CREWaND NHMRC Centre of Research Excellence on Women and Non-communicable Diseases: Prevention and Detection

# CRE WaND submission on the National Strategy to Achieve Gender Equality

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NHMRC Centre of Research Excellence on Women and Non-communicable Diseases: Prevention and Detection
Level 3, Public Health Building, University of Queensland | Herston, QLD 4006

**Email** wandcre@uq.edu.au | **Phone** 07 3365 5197 | **www.wandcre.org.au**

# Introduction

## About the CRE WaND

Non-communicable diseases (NCDs) are responsible for two-thirds of deaths among women. The Centre of Research Excellence on Women and Non-Communicable Diseases (CRE WaND) looks to move women's health beyond reproductive and sexual health to encompass and prioritise the prevention and detection of NCDs.

CRE WaND is funded by the National Health and Medical Research Council (NHMRC). It brings together a multidisciplinary team of researchers and clinicians with outstanding expertise in women's health, epidemiology, advanced biostatistical methods, health economics and econometrics. Our partners include Monash University, The University of Queensland, the University of Melbourne, Deakin University, The Australian Prevention Partnership Centre, the Collaboration for Enhanced Research Impact, and Jean Hailes for Women's Health.

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## Gender equality in CRE WaND research

The Center of Research Excellence on Women and Non-communicable Diseases welcomes the Australian Government's commitment to developing a National Strategy to Achieve Gender Equality and we appreciate the opportunity to contribute to the discussion on priority areas. The Australian Government has demonstrated a clear commitment to improving health outcomes for women, through the National Women's Health Strategy 2020-2030, the National Plan to End Violence Against Women and Children 2022-23 and the National Women's Health Advisory Council. The National Strategy to Achieve Gender Equality is crucial if Australia is to address the underlying social determinants of health that impact women's health, wellbeing, and ability to appropriately access health care services.

Research from the CRE WaND does not specifically focus on sex-based differences in health outcomes for men and women. However, gender bias does impact women's health and well-being and it contributes to:

- the historic lack of research into the sex-specific risk factors for non-communicable disease
- the increased risk of disease due to the gendered impact of social determinants of health (e.g. financial stress, housing, domestic violence, employment, time-poverty, childrearing, or unpaid caregiving for disabled or elderly friends and family)
- the impact of sex-specific conditions, and life events on women's health and well-being (e.g. endometriosis, polycystic ovary syndrome, fibroids, menstrual disorders, infertility, miscarriage and stillbirth, perinatal mental health issues, peri-menopause and menopause).

In this consultation document, CRE WaND members have outlined recommendations for addressing gender equality issues impacting their spheres of expertise.

We acknowledge that the boundaries around what "women's health" incorporates are not always clear and that sex and gender are distinct concepts. Our research frequently focuses on health topics related

to the female sex (e.g. menstruation, childbirth, and menopause). We acknowledge that not everyone who identifies as a woman experiences these female-specific health issues or identifies as female.

# Parental leave

**The issue**

The current government-funded model of parental leave payments does not sufficiently promote gender equality or sharing of the responsibilities of caring for young children.

**The evidence**

Access to affordable childcare and equitable division of household labour are major barriers to achieving gender equality and reducing the gender wage gap. The introduction of the increased childcare subsidies from July 2023 will go some way to reducing this barrier and encourage greater participation of women in the workforce. However, Australia's current parental leave entitlements are not designed in a way to promote gender equality.

In Australia, eligible working parents receive 18 weeks of parental leave pay at the national minimum wage from the government. The information relating to the payment implies that it is the woman who gives birth who will be the 'eligible' parent, as the rules stipulate that the primary caregiver can only be someone other than the birth mother under exceptional circumstances. Also, there is a separate entitlement of two weeks paid leave described as 'Dad and Partner Pay'. In addition to government payments, people employed in some industries or companies have various levels of paid parental leave entitlements.

In Scandinavia, tax revenue is used to provide all working parents with up to 16 months of government-sponsored paid parental leave after the birth or adoption of a child. Importantly, parents are able to share the parental leave between them as they prefer, and the system gives the same rights to mothers and fathers. In addition, to incentivise men to share caring responsibilities, unless the woman is a sole parent, some of the paid parental leave (around 3 months) can only be taken by the father. Research from these countries shows that when fathers take long leave, parents share both household tasks and childcare more equally after the leave[1]. In addition, women have better income development suggesting that a 'father's quota' at least in part also fulfills the aim of gender equality outside the parental leave system[2,3]. The introduction of non-transferable paternity leave in Iceland has also reduced the proportion of couples who separate after a child is born.

**Recommendations**

We believe that adopting the Scandinavian model of parental leave will go a long way to improving gender equality.

**References**


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# Menopause and work

**The issue**

Perimenopausal and post-menopausal symptoms can impact quality of life, and may inhibit a person's ability to work. Lack of workplace support for those experiencing menopausal symptoms may also be driving early retirement and contributing to the gender pay gap. However, Australian data on the extent of the issue and its impact on quality of life, contributions to the gender pay gap, and the economy is lacking.

**The evidence**

A market research survey published in 2022 in the UK indicates that as many as 4 out of 10 women felt their work performance had been negatively affected by menopausal symptoms and were uncomfortable discussing menopause with their managers[1]. Research published in 2013, again on women in the UK, found similar results[2]. In contrast, an Australian survey of nurses working at three hospitals in Sydney did not find any significant associations between reproductive stage (being peri or post-menopausal) and work limitations. However, 60% of the women surveyed reported not feeling comfortable discussing menopause with managers[3].

The research does show that women want change in the workplace. Organisational support, in the form of greater awareness of menopause, supportive policies around flexible working hours and sick leave, and improvements to workplace temperatures or ventilation are frequently identified as helpful coping strategies [1,2,3,4]. Projects trialing workplace interventions and support are in development in Australia (No Sweat[5]) and the UK (MenoKit[6]) but require further funding.

**Recommendations**

1. Further research is needed to understand the impact of menopause on Australian women's experiences at work, and whether menopause is a factor in women's decisions to reduce work hours or leave employment, and how this contributes to the gender pay gap and financial stress.
2. Funding is required to trial and scale up workplace interventions providing menopause support in the workplace.
3. Health promotion is needed to increase awareness of menopause as a natural stage of life and reduce stigma around talking about menopause in the workplace.

**Links to references**


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4. Hardy C., Griffiths A., Hunter M.S., What do working menopausal women want? A qualitative investigation into women's perspectives on employer and line manager support, *Maturitas*, (2017) 101, 37-41, DOI:10.1016/j.maturitas.2017.04.011.


# Social Stereotypes

**The issue**

Nomenclature cements the harmful stereotype that care for the foetus, infant, and young children is women's responsibility.

**The evidence**

In Australia, services for pregnancy care are positioned and labelled as being for women. The Australian Government information site Pregnancy, Birth and Baby refers throughout to 'my' rather than 'our' pregnancy and describes services available as being for individual women rather than couples with shared needs for information and care.

Primary care services for postpartum care and healthy baby checks are labelled in diverse ways in states and territories. Some as being for women and children: Maternal and Child Health Services (Victoria) and Maternal and Child Health (Australian Capital Territory), in others as being for children: Child and Baby Health (Queensland), Child Health Services (Northern Territory), Child and Adolescent Health Service (Western Australia), and in a few as for children with their families: Child and Family Health Service (New South Wales and South Australia), and Child Health and Parenting Service (Tasmania). Men or other co-parents are not referred to, conveying a strong message that these are services only for women as primary caregivers of young children.

The consequence is that these essential services cement harmful stereotypes and reinforce gender inequality[1]. The respectful inclusion of men, including those from culturally and linguistically diverse backgrounds remains inconsistent and often service specific rather than being based in system-wide policy and practice[2]. They are not experienced as being 'father-friendly'.

In general, staff feel unprepared and uncomfortable providing care that is inclusive, respectful, and considerate, and counters stereotypes about the roles and responsibilities of caregiving and unpaid household work.

However, this can be changed. The What Were We Thinking Program provided by maternal and child health nurses in primary settings demonstrated that the skills of providing gender-informed father-

inclusive care can be learnt[2]. The benefits to women's mental health were significant medium term and sustained.

**Links to references**


1. Fisher J. Gender competence and mental health promotion. *World Psychiatry* 2020, 19(1), 34-35. DOI: 10.1002/wps.20694
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