated against women costs the nation $13.6 billion each year, and by 2021 the figure is likely to rise to $15.6 billion if extra steps are not taken (FaCHSIA 2009). The National Plan recognises that some groups of women experiencing violence will have limited access to services, or have specific needs that are not met by current levels of service provision (FaCHSIA 2009).

Weight and nutrition

Excess body weight tends to be more prevalent among people further down the social and economic scale. Analysis of the AusDiab 1999–2000 data shows a clear social gradient in the prevalence of obesity among adult women (Friel 2009). The most disadvantaged socio-economic groups have double the rate of obesity of the highest socio-economic group. Young women are more prone to obesity than other age groups. The proportion of total disease burden for females attributed to being overweight is 4.3% (males 4.4%) (RACGP 2006).

Non-communicable (chronic) diseases and gender

Non-communicable diseases (or chronic diseases) are closely related to the conditions under which people live; in other words, the lifestyles of people influence their health and quality of life (WHO 2008). The primary chronic diseases include cardiovascular disease, cancer, mental health, diabetes mellitus, chronic respiratory disease including asthma, chronic kidney disease, and musculoskeletal conditions. They are linked to common risk factors: tobacco use, alcohol abuse, unhealthy diet, physical inactivity, and environmental carcinogens. World Health Organisation (WHO) research shows that these risk factors have economic, social, gender, political, behavioural and environmental determinants. Moreover, the WHO and the UN have called for countries to include gender and other differences between population groups in their research and prevention strategies:

> *Countries need to establish new, or strengthen existing, policies and plans for the prevention and control of non-communicable diseases as an integral part of their national health policy and broader development frameworks … with special attention given to dealing with gender, ethnic, and socio-economic inequalities together with the needs of persons with disabilities … Emphasis will be laid on diseases that affect women in particular, in order to promote women's health and gender equity … (WHO 2008, p. 15).*

The incidence, prevalence and experience of NCDs conform to a social gradient. Globally, biological difference, gender roles, socio-economic position, and social marginalisation expose women and men to different NCD risks, dictating whether people can modify their NCD risk behaviours, and determining the success of NCD interventions (PAHO n.d.). Women's equality and empowerment is one of the effective means of addressing the root causes of NCDs. NATSEM (2012) has found that as well as relieving suffering, addressing inequity has the potential to save millions of dollars in health system and welfare costs:

> *Those who are most socio-economically disadvantaged are twice as likely to have a long-term health condition than those who are the least disadvantaged. The cost of government inaction on the social determinants of health leading to health inequalities for the most disadvantaged Australians of working age is substantial. If there were no inequity in the proportions in good health or who were free from long-term health conditions, then an estimated 370,000–400,000 additional disadvantaged Australians in the 25–64 year age group would see their health as being good and some 405,000 to 500,000 additional individuals would be free from chronic illness (NATSEM 2012 p. ix).*

In other words, the people with the greatest social and economic disadvantage have the poorest levels of health. As people are positioned further down the socio-economic ladder their risk of shorter lives and higher levels of disease risk factors increases (AIHW 2010a; Friel 2010; Diabetes Australia 2012). In contrast to the level of need, "socioeconomically advantaged women are more likely to use specialist medical, allied health, alternative health and dental services than less advantaged women. Thisis of particular concern when trying to prevent and treat chronic disease … where optimal care requires use of multidisciplinary services" (Friel 2010). Given that women have higher rates of chronic disease than men and live for longer with those diseases, that there are gender differences in both diagnosis and treatment, and that a greater proportion of women live in social and economic disadvantage, the social gradient in health is undoubtedly gendered.

That said, little is known about the impact of NCDs on Aboriginal women or how they manage the burden of NCDs in their families, although it is known that Aboriginal people, who have experienced total social disruption of their way of life, marginalisation and social exclusion, suffer the highest rates of NCDs in Australia.

While it is understood that managing gender influences and living conditions are key to decreasing the burden of NCDs, particularly CVD and Type 2 diabetes, there is a lack of Australian analysis of gender and NCDs across population groups such as women with disabilities, women from culturally and linguistically diverse backgrounds, rural women, and same sex attracted women. Social, rather than physiological factors determine NCD patterns. Therefore, gender-sensitive and culturally appropriate approaches are required for both prevention of chronic diseases and effective self-management that allows women to reach optimum good health. The NCDs reviewed here have distinctly gendered dimensions which are highlighted to illustrate why gender analysis matters.

Cancer

Since 2006, lung cancer has overtaken breast cancer as the leading cause of cancer death in women (Cancer Council Victoria 2010), a direct outcome of the increased rate of women smoking since the 1970s (AIHW 2010b); Lung cancer is the only common cancer among women for which mortality rates are increasing rather than decreasing (Cancer Council Victoria 2010; AIHW 2012). Unlike the decreasing trends in lung cancer for men, trends in the age-standardised rate of lung cancer for females has been increasing since 1982, and is expected to continue to increase slowly by 0.4 cases per annum (AIHW 2012). The largest increase in rates is expected in females aged 85 and over, increasing from 156 cases per 100,000 females in 2007 to an estimated 214 cases per 100,000 in 2020; large increases are also expected in females aged 65–84 years (AIHW 2012, p. 52). Smoking is the single biggest risk factor for lung cancer.

Breast cancer is the most commonly diagnosed cancer among women, at a rate approximately double that of bowel cancer (AIHW 2010b). Active smoking is associated with an increase in breast cancer risk among postmenopausal women (Luo, Margolis, Wactawski-Wende 2011); smoking, alcohol, obesity and diabetes are the greatest risk factors for bowel cancer (Snowden 2009) and pancreatic cancer, in which 20% of cases in Australian women over 35 are also linked to smoking (Cancer Council Victoria 2010).

Cardiovascular disease (CVD)

The main cardiovascular diseases are coronary heart disease (CHD), including heart attack, angina, stroke, and heart failure. Women are four times more likely to die of heart disease than breast cancer. In 2008, heart disease claimed the lives of 11,221 Australian women, while 2,774 died of breast cancer (Heart Foundation 2011). While heart disease is the overall leading cause of death in women, it is not as relevant among younger age groups, with cancer the highest killer of women aged 25–64 years old. Heart failure is the leading cause of death in the oldest female age group, particularly in women aged over 65 years. Depression is a significant co-morbid factor for women with CVD.

While CVD has strong familial pathways, much of the CVD burden can be explained by known modifiable risk factors. Most Australian women (more than 90%) have at least one modifiable risk factor for CVD and half of all women have two or three risk factors which include smoking, diabetes, lack of exercise, psychosocial distress, poor diet, being overweight, and not taking anti-hypertensive drugs and/or taking cholesterol lowering drugs (Mitchell 2011). Many of these risk factors are very common among Australian women: the vast majority consume inadequate amounts of fruit and/or vegetables, three-quarters are physically inactive, more than half are overweight or obese, and almost half have high blood cholesterol. Many of these risk factors are already common among females as young as 35–44 years: it is more common for females to be overweight or obese than to have a healthy weight; and one in five of those aged 20–29 years smoke daily (Heart Foundation 2011).

High-risk groups for CVD are Aboriginal and Torres Strait Islander men and women, culturally and linguistically diverse populations, women with co-morbidities such as diabetes, and older women living with a disability. Social isolation, depression and marginalisation are all predictors of CVD. Smoking is a key common risk factor across all high-risk groups. The social determinants of CVD in women are highlighted in the adjacent column.

SOCIAL DETERMINANTS OF CVD IN WOMEN

The Australian Institute of Health and Welfare has found that many important diagnostic and therapeutic procedures for CVD tend to be less common among [Australian] women than men. Key findings from this evidence indicates that heart disease in women is largely being undiagnosed, under-managed and under-reported, with a poorer prognosis, greater likelihood of disability and higher rates of illness and death compared with men. Social determinants such as socioeconomic status, cultural background, health literacy, and rurality also adversely impact on cardiovascular health in women. Women view heart disease of low personal relevance, as an easily fixable condition, and have limited understanding of the clinical risk factors. In addition, changing social norms about body shape and eating patterns indicate women are more likely to view themselves as healthy even if they are overweight or have other risk factors, meaning they are less likely to respond to prompts to improve their heart health (Heart Foundation 2011, p. 9).

Gender differences for women in CVD include:

- Higher levels of hypertension
- Higher levels of renal dysfunction (a major factor in CVD)
- Lower rates of recommended therapies for acute coronary care on hospital discharge (Heart Foundation 2011, p. 9).
- In 2006–07, women hospitalised with relevant cardiovascular diagnoses were less likely than men: to have coronary angiography or echocardiography; to undergo carotid endarterectomy; to receive coronary artery bypass grafting or percutaneous coronary interventions; or to have a heart defibrillator implanted (AIHW 2010a, p. x).

Mental health

Depression causes a significant burden of poor health in women, causing 10% of the total disease burden. Violence is the major social factor that underpins depression. Violence is still the leading contributor to death, disability and illness for women. The mental and physical impact of violence against women causes a higher burden of poor health than the risk factors of smoking, alcohol and obesity combined. Among women who experience three or more forms of gender-based violence (such as rape, sexual assault, stalking or being bashed by a partner), the lifetime rate of mental disorder is 89.4%. For women who have not experienced violence, the rate is 28% (Rees 2011).

Diabetes

In high-income countries, the prevalence of type 2 diabetes tends to be highest in people who are poor (Unwin, Whiting, Roglic 2010), which gives rise to food insecurity and housing unaffordability (Raphael, Daiski, Pilkington 2012). The most important determinants of type 2 diabetes are related to obesogenic environments that foster low levels of physical activity and access to energy-rich diets (Unwin et al 2010). "Gender roles and power dynamics shape vulnerability to diabetes, affect women's health-seeking behaviour and access to health services, and influence the impact of diabetes on women's health" (IDF 2012, p. 1). For some women, their low social status equates to low nutritional status, while cultural dress and mobility codes restrain women's physical activity. Where there are barriers in accessing healthcare, there are increased rates of health complications. As the prevalence of type 2 diabetes in women of reproductive age has increased, so too has the prevalence of gestational diabetes (GDM), a form of diabetes onset (or first-recognised diabetes) during pregnancy. GDM is a major cause of maternal and infant morbidity and mortality and a key factor in the intergenerational transmission of diabetes (IDF 2012).

Women are much more likely to be sole parents, and as such are much less likely to undertake regular exercise. Their underemployment or low employment may mean they have fewer social networks and social connections, which are predictors of sustained participation in physical activity (Miller, Trost, Brown 2002; Brown, Heesch, Miller 2009). Lone parents with diabetes have little time for personal self-care, insufficient money for necessary blood-testing equipment, and compromised optimal food intake (Raphael et al 2003).

Gender mainstreaming and gender equity

One of the actions that health systems can take to improve health outcomes for women is gender mainstreaming. The aim of gender mainstreaming is to infuse gender analysis, gender-sensitive research, women's perspectives, and gender equity goals into policies, projects and institutions.

Despite its pioneering work on women's health policy, gender mainstreaming has been minimal in Australia, and gender equity is rarely, if ever, identified as an outcome measure for policy and programs (Keleher 2012). Indeed, the degree of gender blindness in Australia's health policies suggests that there may be active resistance to gender mainstreaming and/or that there is a lack of specialist expertise regarding women's health among policy makers (Keleher 2012). Certainly, some Australian States (NSW, Victoria and South Australia) have demonstrated capacity for women's health policy based on the social determinants of health and the need for strengthened intersectoral work that is necessary to secure effective outcomes for women, particularly in the area of violence against women. However, health policies at state/territory and national levels are only rarely gender-informed (Keleher 2012).

The purpose of a health system should be to increase health, well-being and equity, and to decrease inequities. However, the tendency of health policies and programs to be gender blind undermines those fundamental goals. Health policies, whether for cancer, heart disease, mental health, or ageing women, should provide a guide for health practice and programs by ensuring that:

- health systems are responsive to women's particular needs and work with women's health and NGOs for information about best practice;
- strategies are developed to improve the health status and experiences of all women, particularly vulnerable and marginalised women;
- there is a commitment to expanding service, workforce and system capacity for gendering of policies and programs;
- there is accountability and outcomes for women which are measured and transparent;

- gender mainstreaming is promoted by the health sector, so that gender is embedded in policies across sectors, e.g., in social inclusion, disability and employment policies.

As Sen and Oslin argue (UN 1995), gender inequities are persistent in all societies:

> *While its forms vary across time and space and may be blatant or more subtle, the system of gender power that places women in subordinate social positions has been remarkably pervasive and persistent. The consequences of gender power can be felt by women and men in practically every field, and most certainly in health (Sen and Ostlin 2007, p. 12).*

Gender equity is defined by the gendered power relations between women and men that mitigate poor social and health outcomes for women. The effects of gendered power relations are different for women and men. Obstacles that women face in their quest for autonomy and opportunities are: the likelihood that they will be identified with the domestic rather than the public spheres; limiting social contexts; prejudice in their domestic and public lives; stereotyping; and the subtle and gross ways in which women and girls are rendered invisible and disempowered (Keleher and Franklin 2008). For example, some policing and legal systems do not actively discourage violence against women and girls, and they fail to bring charges against the perpetrators, actions which actively disempower women and make their experiences of violence invisible. Psychiatric institutions that expose vulnerable women to the predatory behaviours of some men also fail to value women's need for safety, and expose women to obvious risks (Lelliot and Quirk 2004, and Graham 1998 cited in VWHS 2009).

Societies and communities in which gender stereotypes are upheld have more unequal power relationships, and are more likely to tolerate cultures of violence against women and girls (VicHealth-DHS 2004). Aboriginal women account for 75% of the victims of Aboriginal violent crime and, overall, are 4.6 times more likely to be the victims of violent crime than non-Aboriginal people.

If women's health and population health are to be improved, health systems have a responsibility to acknowledge social relations, social factors and conditions. Equitable gender outcomes are derived from redressing inequitable social, economic and political determinants of health that arise from disempowering social norms and unequal distributions of power and resources.

Women's health and well-being in relation to work

Through their unpaid work as carers, women meet the physical, social, emotional and financial needs of younger and older populations, as well as family members with illness and disability. Responsibility for unpaid work has serious implications for women's financial independence and for their health. Indeed, there is a growing feminisation of poverty among women and their children. In 2005, the annual cost of replacing unpaid carers was estimated to be $30.5 billion (NATSEM 2004 cited by Carers Victoria 2003). Health system reforms are increasingly shifting the care of sick persons from institutional care to home care, yet the effects on health of caring is under-researched and to a large degree remains invisible. Respite care is scarce, while support for carers is limited and provided on an ad hoc basis (Carers Victoria 2003).

Despite gains in paid work participation rates over time, women's earnings remain persistently lower than men's incomes. Over their adult lives from 25 years of age, men can expect to earn 1.5 times the income of women (FaHSCIA 2010). In 2006, men held around 66% of total superannuation account balances, compared to 34% for women. By 2008, superannuation balances and payouts for women were approximately half of those of men. While the gap has narrowed, women will remain vulnerable to poverty in retirement, as the gap is predicted to persist for coming generations (Aust Human Rights Commission 2009).

The gender pay gap and its effects are highlighted by the Australian Human Rights Commission, quoted in the following column.

THE GENDER PAY GAP

The gender gap exists because of women's patterns of work and care: their disproportionate responsibility for unpaid work and their lower pay relative to men. However, the factors shaping these patterns of work and care are complex and interconnected. A close examination of women's and men's lives reveals the cumulative and consequential nature of experiences and decisions relating to paid work and care over the lifecycle that lead to the gender gap in retirement savings. Instead of accumulating wealth through the retirement income system as intended, due to experiences of inequality over the lifecycle, women are more likely to be accumulating poverty (Australian Human Rights Commission 2009, p. 1).

Participation in the economy is a key determinant of health. Women are increasingly participating in the paid workforce and managing careers to provide needed household income while carrying a disproportionate burden of caring for family members. Women are intensely vulnerable because of the social pressures associated with dual roles in the paid and unpaid economy, as well as the unrecognised impact on them of economic reforms, health sector reforms, and changing employment regimes. It is primarily women who find that they are expected to juggle unpaid caring responsibilities with paid work while absorbing the financial impact of economic reforms—such as the increasing casualisation of work, i.e., insecure work without paid leave entitlements—concentrated among occupations and industries that are typically low paid (Richardson 2012). In August 2010, 2.2 million, or 24 per cent of employees, did not have paid leave entitlements, and of these, 55 per cent were female (ABS 2011). Women earn much less than men over their working lifetimes, and have much smaller superannuation levels, and as a result older women tend to be reliant on the welfare system and to spend many years in old age living in poverty (Senate Committee 2008).

The consequences of conservative industrial relations reforms—which are drivers of increasing inequality—jeopardise women's health and long-term financial well-being. Punitive labour market reforms—e.g., the abolition of penalty rates; the impact of increasingly casualised labour—affect job security and impact on women's quality of life and their access to money which, in turn, constructs and maintains social norms concerning the value of women's economic security. Health system practices such as early discharge from hospital, along with difficulties of accessing respite and residential aged care, nursing home care for people with severe disabilities, and supported accommodation for people living with serious mental illness, are increasing the burdens of caring, which, as a consequence, construct and maintain expectations about women's duties and responsibilities. Unpaid caring responsibilities also restrict women's opportunities for earning income, and magnify their experience of illness and disease.

Both job insecurity and unpaid caring duties constitute social expectations that are intensely gendered. There is increasing segregation of women in lower-paid, less secure, and informal jobs, which combines with the stress of monotonous work and low levels of autonomy. Societal norms underpinning gender discrimination in the workplace also impact on women's health and well-being. A well-recognised strategy to integrate gender concerns into the workplace is that of family-friendly workplaces: how these can be strengthened is outlined in the following column.

STRENGTHENING FAMILY-FRIENDLY WORKPLACES

The need for family-friendly workplace policies and practices to be strengthened is essential for the health and welfare of all populations. Family-friendly work programs include: child-care, elder care, maternity and paternity leave, support for women during maternity and on return to work, the possibility of being able to nurse infants, the possibility for flexible starting and finishing times determined by the worker, and the possibility for flexible leave arrangements and career-break schemes determined by the worker, tele-working and home-working. Measures should be taken to prevent irregular, unpredictable work schedules over which the employee has little control (Messing & Ostlin 2004, p. 33).

Much more workplace health focus is necessary on upstream policy and program approaches to ensure more gender equitable work places. The structure of work in terms of family-friendly workplaces, job and income security, job protections, maternity leave and child-care (see below) are all essential for healthy work environments for women. Governments, unions, managers, employers, small organisations and large corporations all have leadership roles to play in ensuring women are enabled to work in ways that advantage rather than disadvantage their health, and that are equitable and fair. The benefits of family-friendly workplaces have been well-documented in economic, productivity and business terms (State Government of Victoria 2010; Government of Western Australia 2011).

PUBLIC FUNDING FOR CHILD-CARE

High quality child-care is a key determinant of women's workplace health. High-quality child-care is distinguished from low-quality child-care, which has untrained caregivers who are caring for too many children at a time and who may have high levels of job dissatisfaction.

"Child-care is an important intervention for gender equity because it promotes women's economic and social equality (Keleher and Armstrong 2005, p. 77). The OECD (2004) has argued that public money should only be provided to public and not-for-profit child-care services that have transparent parent-managed boards, with public agency oversight of services and their location" (Keleher 2008, p. 341). The corporatisation of child-care in Australia has impacted on the quality and affordability of child-care, and women's access to the paid workforce (Keleher 2008).

Why citizenship matters for women's health and well-being

There are strong connections between civil citizenship rights, political citizenship rights, and social citizenship rights, albeit that political and civil rights mean little if citizens are so unequal or impoverished that they cannot exercise those rights (Brodie 1997). Those civil, political and social rights include the rights to economic security and to affordable healthcare as well as the conditions in which good health is attainable. Women's citizenship and political participation, therefore, are structural determinants of health, as well as mechanisms through which social inclusion occurs.

Women's movements have challenged the legal and social barriers that undermine women's citizenship, including rights at work, rights to equal pay, sexual and reproductive rights, and rights to inheritance (Summers 1994). Women's legal rights within their homes are better recognised than in the past, although public attitudes to women's citizenship rights could still be strengthened, particularly for lesbians, women with disabilities, and refugee women, while efforts to overcome discrimination for women marginalised by sexuality, race or ethnicity need to be intensified (Sen and Ostlin 2007).

Democratic processes are given expression through active citizenship. Thus, women's access to power has always been a prominent concern of the Australian women's movement. The representation of women in politics and positions of leadership and decision-making in public life, business and industry, are critical determinants of the conditions that impact on women's health and well-being. Women's full citizenship is critical to their health: arguably, non-Indigenous women became citizens when they won the right to vote in the early 1900s. Citizenship, however, is more than the right to vote, as it also includes rights under law, both in the domestic and public spheres.

The connection between empowering processes including the control over one's body and the directions of one's life, such as control over reproduction and fertility, are intimately tied to women's opportunities for good health and well-being (AWID 2011). Therefore, a key avenue to strengthen women's democratic rights and access to health rights is through changes to the law via elected representatives.

However, Australian Parliaments have comparatively low representation of women: at the national level in 2012, just 24.6% of the House of Representatives and 38.1% of the Senate are constituted by women (Inter-Parliament Union Database 2012). Representation of women in elected positions in local government hovers around 27%, and women occupy just 5% of chief executive officer positions (ALGA 2012). Much more education and training is needed among staff working in the public sector as well as in the non-government sector to ensure that attitudes to women can be discussed and addressed. Ultimately, training can help to ensure that government policies reflect gender equity as well as the diversity of the communities they serve.

Summary

The health and well-being of women is dependent on their status in society, their incomes and opportunities for social and economic participation which, in turn, are shaped by social, economic, political and cultural factors. The consequences for women's health and well-being of social norms that create gender stereotypes, discriminate against women and girls, uphold unequal laws, and create inequality, are critical.

The health and well-being issues for women outlined in this paper are socially constructed and therefore amenable to change. The most disadvantaged women suffer the highest burden of poor health, indicating the need for gender-specific strategies that take account of low incomes, marginalisation, and the burdens of caring. Women's roles in decision-making structures urgently need attention, along with well-funded action on all aspects of gender-based violence. Decisive action is necessary at all levels of the political system to promote better policies and services, changes that will eventually lead to positive social change and improved environments for health.

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