STRATEGIC OBJECTIVE C
WOMEN & HEALTH

STRATEGIC OBJECTIVES C

Objective C.1 Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.

Objective C.2 Strengthen preventative programmes that promote women's health.

Objective C.3 Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.

Objective C.4 Promote research and disseminate information on women's health.

Objective C.5 Increase resources and monitor follow-up for women's health.

'(92) Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health. Lack of food and inequitable distribution of food for girls and women in the household, inadequate access to poor urban areas and deficient housing conditions, all overburden women and their families and have a negative effect on their health. Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.'

(Beijing Platform for Action (BPFA))

OVERARCHING CONCERNS

Despite advances in this area over the last 10 years, rising medical and dental costs, gap payments for bulkbilling and the impact of the global financial crisis have proven to be considerable barriers to health for women across all ages, sectors and geographic area. A trend to buy 'over the counter' medication instead of seeking medical advice is emerging. Health issues increase in the over 70 age group with women being more vulnerable as they are the bigger percentage of this age bracket, live longer and have less retirement funding to deal with the increasing burden of medical bills or access to doctors. Women on low incomes and those on benefits are more vulnerable, reporting the inability to pay bills. The affordability of dental care and the lack of access to public dentistry is a key barrier for women across all demographic and geographic groups.

Lack of General Practitioners (GP's) and health professionals remains a key barrier to health for women in rural and remote areas. Where the majority of doctors are male, there is a concern by women, especially young and indigenous women, to discuss and access sexual and reproductive health services. New medical graduates are reluctant to practice in country areas. Insufficient numbers of GPs combined with long waiting times, difficulties with

transportation and gap payments for non bulk billing makes this a considerable barrier for those with a chronic condition and women with disability.

One-third of the female population lives outside metropolitan areas. The demarcation between them and other women in Australia should be geography, not disadvantage. Inadequate services for women within rural and remote areas and the deskilling and axing of health services with in regional areas has meant very poor access to health screening, (breast, pap smears, thyroid problems, and bone density scans for example). For maternity services, women are removed from their family, kin and community to have children, creating greater costs for their families to be with the mother while she gives birth.

Chronic disease services (e.g. diabetes, dialyses) are hard to access in regional, remote and rural areas. Women in rural areas have a much poorer survival rate. Indigenous women have less access to transport, education and services increasing their health disadvantage. The persisting poor health status of indigenous women is evidenced in their life expectancy being 10 years less than non-indigenous women. Maternity care for women across all geographic areas and communities is of concern. There are few accessible mental health services for women. Of those that exist, few operate outside normal office hours and there remains a lack of specialist knowledge for women suffering from depression and mental health issues in emergency wards of hospitals. Women balancing work and family pressures need accessible, timely and appropriate services that help them to avoid stress related conditions and illnesses. Relevant NGO service providers have been available to provide crisis support, however, lack of funding and the impact of the global financial crisis have seen such NGO's stretched to the limit, having to reduce caseloads and streamline services.

Rural women are not necessarily advocating for a host of new programs or special services. Rather they need the rural proofing and adjustment of existing programs and the extension, through wider location, outreach and telecommunication initiatives, of existing services.

Non-inclusive services and programs, inaccessible buildings and venues, lack of inaccessible and unaffordable transport and inaccessible examination tables and lack of appropriate equipment severely are also key barriers for women with disabilities. Lack of interpretation services and information in easy and accessible forms that does not rely on high literacy is a major barrier to refugee and migrant women's health. Negative stereotyping and discrimination stills exists for many lesbian women accessing medical services which leads to delayed accessing of services or non attendance of health services, the impacts of which results in serious health issues and increased stress related illnesses. The needs of vulnerable older lesbians in aged community care remain unmet.

Despite strong advocacy, girls with disability continue to face the threat of forced sterilisation in instances where there is no serious threat to health or life. Mandatory reporting of sexual activity of minors (younger than 16) by doctors combined with limited access, inadequate sexual and reproductive health services and in some cases discrimination, results in a lack of access to abortion, legal contraception, family planning, IVF and other reproductive health related issues.

A 2006 study found that nearly 70 per cent of GLBTI women modify their daily activities because of fear of prejudice and discrimination which has an impact on their health and wellbeing. Lesbians have higher rates of mental health disorders than heterosexual women and also have higher rates of obesity, smoking and unsafe alcohol and drug use, and are more likely to self-harm (*drawn from Pitts, M., Smith, A., Mitchell, A., and Patel, S., (2006) Private Lives: A Report on the Health and Wellbeing of GLBTI Australians, Australian Research Centre in Sex, Health and Society: Melbourne* page 48. Also available online at www.latrobe.edu.au/arcshs/private_lives.htm , *Higher mental health problems* page 32)

Women continue to be primary carers of the sick, elderly and those with disability. Lack of respite for both themselves and the person(s) they are caring for, results in limited opportunity to develop long-term plans, challenges with joining the work force due to caring responsibilities, limited career pathways, small amounts of funding and financial support from government and limited career prospects for both themselves and the person they are caring for. With the increase of women into the workforce, the issues of cost and accessibility of child care and disability care and the increase of work hours, many older women are taking on carer responsibilities.

Current government provision for respite for both carers of family members with a disability and for those being cared for is often not enough or at a time most needed. Older carers, caring for younger family members have the additional anxiety of wondering if the plans they have made for the person for whom they care, will be achievable once they are no longer around to protect that person's interest. Many women carers struggle with this anxiety and often put pressure on female siblings to perform the caring duties.

GAINS

- Young woman aged 18 to 26 years received free cervical cancer vaccine injections, Gardisil, over two years between July 2007 to June 2008.

- National consultations on the development of a National Women's Health Policy to improve the health and wellbeing of women, especially those with the highest risk of poor health (2009/2010).

GAPS

- There is a reduction in accessible, affordable, clinically and culturally appropriate and timely monitoring and preventative screening, particularly for people in rural/remote areas and CALD and indigenous women.

- Access to quality health care in rural and remote areas has deteriorated to a point where preventative medicine is rationed and routine medical centre cases having to be sent to the emergency wards, as waiting times are several weeks.

- There is a clear need for added and ongoing monitoring in the area of women's preventative health and the collection of systematic data on gender initiatives, as well as statistical information on the diversity of women and how this reflects on their health.

- There is need for an improved patient assisted travel scheme to compensate rural people who need to travel long distances to access health care; for easier access to oral health care; and for a better way to develop and distribute the health workforce.

- A call for the Australian Bureau of Statistics and the Australian Institute of Health and Welfare to stimulate the collection and publication of sex and location disaggregated data on health, disease and health service usage.

EMERGING ISSUES

- High costs of medical care including dental care prevent women from accessing quality health outcomes.
- A drop in women accessing preventative programs to promote women's health such as breast screening, pap smears etc.
- A shift to 'over the counter' medicines rather than preventative health care.

SUGGESTED UN LANGUAGE FOR KEY PRIORITY AREAS OF ACTION

- Calling on governments to provide more accessible, available and affordable primary health-care services of high quality, including sexual and reproductive health care, which includes family planning information and services, and giving particular attention to maternal and emergency obstetric care, as agreed to in the Programme of Action of the International Conference on Population and Development.
- Urge governments to develop information, programmes and services to assist women to understand and adapt to changes associated with ageing and to address and treat the health needs of older women, paying particular attention to those who are physically or psychologically dependent.
- Calling on governments to design and implement, in cooperation with women and community-based organizations, gender-sensitive health programmes, including decentralized health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural women and women with disabilities and the diversity of women's needs arising from age and socio-economic and cultural differences, among others; include women, especially local and indigenous women, in the identification and planning of health-care priorities and programmes; and to remove all barriers to women's health services and provide a broad range of health-care services.
- Urge governments to integrate mental health services into primary health-care systems or other appropriate levels, develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence especially domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict.
- Urge governments to develop policies that reduce the disproportionate and increasing burden on women who have multiple roles within the family and the community by providing them with adequate support and programmes from health and social services.
- Calling on governments at all levels to consider the needs of persons with disabilities in terms of ethical and human rights dimensions.
- Calling on governments to eliminate specific forms of discrimination that all women may face with regard to reproductive rights, household and family formation, and international

migration, while taking into account health and other considerations relevant under national immigration regulations; giving special attention to indigenous, lesbian, refugee and women with disabilities.

UN REFERENCES

BPFA
Strategic Objective C.1 Action 106 (c) (y)
Strategic Objective C.2 Action 107 (j)
Strategic Objective C.2 Action 107 (j)
Strategic Objective C.5 Action 111 (a)

B+5 OD
B+5 IV Action 55, 58, 60

CEDAW
Article 12

MDGs
MDG 4, 5

Reference in other documents
E/ESCAP/BPA/2009/CRP.1 para 32, 40

CSW Outcomes Documents 2005 – 2009

E/CN.6/2006/15 para 10 (b)
E/CN.6/2007/9 para 14.4 (a)
E/CN.6/2008/11 para 21 (ee)
E/CN.6/2009/15 para 15 (aa) (dd) (hh)