



WOMEN'S HEALTH IN THE NORTH
PRESENTER: KATHLEEN WALSH

VAADA CONFERENCE

Health for all: Advocating for people who use alcohol and other drugs

One Size Doesn't Fit All ...

A women's health perspective to program and service planning

This Presentation:

- A very brief overview of Women's Health In the North (who we are and what we do)
- The Gender Agenda - some definitions.
- The social context for looking at drug and alcohol use/abuse.
- A snapshot of some of the issues impacting upon women that have implications upon their substance use; and
- A presentation of just one tool available for applying a gendered lens to program and service planning.

Women's Health In the North

As the regional women's health service for the northern metropolitan region of Melbourne, Women's Health In the North undertakes a number of activities to support the health and wellbeing of women who live, work and/or study in the region, including:

- Information Services, resources and advice to women and organisations.
- Health Education to groups of women in the community.
- Workforce Development /Training to service providers on women's health.
- Advocacy to support, promote and advance action on women's health issues.
- Research that investigates, reports upon and publicises women's health issues.
- Health Promotion and Community Development projects to improve women's health.

WHIN has 15 years experience in providing services to women in the region, and has particular expertise in meeting the needs of women who are most marginalised by the health system, and who might generally be referred to as 'hard to reach' or 'at risk'. WHIN is committed to making all the difference to the health and wellbeing of women in Melbourne's north

One of our 2005-2009 Health Priorities included minimising the harmful impacts of alcohol and other drugs on women's lives.

The presentation today falls out of WHIN's Alcohol and Drugs program, and I would like to take this opportunity to thank all our program partners and collaborators, many of whom are represented here today (full list attached).

Our work on this topic has been considerable ... we first started back in early 2004, and concluded work on this program in mid 2006 with a thorough evaluation of nine projects that addressed the full spectrum of health promotion strategies: information, education, skills development, social marketing, community action, working with other groups and organisations to influence their delivery of programs and services, and advocacy.

All of our health promotion work begins with a comprehensive literature review and needs analysis and it is from this work that I intend to talk about alcohol and drug issues for women, and in doing so, impress upon today's audience the need to look specifically at gender issues when planning programs and services.

If there is one 'take home' message from today's presentation I hope it is that we can't just take our existing programs and services 'add women and stir'; attention does need to be given to the different lives and experiences of both men and women, and also of the different needs and experiences of women themselves.

Dorothy Broom: Gender is not an optional extra that should be considered one the 'real' causes of drug abuse have been addressed, nor is it a luxury to left until funding is more generous. (1995)

First, some definitions

The Gender Agenda:

Sex refers to the biological differences between females and males. In health this has traditionally focused on reproductive differences. However, anatomy, physiology and genetics present a broader range of issues in which differences in men and women can be identified.

The consumption of alcohol and drugs for example, impacts on women's and men's bodies in very different ways.

Gender refers to the different social and cultural roles, attitudes, behaviours, expectations and constraints placed upon women and men by virtue of their sex. It affects all aspects of the lives of women and men and is an important determinant of health and well-being¹.

If our goal as health promoters and other service providers is to improve the quality of health and attain equitable health outcomes for all members of our community, then we need to be robust in our thinking. We need to be sure that the multiple realities of people's lives are included in any service system planning. One way of achieving this is by adopting a social model of health.

What is a Gendered Approach:

- Applying a gendered approach (lens).
- Is a way of looking at information.
- Identifies and analyses the similarities and differences, situation, need and priorities between men and women.
- Takes into account such variables as biology, genetics, socio-economic circumstances, culture, behavior, and gender.

Why Take a Gendered Approach?

- Recognises the need for the full participation of women and men in decision-making.
- Gives equal weight to the knowledge, values and experiences of men and women.
- Ensures that both men and women identify their health needs and priorities and acknowledges that certain health problems are unique to, or have more serious implications, for women and men.

¹ Women's Health Association of Victoria (2001). Women's Health Association of Victoria/Women's Health Association of Victoria Banners 'Why Women's Health'

- Leads to a better understanding of the causes of ill health.
- Results in more effective interventions to improve health.
- Contributes to the attainment of great equity in health and health care.

World Health Organisation quoted by Women's Health Victoria on the Women's Health Association of Victoria Banner 'Why Women's Health'

The social model of health gives primacy to the social, economic and cultural determinants of health, with health understood in terms broader than the mere absence of physical disease, illness or injury. Where people work and live, their options for work and leisure or how they connect to their communities and social networks – these are but a few examples of the broad determinants of health. What we also need to understand, is that these broad determinants are not 'neutral' in so far as they have very specific impacts on women and men.

Evidence supports the fact that broad determinants of health produce contexts, situations and needs that are unique and serious for women and that demand tailored interventions. For example, women are more likely to suffer depression and stress from competing demands in their lives as carers, workers and lovers.

Determinants of Health:

- Income and social status
- Employment status
- Education
- Social environment (including social support and social exclusion)
- Physical environment (including access to food, housing and transport)
- Healthy child development
- Personal health practices and coping skills
- Health services
- Social support networks
- Biology and genetic endowment
- Gender
- Culture

Canadian Women's Health Strategy, quoted in women's Health Matters: From Policy to Practice –a 10 point plan for Victorian Women's Health

Women are more likely to sustain injuries from violence perpetrated by people known to them. And they are more likely to be medicalised by an unsympathetic service system.

Thus, when it comes to the experience of health and the quality of life of those in our communities, gender matters – and it matters a lot.

Social Context and Alcohol & Drugs

Consistent with a social model of health approach, it is important to initially locate alcohol and other drug use by women within a life stages framework. This allows substance use to be placed within the context of other broader influences on women's health and wellbeing.

Consider for example the particular and different needs of young women, women in their middle years, and older women

Adolescence is associated with falling self esteem for girls and increased risk-taking behaviour. At the same time – as you will be all too familiar - alcohol and other drug use often begins during adolescence.²

² Pagliano AM & Pagliano L (2000). Substance Use Among Women: A Reference and Resource Guide. Brunner/Mazel, USA.

Behaviours such as smoking, binge drinking and unhealthy eating are all related, and these behaviours in turn increase the probability of detrimental physical, social or psychological consequences.

A number of research findings indicate that sexual risk taking behaviour is clustered around alcohol and drug risk taking for young people in particular³.

For women in the middle years, there is much evidence that links drug and alcohol issues with their social roles and relationships. For example, women are more likely than men to be with a substance-abusing partner.⁴ And women in relationships with alcoholic men generally have poorer mental health and are more likely to be depressed and anxious. These women are more likely themselves to be using alcohol and/or tranquilisers simply to cope.⁵ The majority of women in treatment for substance dependence are mothers and for them, issues of treatment accessibility and their concern about losing custody of children continue to be raised.⁶

Older women face the double discrimination of ageism and sexism, which diminishes even further their access to such things as employment, income, and housing. Older women often report feeling undervalued, and the prevailing stereotypical view is one of dependence, being passive, incompetent and unattractive, experiences which combined tend to render older women feeling unimportant and invisible.⁷ In terms of substance use, misuse of prescription drugs by older women has been identified as a major area of concern.⁸ Sleep changes associated with ageing are more prevalent in older women. Harms associated with over prescription and their long term use, include accelerated physical decline which places women at higher risk of both falls and cognitive impairment.

Women's Lived Realities

A life stage analysis provides the broad social context and associated risk factors, however it is also important to overlay this with a closer examination of the lived realities of women's lives.

Generally speaking, there is a lack of in-depth research and data about substance use and misuse amongst different groups or communities of women, such as women from culturally and linguistically diverse backgrounds and refugees, and homeless women.

However, it is fair to say that often their social circumstances, such as poverty, social isolation, unemployment and general disadvantage, place them and other members of their families at increased risk of substance use and misuse. They are often marginalised which in turn often leads to psychological stress and lower self esteem.

These are all issues associated with risk factors for substance abuse. For example, and please note that this is not an all inclusive list of examples:

Women who have been sexually abused, women in prison, indigenous women, and women with disabilities are just a few of the groups with additional needs that I would like to comment on. And I am sure that within your organisations and communities there will be others with unique experiences as well ...

Women Who Have Been Sexually Abused

Women who have a history of sexual abuse in childhood and adult life appear to be over represented among women seeking treatment for alcohol and drug dependence and psychiatric disorders.⁹

The links between violence and abuse and both mental health and alcohol and drug use are serious considerations in our delivery of programs and services to women.

Women in Prison

³ Women's Health In the North Health Behaviours – Risk Taking Behaviours (2007) (Draft).

⁴ Hamilton M, Kellehear A and Rumbold G (1998). Drug Use in Australia. A Harm Minimisation Approach. Oxford University Press, Melbourne who cite the Copeland and Hall (1990) study.

⁵ Hamilton M, Kellehear A and Rumbold G (1998). Drug Use in Australia. A Harm Minimisation Approach. Oxford University Press, Melbourne who cite the Copeland and Hall (1990) study.

⁶ Hamilton M, Kellehear A and Rumbold G (1998). Drug Use in Australia. A Harm Minimisation Approach. Oxford University Press, Melbourne who cite the Copeland and Hall (1990) study.

⁷ Anderson J and Luxford Y. Women Growing Older: A Health and Wellness Manual for Working with Women Around 60 Years and Over. Southern Women's Health and Community Centre.

⁸ Alcohol and Drug Council website address at <http://www.adca.org.au/>

⁹ Ladwig G (1989). 'Substance Abuse in Women: Relationship Between Chemical Dependency of Women and Past Reports of Physical and/or Sexual Abuse'. The International Journal of Addictions, 24(8): 739-754.

In 2002, 15% of women sentenced in Australian prisons were convicted of dealing, manufacturing, possessing or using an illicit drug as the most serious offence for which they were imprisoned.¹⁰

On top of these numbers, other women entering prison also show very high rates of substance use. In Victoria it has been estimated that four out of five women enter prison with drug and alcohol dependencies.¹¹

Indigenous Women

Dispossession and loss of cultural identity have contributed to problems of alcohol and drug use among Aboriginal people.¹² In considering substance use among this population group, it is important to note that only a minority of Aboriginal women use intoxicating substances.

What's of major importance however is the impact of problematic alcohol consumption by Aboriginal men upon women.

In terms of young Aboriginal women, surveys have found that while fewer young women than men drink alcohol, they also suggest that drinking may be on the increase. Of those who do drink, an alarming number consume alcohol at harmful or hazardous levels.¹³

Women with Disabilities

Many women with disabilities do not have the opportunity to fill social roles many of us take for granted in our lives, such as mother, wife, lover to name just a few, and this can often lead to such things as poor health, and exposure to violence.¹⁴

Some international literature cites women with disabilities as more likely to experience emotional, physical and sexual violence than other women, and that alcohol and drugs may be used to cope with violence.¹⁵

This is but a snapshot of some women's lives and experiences, and indeed there are other high need and vulnerable individuals and groups. What's important – no matter who we are targeting in our program and service planning, is that these needs and experiences are accounted for.

Gendered Planning

(Please note, this framework is drawn from a piece of work WHIN undertook with a Primary Care Partnership a couple of years ago. The focus of this work was to assist mainstream services in their program and service planning. A copy of the tool 'Health Promotion Planning & Taking Account of Gender' is attached.)

The four bases that should be covered to ensure gender sensitive planning in health promotion are:

1. Develop a population profile that builds on life-stage and sex-disaggregated data and includes qualitative research into the lives of women.

This includes women's productive and reproductive roles. It includes education, employment, housing status, income and benefits.

Its important to know things like that across the year (2000-2001) that 36% of people presenting to treatment services in Victoria for heroin and opiates were women, and that 21% of these women were on community correction orders¹⁶.

¹⁰ Department of Prime Minister and Cabinet (2003). The Health and Wellbeing of Women in Prison: Issues Impacting on Health and Wellbeing. Commonwealth Office of the Status of Women, Canberra.

¹¹ Department of Prime Minister and Cabinet (2003). The Health and Wellbeing of Women in Prison: Issues Impacting on Health and Wellbeing. Commonwealth Office of the Status of Women, Canberra.

¹² Davis J. 'Alcohol and the Aboriginal Society: Is Racism Dead in the Alcohol an Drug Field?' as cited in Hamilton M, Kellehear A and Rumbold G (1998) Drug Use in Australia. A Harm Minimisation Approach.

¹³ Davis J. 'Alcohol and the Aboriginal Society: Is Racism Dead in the Alcohol an Drug Field?' as cited in Hamilton M, Kellehear A and Rumbold G (1998) Drug Use in Australia. A Harm Minimisation Approach.

¹⁴ Swift K (1998). 'What is the Impact of Disability on Gender?' Paper written and delivered at the Communication Aid User Society Conference, 'Communication is Unlimited', Brisbane.

¹⁵ Addiction Research Foundation. (1996). The Hidden Majority: A Guidebook on Alcohol and Other Drug Issues for Counsellors who Work with Women. Toronto.

¹⁶ Women's Health In the North (2005) Women in Melbourne's North: A Data Book for Program and Service Planning in Health, Women's Health In the North: Thornbury Published by Women's Health In the North.

This data can help shape what information is provided to women and where and how such information is distributed – at the point of exiting prison for example.

2. Generate services/interventions that respond effectively to the needs expressed by women.

Participation by women and women's services in planning is important. Facilitating their participation in practical ways is critical.

Programs and services are often designed around school hours for example, but in our experience few actually provide child care. Residential treatment services that do not accommodate women and their children are a very obvious example of this issue.

3. Build organisational capacity (workforce development, resources) to enhance agency responsiveness to the health needs of women.

It's important that gender sensitive practice is supported organisationally by policies, procedures and systems.

And finally,

4. Conduct program evaluation using gender sensitive indicators.

It's important to know that our programs and services make a difference to people's lives, and because of the differences in the lives and experiences of men and women, our evaluation efforts must take account of these differences.

There are many ways in which a gender lens can be applied to policy analysis, and program and service planning, implementation and evaluation. Information and tools are accessible to help utilise a gendered approach in health policy, planning and program delivery. In an era of evidence based health policy and practice, it makes sense to use all evidence including that which is gendered¹⁷.

Conclusion:

Women are different from men. Vive la difference!

Clearly, there are some conditions that affect more women than men. There are some conditions that affect women differently than they affect men. Similarly for men, there are a range of health issues that only affect them and are related to their gender roles .

Too often though, healthcare has been dispensed as if "one size fits all" ... Women need healthcare tailored to women's bodies and mindful of women's social roles. (Canadian Health Network, Canada 2003)

JA Califano: 'our failure to confront the special needs of girls and women with substance abuse problems is inexcusable. The one size fits all prevention and treatment approach ... has condemned millions of girls and women to tragic episodes of abuse and addiction that have ruined many lives.'

And finally, our website is useful for links and contacts with other women's health services ... there is a women's health service in each geographic region of Victoria, as well as several statewide services. Our mandated role is to work with other local organisations and services to improve health outcomes for women.

There are also copies of planning tools and other resources available . Two in particular to draw your attention to is: the discussion paper: Women's Health Matters; 10 point Plans for Women's Health in Victoria developed last year by the women's health services; and the Why Women's Health Banners which are available for borrowing – two of the 10 titles of interest to this audience might be Women and Alcohol and Women and Smoking. These can be found on WHIN's website: www.whin.org.au

Contact details:

Kathleen Walsh
Executive Director
Women's Health In the North
680 High Street
Thornbury 3071
03 9484 1666
www.whin.org.au

¹⁷ Women's Health Association of Victoria "Why Women's Health' banner.

Acknowledgements

Women's Health In the North (WHIN) thanks all those involved in the planning, implementation and evaluation of the Alcohol and Other Drugs program. To the following agencies and organisations involved in partnerships throughout the program, sincerest thanks for bringing your energy, expertise and commitment to minimising the harmful impacts of alcohol and other drugs on women's lives:

'Making a Difference', Inner East Community Health Service.
Atherton Gardens Community Centre (Jesuit Social Services).
Bridgehaven.
CASA House.
City of Darebin
City of Hume.
City of Yarra.
Darebin Community Legal Service, Prison Advocacy Program.
Flat Out.
Gay and Lesbian Health Victoria.
Hadfield Ladies Gymnasium and Hadfield Community Association.
Hume/Moreland School Focused Youth Service
Immigrant Women's Domestic Violence Service.
Melbourne Division of General Practice.
Moreland City Council.
North East Valley Division of General Practice.
North West Melbourne Division of General Practice.
North Yarra Community Health Service.
Northern Division of General Practice.
Northern Enterprising Women.
NSW Multicultural Communication Service.
Sunbury Community Health Service
Turning Point Drug and Alcohol Centre.
Victorian Women with Disabilities Network.
Women's Alcohol and Drug Service, Royal Women's Hospital.
Women's Health Victoria.

HEALTH PROMOTION PLANNING – TAKING ACCOUNT OF GENDER

THE GENDER AGENDA: If our goal as health promoters is to improve the quality of health and attain equitable health outcomes for all members of our communities, then we need to be robust in our thinking. We need to be sure that the multiple realities of people's lives are included in any service system planning. One way of achieving this is by adopting a social model of health.

The social model of health gives primacy to the social, economic and cultural determinants of health, with health understood in broader terms than the mere absence of physical disease, illness or injury. Where people work and live, their options for work and leisure or how they connect to their communities and social networks – these are but a few examples of the broad determinants of health.

What we also need to understand, however, is that these broad determinants are not 'neutral' in so far as they have very specific impacts on women and men. Social context, economic position, political and legal institutions and cultural norms each differentially affect the health of women and men, with women usually faring much worse than men and not all women faring the same.

Evidence supports the fact that broad determinants of health produce contexts, situations and needs that are unique and serious for women and that demand tailored interventions. Women are likely to suffer depression and stress from competing demands in their lives as carers, workers and lovers. Women are likely to sustain injuries from violence perpetrated by people known to them. Women are likely to be medicalised by an unsympathetic service system and prescribed drugs. Thus, when it comes to the experience of health and the quality of life of those in our communities, gender matters – and it matters a lot.

This is why specialist services such as Women's Health In the North will always focus their efforts on achieving equitable outcomes for those with comparatively poorer health status – women put most 'at risk' by the broad determinants of health. Yet, a gender sensitive perspective need not be confined to the women's health sector alone. A gender sensitive perspective can be an essential rather than optional ingredient in any service system planning. It can be mainstream rather than marginal. After all, inclusivity is the key to equity in health outcomes. And isn't this the very thing we want as health promoters?

WHAT DOES A GENDER SENSITIVE PERSPECTIVE LOOK LIKE? It is important to note that a gender sensitive perspective means more than 'women have different bodies sexually and reproductively' or 'let's take this existing program, add women and stir'. Instead, a gender sensitive perspective puts a premium on how the broad determinants of health produce not just different but poorer outcomes for women. For example, the division between public and private, or work and family, is a social norm in

contemporary Australia. A gender sensitive perspective would reveal how this norm limits women's community and economic participation, and how this in turn increases poverty, decreases economic independence, compromises social networks and supports and puts women at risk of violence that they then find hard to name. All of which, of course, lead to poorer health outcomes. Without a gender sensitive approach, this reality of women's lives remains invisible. And as long as it is invisible, any planning or service system response can only be partial rather than inclusive of community needs.

Moreover, thinking from a gender sensitive viewpoint can lead to further productive ways of more inclusive planning. Once we know how certain broad determinants of health differentially affect women and men, we can ask questions like: 'How are women themselves differently affected?' and then 'whose needs must we also include in our service system response?'

Following the example above, we might challenge our own assumptions about what the private nature of family life entails. Not all families are modelled on the Western nuclear ideal-type. Are there women from culturally and linguistically diverse (CALD) communities in which supports from extended family members or social settings are more readily available? If so, their needs will be quite different from middle class Anglo-Australian women and the provision of mainstream support groups may be entirely inappropriate. We could instead plan for community awareness-raising activities about different kinds of family types in Australia to defend against perceptions of 'outsider' status projected onto CALD women and their families and to enhance social cohesion. We can only know our options if we follow an inclusive inquiry.

Taking our example further yet, are there women who through economic necessity have no choice but to juggle work and family commitments – women from non-English speaking backgrounds, women from low socio-economic backgrounds, or single mothers? If so, these women would experience considerable stress in typically low-paid jobs or un-friendly family workplaces. They might also experience poor support from their social networks, imagined as 'bad mothers' because they work. All of this would in turn influence their health outcomes and needs. Our service system response would therefore need to make visible the lives of these women, and would need to be as inclusive of them as the women 'at home with the kids' revealed through our initial inquiry. Again, social support groups for these women could be one way to go, but we would do well to include advocacy for family-friendly working conditions or affordable child-care as well as community awareness-raising activities about the 'double load' of working women.

Indeed, one way to describe a gender sensitive perspective could be 'to make visible the invisible' – and to keep doing this every step of the way so that our efforts yield better inclusivity and more equitable outcomes for all!

A QUICK CHECKLIST FOR GENDER SENSITIVE PLANNING:

There are four bases that should be covered to ensure gender sensitive planning in health promotion:

1. Develop a population profile that builds on life-stage and sex-disaggregated data and includes qualitative research into the lives of women.
2. Generate health promotion interventions that respond effectively to the needs expressed by women.
3. Build organisational capacity (workforce development, resources) to enhance agency responsiveness to the health needs of women.
4. Conduct program evaluation using gender sensitive indicators.

The following 16-point checklist will get you started in gender sensitive planning for health promotion. It is not an exhaustive list. It can however be used as a guide for how to enhance gender sensitive health promotion and as an 'audit' tool for your programs.

Planning Stage	Checklist Question	Yes (✓)	No (✓)
1. Population Profile	Does your data include educational, employment, income and benefits status differences between women and men?		
	Does your data provide a picture of productive and reproductive roles and family structure (eg single mothers)?		
	Does your data include country of birth and language of choice of women?		
	Does your data include trends in morbidity and mortality and patterns in service utilisation / hospital admissions amongst women?		
2. Health Promotion	Have women and women's services been encouraged to participate in planning? Tip: consider time, place, transport and child-care.		
	Are activities tailored to (and do they address) specific social, economic, cultural and life-stage realities of women's lives?		
	Are women encouraged to attend activities? Tip: consider appropriate facilitation, time, place, transport, child-care.		
	Do activities contribute to improving the quality and experience of health amongst women? Tip: include the wider service system.		
3. Capacity Building	Does your organisation's health promotion vision affirm a commitment to gender sensitive practice?		
	Does your organisation have systems in place to identify areas that do not practice gender sensitive approaches?		
	Does your organisation provide gender sensitive training, workforce development and resources for staff, managers and boards?		
	Does your organisation have a gender sensitive commitment formalised in its policies and procedures (eg recruitment)?		
4. Program Evaluation	Does your program include women's sense of empowerment as an indicator of effectiveness or impact?		
	Does your program actually improve the quality and experience of health amongst women?		
	Is your program reaching the wider service system with gender sensitive messages that challenge 'neutral' determinants of health?		
	Is your program consolidating gender sensitive approaches within your agency? Local government? PCPs? The region?		

NEED MORE INFORMATION, RESOURCES OR SUPPORT WITH YOUR GENDER SENSITIVE PLANNING?

Please contact Women's Health In the North 680 High Street, THORBURY VIC 3071 (03) 9484 1666 info@whin.org.au
 Women's Health In the North is the northern metro (Melbourne) region's women's health service, and provides information, resources, education, training, research, advocacy and consultancy services.