



Why Women's Health?

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Why women's health?

- Policy on the national health priority areas ignores evidence about differences between men and women and the need for services that cater for their differing needs.
- Women in a rural area of Victoria are told they might as well have their ovaries out at the same time as having a hysterectomy!
- Your friend's pregnant sister needs someone to accompany her every time she has a check up because no female obstetricians are available at the public hospital.
- There is an increasing rate of cosmetic surgery, anorexia and bulimia among women, alongside weight loss drug advertisements insinuating that life is miserable if you aren't slender.
- You're told HRT is the best way to get through menopause.

Its stories and snippets of information like this that continually reinforce to us the need for women's health as something separate from health generally. Experience has shown, however, that these types of stories rarely convince those without an understanding of women's health or the women's movement of the need for women's health as a separate entity. And in the current environment, with increased discussion, interest and work being carried out around men's health and a gendered approach to health, a more comprehensive response to the question, 'why women's health?' is needed. This is particularly true when we hear comments like, 'we've done women's health, now it's men's health's turn'.

After a quarter of a century of women's health activism, it is a good time to revisit why we 'do' women's health – why do we need to focus on women and why do women's health services such as Women's Health Victoria exist? This question has been described in a number of documents over the years,¹ but looking at this question today allows us to show what changes have taken place as the answers to these questions have not remained the same.

The short answer to why we do women's health is that women are different from men, they experience different things while growing up and as adults; biological factors can influence health and well-being outcomes; factors related to gender can affect treatment choices; health (and ill-health) can affect women's role in society (and women's role can affect their health); and women are the majority of carers for people who are both healthy and not so healthy. Women's health is about recognising these differences. It is not about competition between women's and men's health. Nor is it about women's health being 'done' instead of men's health (or vice versa). Women's health is about acknowledging the differences between women and men, without overshadowing the commonalities. While recognising the importance of men's health, general health services and approaches that are sensitive to gender, the need for women's health remains.

So what is women's health?

Women's health is often seen as being about the health of women's reproductive 'bits' – namely wombs, breasts and vaginas! Women's health nurses are employed to provide breast and cervical screening services. Women's hospitals provide specialist gynaecological and childbirth services. 'Well' women's health services are promoted as providing a full range of services when in many cases they are narrow and focus on women's reproductive health. Health status data though show us that it is not only reproductive issues that cause women's ill-health.²

Women's health then is about all health issues that affect women. Women's health is about recognising the diversity of women's lives and the diversity that exists among women. Key principles are encouraging women to take control of their bodies (based on a full range of information and access to appropriate health care), education, collaborative decision making between women and their health care providers (with women deciding for themselves what happens to their bodies), and a social model of health (that takes account of more than just body parts and recognises the context of women's lives, e.g. the influence of social factors such as housing and employment on health and well-being). Women's health is based on an all-encompassing view of health whereby, "health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity"³ and has as its starting point personally-defined needs (e.g. what the woman thinks is right/wrong), rather than professionally-defined needs (e.g. what a doctor thinks is right/wrong).⁴

In order to understand what women's health is, and why we do it, it's also necessary to understand the history of the Australian women's health movement over the past 25 years. Feminist critiques over the past quarter of a century have focussed on women's inability to participate equally in the health care system because of a power imbalance created by men's control of the system. Doctor-patient interactions were characterised by domination and subordination.⁵ Women's experience within the health care system reflected their place in society, with men's experience being viewed as the norm and women's experience as being deviant from this.⁶ Furthermore, health has been understood to be the same as medicine and science (with a focus on illness, not wellness), which have a long male-dominated history of looking at the world based on the experiences of men in their own interests, never by or for women themselves.⁷ There is also a need to understand that women's health arose from community development, preceding the consumer movement, and has been based on women's rights to access information and services which they themselves see as appropriate. It arose from within the feminist movement and has been political from the beginning.

But it's not like that any more?

When talking about why we need women's health, one of the common issues raised is that 'things have changed' and 'it's not like that anymore' ('that' being a situation where women's interests are not taken into account). Indeed, much has changed over the past 20 or so years. Medical power has been, and continues to be, challenged. The over-medicalisation of women's lives is discussed openly in the media and women often refuse certain treatments and seek alternatives.⁸ But we should not forget that the kind of evidence available today about differences between women and men and being able to question the things that we do today are only possible because of 25 years of women's health advocacy, research and services.⁹

Despite successes such as these, it is incredibly disheartening that the original aims of the women's health movement of having women's voices heard and women having choice and control through access to information are still being demanded from women. Consultations with Victorian women in 1998 consistently found that women wanted information in order to make informed choices but that they weren't receiving it¹⁰ - this finding alone demonstrates the continued need for women's health.

Although some things might have changed, the history of health and medicine and the history of the women's health movement are important to understand if we are to understand why women's health is important today. Jill Astbury, in her book *Crazy for You*¹¹, looks at the development of our understanding about women's mental health. She shows very clearly that current research and understanding about women's mental health is still based on assumptions and conclusions that are based on older studies, that were poorly conducted and based on particular myths and culturally biased attitudes towards women. Freud's work, for example, was based on particular views of women and their psyches. It has influenced, and continues to influence, psychological research and textbooks over the years. So great was Freud's influence that, until the 1980s, his view that childhood sexual abuse was so rare as to be insignificant was the dominant belief system amongst psychologists. It is because of the continued effect today of views, beliefs and practices from our history that women's health needs to be understood in the context of what has changed over time. In the words of Lois Bryson, "every day we confront the drag of the past. Old ideas about women's and men's roles and ways of behaving still flourish, and get in the way..."¹²

The issues today (or what hasn't changed)

Although some of the issues may have changed over the past 20 or so years we need to know what the issues are today and understand why they are important if we are to understand why we continue to do women's health. Some of the key issues are:

- Male dominated health services and gender-blind service delivery
- Medicalisation of health
- Women as wombs
- Lack of access to information
- Gender-blind research and policy.

Male dominated health services and gender-blind service delivery

Today there are continuing complaints from women that medical practitioners relate to them in condescending and patronising ways¹³ and a recent study has also found that a significant minority of women believed they had experienced inappropriate treatment from doctors during intimate physical examinations.¹⁴ Consultations with women show that they want their concerns taken seriously, to have greater say in their medical treatment options and the reality of their lives recognised.¹⁵ Contributing to women's complaints about their interactions with health service providers are three key factors: a failure by service providers to listen to what women tell them; a failure to acknowledge gender differences in service delivery; and male domination as practitioners and of health service providers' boards.

If women are to receive optimal health care with optimal health outcomes then it is essential that women's concerns are listened to and that they are active participants

in their interactions with health professionals. This issue of being heard has a huge influence on women and their health. The problem of not being listened to (or not even being able to speak) is particularly noticeable in the area of women's mental health and in many cases contributes to exacerbation of mental ill-health.^{16 17} A prime example of this is a woman following the birth of her first child being diagnosed with post-natal depression and being prescribed anti-depressants rather than investigating the sleeping patterns of her baby and taking into account the fact that she has given up a very busy career and has a limited support network.^{18 19}

Many women telling their own stories, as well as a range of writers and commentators, have shown that the failure to recognise gender differences is still more common than we would like. The design of mental health services, for example, rarely acknowledges that men and women will have different needs and expectations²⁰ with women more likely to be caring for children or involved in a sexual relationship.²¹ Evaluation of a young women's support and accommodation service has shown that failure to provide a gender-specific space for young women, as opposed to a gender-neutral space where both men and women use the service, would result in increased homelessness among these young women and higher levels of suicide.²² A further example of women's needs being overlooked in service delivery is the reports made to Women's Health Victoria in 1998 that country women accessing tubal sterilisation services in Melbourne were being told to go home and ask their husbands to sign a consent form to allow the procedure to proceed.²³

Underlying both of the issues just talked about is male domination of the health system.²⁴ At the Royal Women's Hospital in Melbourne, for example, the majority of practitioners are men. There is also male domination of the various hospital boards in Victoria. Both the State and Federal Health Ministers are men. The experience in general practice has shown that when there is a critical number of women providers then practice and policy change.²⁵ Currently one-third of Victoria's general practitioners are women²⁶ and evidence shows that they practice in a style different to their male colleagues, with the provision of longer consultations and fewer procedures performed.²⁷ Not only are doctor-patient interactions affected by this, but also the whole way general practices operate.²⁸ It seems clear that having more women employed throughout all parts of the health system would result in changes that would better address the needs of women.

Medicalisation of health

Pregnancy offers a good example of medicalisation of what is for most women normal and unproblematic. Pregnancy is defined by medical professionals in terms of its risks with the best a woman can hope for is being classified as 'low risk'.²⁹ The high rate of caesarean sections (more than 20 per cent of Victorian births are by caesarean³⁰) is well recognised.

Consultations with women in Victoria and throughout Australia show women want fewer medical interventions in their health care treatment.³¹ Indeed, many women come into contact with the health care system frequently when they are not ill - when pregnant, for contraceptive purposes or for asymptomatic cervical and breast screening. When Victorian women were asked about their main health issues in 1998 in preparation for the state-wide women's health plan launched by the Liberals (and since discarded with a new plan being developed by the Labor government), rural women stated that good, reliable, safe public transport was a priority.³² This clearly shows that how women view their health and what's important to maintain good health is very different to the way medical service providers view health. Social

isolation is a major factor affecting women's health but no amount of medical intervention will change this.³³

It is for this reason that the women's health movement has always worked within a social model of health. Today, this is a key component of the women's health movement – to work beyond a mere medical model of health and to advocate for its use throughout the health system. Part of Women's Health Victoria's work is preparing submissions on State and Federal health policy, best-practice guidelines, service proposals, and so forth. A common thread throughout most of our submissions is that there is a lack of recognition of the social model of health. As a result, the social reality of women's lives and its impact on their health is ignored. This has the effect of making policy or practice guidelines of limited use as they are ignoring the very factors that would lead to their success. A prime example in the Draft National Evidence Based Guidelines for the Management of Type 2 Diabetes Mellitus (with a focus on primary prevention)³⁴ is the promotion of changes to nutrition and exercise. These aspects of individual's lives are heavily influenced by social, not clinical factors. Women, who in most cases have the main responsibility for family food preparation, will not change their family's diet if their own diet has to change but will prepare separate food for themselves. If the father or husband's diet has to change, however, then the diet of the whole family tends to change.³⁵

Women as wombs

As a result of the medicalisation of women's health, the general public's view is that women's health is reproductive health. Unfortunately, it is not only the general public that have this view. A 55 year old woman who had stopped menstruating 10 years previously went to see an ENT (Ear, Nose and Throat) specialist about a nasal drip and was told that the nasal drip was probably due to menopause. That this is a true story recounted to us only a few days ago almost defies belief. What it does show is that women's reproductive bits and processes are always seen as somehow being responsible for women's health (at the very least it's often assumed you've got your period if you're in a bad mood, regardless of whether your dog just died, you haven't had enough sleep, or you're working with a bunch of morons).

Mental health in particular continues to look for reasons related to women's reproduction (from menarche to menopause) to explain psychological distress. A publication assessing the status of current knowledge on this topic concludes that there is a current poor level of understanding because it rests on unwarranted assumptions and conclusions.³⁶

Lack of access to information

Women keep saying that they want information so that they can make informed choices regarding their health care.^{37 38 39 40} Stories from women's health nurses in Victoria show that some women in Victoria are being told they should have their ovaries removed when having a hysterectomy to reduce the risk of ovarian cancer without being provided with information on the alternative (keeping their ovaries) or on the side effects of not having their ovaries anymore (menopause).

Yet the information is available but women have difficulty finding and accessing such information because many health care providers do not provide women with the information they want. Indeed, in the current environment of web-based technologies and increasing commercialisation in health there is an information overload on many health topics. We find though that despite an apparent over abundance of

information, women are still not getting to learn about the things that they actually want to know about.⁴¹

Central to this issue of lack of information is access to quality information. How do women choose which information to believe if they are confronted with contradictory information or a range of information from a number of different sources? We know that many women get information about their health from magazines⁴² and that women's health stories abound in the newspapers.⁴³ However, studies have also found that information in magazines and newspapers is often limited, if not confusing, does not tell the whole story, focuses on women's reproductive role and in the case of advice columns, is often unsuitable.^{44 45 46}

Gender-blind research and policy

One of the issues that we are repeatedly made aware of at Women's Health Victoria as a result of our environmental scanning process is the gender-blind nature of much health and medical research and policy. Research and policy are inextricably linked with each other and with medical practice – each has an influence on the other. Research results for example inform medical practice, policy affects the environment in which practice takes place, research questions are formulated based on observations in practice, and so on and so on. The problem is, there are serious gaps in knowledge about women's health because, as is now well known, medical research has frequently excluded women as participants.^{47 48} In many cases research is conducted with men and women but the results do not show if there are any differences between them. There may be no difference, but this must be shown and not assumed. This is a problem because clinical best-practice guidelines, decisions about what course of treatment is offered by health service providers, decisions about what health treatments will be funded by government, to name but a few, are all influenced by this very medical research that excludes women or that assumes men and women are the same.

A key issue is that health service planning and provision takes place within a policy framework (used broadly to mean government policy and planning). Five National Health Priority Areas (obviously important because they're always referred to using capitals) have been identified for Australia – cancer control, injury prevention and control, cardiovascular health, diabetes mellitus and mental health. Three reports have been published on diabetes mellitus,⁴⁹ cardiovascular health,⁵⁰ and mental health⁵¹ to report on these priority areas as well as a range of other documents. Women's Health Victoria has analysed these reports and the current National Mental Health Plan⁵² in depth. These national policy documents, which also influence policy at the state and local level are predominantly gender neutral. Most disconcerting is that even when data are presented on differences between women and men (e.g. the report on cardiovascular disease shows notable differences between men and women in terms of drug treatments received in hospital) these are not taken into account at all in terms of policy recommendations.

In the case of the National Mental Health Plan, it is well known that women and men experience mental health very differently but this is not recognised. For example, the plan discusses depression and suicide among young people. It is well known that there are huge differences between boys and girls in terms of incidence and manifestation, but the plan does not include any gender-specific evidence or strategies. There is a complete failure to acknowledge that for a mental health plan to be successful, these differences should be acknowledged. Why is this important and why do we see it as a problem? Because the national plan influences funding decisions, service/programme development and delivery, and thus also women

themselves. This gender blindness at the national level also reinforces the notion that we don't need gender-specific services/programmes/policies.

Why women's health services?

Women's health services essentially exist to address the issues we have outlined above. Women's health services' role is to ensure that individual women have access to women-sensitive services and access to information so they can make informed decisions regarding their health. A key role is also to continue lobbying of government, as well as other health institutions, to ensure they recognise social issues and provide policy and services that meet women's needs. It is these two roles for women's health services, direct service provision and advocacy, that are the planks of Victoria's Women's Health Program, known as a dual strategy.

The Victorian Women's Health Program, begun in 1988, has resulted in a logical distribution of regional and state-wide services (Women's Health Victoria being one of these state-wide services). Because of the gradual emergence of the current services within the Program (refer Beaumont, 2000⁵³), the services delivered by each of the services is not the same (and there is clearly a different role at the state and regional level). The common thread throughout each of these services is a commitment to providing services to women, by women, within a feminist framework and within a social model of health and to maintain advocacy to government (at local, state and federal levels) and service providers to ensure that in the future we don't hear comments from women such as ...

"No, they just want you out ... it's up to you to ask ..."

"I got a male consultant and he examined me and said I'll put you on HRT and I said no way and he said every woman should be on it ..."

"Doctors don't ask if you have had a pap smear ... my doctor has never asked ..."

"Stress bought about by doctors and social workers ... expectations too high and you can't get any help ... they know everything from the book but they don't know what it's like ..."

"I took a girlfriend there for the same thing ... no discretion, they were pigs ... she was a piece of meat."⁵⁴

FOOTNOTES

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