

## **Women's Health Matters**

### **Western Australian Women's Health Policy and Gender Impact Assessment**

#### **A 10 Point Plan 2010-2014<sup>1</sup>**

#### **Introduction**

The purpose of this action plan is to set a policy agenda for improving the health and well-being of all West Australian women through targeted strategies. With the changing and increasingly demanding roles of Australian women, the health needs of women needs to be framed as an integral part of the national health policy — not as a special interest group or as a subset of reproductive health issues. The plan provides the rationale – why women's health matters and proposes a policy framework premised on social determinants of health and gender equality and the process through which this can be achieved.

Gender equality is considered to be a complex and paradoxical goal that requires ensuring legal equality and equality of opportunity “between men and women while also recognizing that sex based differences may require differential political and policy responses” (Maddison and Partridge, 2007: 1). Gender equality also requires non-discrimination against and between different categories of women.

It is now widely acknowledged that better health outcomes can be achieved by having a “health policy that is approached from a gendered and whole of government perspective – one which responds to the broad range of economic, social and cultural factors that impact on health outcomes for women” (Australian Women's Health Network, 2007: 7).

The proposed plan of action with regard to women's health policy is the first of its kind in Western Australia. The plan drew and benefitted from the experiences of other states, more particularly Victoria and South Australia (Victorian Women's Health Services, 2009; Department of Health, Government of South Australia, 2009). It is to be noted that drawing on the 2006 women's health action plan, Victorian Women's Health Service prepared a 10-point plan for 2010-2014 that proposes to integrate women's health policy with other areas of government services in a coordinated way, embedding gender in the ‘social determinants’ approach to health policy and practice.

Similarly, South Australia has already established an Action Plan Report Card system that identifies women's specific needs and ensures that these needs are integrated into the planning, management and delivery of mainstream services. This system advances health equity with a

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<sup>1</sup> This 10 Point Plan is prepared by Womens Health Services (WHS) on behalf of the Peak of Women's Health WA, Inc.

focus on groups of women with the worst health outcomes and at the same time addresses gender-specific character of women's health issues.

The WA 10 point plan of action can be used as a tool by the Women's Advisory Council (WAC) and other women's agencies -- both government and non-government to influence the State and Federal government and other political parties to commit to integrating women's health policy with other areas of government policy in a coordinated way, endorsing the rights based approach to gender equality as an agenda for the upcoming election.

## **Background**

Unlike South Australia and Victoria there is no specific plan of action for women's health policy in WA. The Strategic Intent 2005-2010 developed by Department of Health focuses on health infrastructure such as hospitals and health workforce. It does not mention health differences between groups or areas, and makes no explicit intention to "reduce inequalities in health status" for any of the disadvantaged groups (with the exception of Aboriginal people) mentioned in other document e.g. The Reid report, the Substantive Equality Framework, the Diabetes and Cardiovascular Disease Framework's Vision for 2007 and Eat Well Be Active. Thus, the review of Australian Government and Health Inequities Project concluded that "WA has only patchy acknowledgement of the need to address health inequities and improve equity of health outcomes" (Newman, Baum and Harris, 2006: 3).

The other major drawback of the Strategic Intent is that it adopted a simplistic approach to a highly complex and multi-dimensional problem like health. From evidence base it can be argued that health policies that are premised on the social determinants of health, gender equality and clear indicators for monitoring and evaluation of health outcomes, are likely to yield better results compared to gender blind and narrow health policies. It is important to mention here that gender equality principle recognizes that women and men have different needs and priorities, and that women and men should 'experience equal conditions for realizing their full human rights, and have opportunity to contribute to and benefit from national, political, economic, social and cultural development' (CIDA, 1999).

It is encouraging that the present government of Western Australia has established the WAC to advise the minister on matters pertaining to women's issues and interest. A proactive WAC is crucial for translating this plan into action in close collaboration with the women's health sector and the cross sector women's groups, with an emphasis on measurable and transparent outcomes. It is also an opportune moment for WA to launch its plan of action for women's health policy as for the first time in Australian history a woman is Prime Minister and new national women's health policy has been on government agenda. Drawing from the 10 point plan for Victorian Women's Health it can be reiterated that state and national women's health policies should be aligned with the proposed plan of action underscoring the importance of gender equity in health

inclusive of health equity between women, with a clear focus on prevention, and a strong and emerging evidence base that are outlined in the national policy discussion paper.

Whilst the national health policy acknowledges the importance of health equity between women, yet by adopting a ‘lifecourse approach’ to women’s health the scope of the policy has become too narrow and simplistic to respond to the diversity and complexity of women’s lives and their health needs.

Instead of a ‘lifecourse approach’ the plan of action proposes a pluralistic approach embedded in the social determinants of health and gender equality principles that can effectively take into account multi-dimensional factors not only limited to age but also inclusive of Aboriginality, cultural, religious and linguistic diversity, disability, sexual identity, geographic location and socio-economic status. This pluralistic approach is also consistent with Victorian 10 point plan for women’s health and the South Australian women’s health policy.

Whilst the plan of action for women’s health policy in WA also incorporates a system of regular monitoring and feedback on health outcomes, it also supports positive outcomes for women and sets standards of better practices in alignment with national priorities and priorities of all state and territory health plans.

### **Women’s Health in WA: Highlights**

According to the 2006 census women in WA constituted a little over half of the total population or 50.17 per cent (982,962). More than 27 per cent were overseas born and around three per cent women identified themselves as Indigenous ([www.omi.wa.gov.au/WAPeople2006/WA](http://www.omi.wa.gov.au/WAPeople2006/WA) accessed on June 24, 2010).

WA is one of the few states that have developed a Health and Wellbeing Surveillance System for continuous data collection to monitor the health and wellbeing of Western Australian since 2002. Despite enjoying the benefits from such a regular monitoring system women in WA face multifaceted challenges arising from social, economic and health inequities. Further, as an outcome of the unique 2002 Women’s Convention, the Women’s Report Card was first published in 2004 to measure the progress of women in WA. The Women’s Report Card provides key indicators of the status of women in the areas including public life and leadership; health, education and safety; policing, violence, crime and imprisonment. The data trends in the Report Card are indicative of the experiences of women and can be used as tool for decision-making by the government, business and community.

However, one major drawback of the WA Women’s Report Card is that it does not provide data for men that are necessary for drawing comparison necessary to measuring women’s status. Some of the inequities which are persistent and require urgent attention as outlined below.

## Women's Health Outcomes<sup>2</sup>

- Women bear greater burden of disability as compared to men and the burden increases with age. Nearly one out of every five women aged 65 years and over needed aids and/or special equipment as opposed to less than a tenth for their male cohorts.
- Prevalence of arthritis and osteoporosis is significantly higher among women than men and the gender difference becomes more acute for women aged 65 and over.
- Women suffer more from type 1, type 2 and gestational diabetes at their younger and middle ages compared to men.
- Asthma is more prevalent among women compared to men and the risk increases with age. Malignant neoplasm of trachea, bronchus and lung is the fourth most leading causes of women's death (Department of Communities, 2009).
- Although cholesterol level and blood pressure are generally higher for men than women and increases with age but the rate of increase is much higher for women as compared to their male cohorts. Ischaemic heart disease is the topmost leading causes of women's death in WA (Department of Communities, 2009).
- Women suffer from greater anxiety, depression and stress-related problems at all ages compared to men. Similarly psychological distress as measured by Kessler10 is much higher among women as opposed to men at all age levels. Dementia and Alzheimer disease is the third major killer of women in WA (Department of Communities, 2009).
- Nearly a tenth of women aged 18 and over were victims of either physical and/or threatened violence in the last months in 2009. Women were three times more likely to suffer from violence in their own homes than in the community (Department of Communities, 2009).<sup>3</sup>
- As compared to men women are more likely to experience greater financial hardship, serious injury, death of someone close and more family members and friends committing suicide with increase in age. Women have lesser social support for all ages when compared with men.

It is important to emphasize that the health status of the Aboriginal women is even worse and this is also true for many women refugees and some categories of CaLD women. Aboriginal

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<sup>2</sup> All the statistics are compiled from Sarah and Alison (2010) Health and Wellbeing of Adults in Western Australia 2009. Overview of Results. Department of Health, Western Australia.

<sup>3</sup> Note that domestic violence rates vary depending on the definition used and the data sources. For a detailed overview please see Hegarty and Roberts, 1998; Ferrante et al. 1996 and Women's Policy Unit, 1992.

women are the fastest growing prison population and are imprisoned mainly for defaulting on debts (Department of Communities, 2009).

### **Some factors that impact on women's health**

- Women's labour force participation rate (LFPR) in WA increased from 57.6 per cent in 2003 to 60.3 per cent in 2008. Simultaneously however, the gender pay gap has also widened from 23.3 per cent to 27.9 per cent during the same period (Department of Communities, 2009). Across Australia women's LFPR has been estimated at 58.7 per cent in 2009, as opposed to 72.1 per cent for that of men. Women are much less likely to work full-time than men (54.9 per cent Vs 84.1 per cent), and comprise over 70 per cent of the part-time workforce (ABS, 2009). LFPR by age shows a sharp decline for the women between the ages 25 and 44, which is not evident for men. Australia's relative standing vis-à-vis other OECD countries such as Canada, Sweden, United Kingdom and United States in relation to workforce participation rate for mothers with young children is much weaker (OECD, 2007).
- Women across Australia have significantly lower rates of superannuation savings than men and also lower median amounts -- \$6400 as opposed to \$13400 for men (ABS, 2001).
- Nearly three-quarters of primary carers in WA were women in 2003. Whilst for around half of the women carers the caring job came as a part of the family responsibility, nearly a third of them found a caring job was the only option open to them to be engaged in paid occupation. Note that across Australia around a quarter of women carers reported fair to poor health, which was more than double as compared to women in general (ABS, 2004) and over a tenth of the primary carers reported a stress-related illness (Access Economics, 2005).
- Across Australia 87 per cent of one-parent families with children under 15 years were headed by women (ABS, 2007). These families largely live in poverty. Thus for example statistics in WA show that around 60 per cent earned a weekly income ranging between \$1 and \$999 (Department of Communities, 2009).

### **10 Point Plan 2010-2014 for Women's Health Policy and Gender Impact Assessment**

As women's health status is an outcome of a myriad of factors that determine women's lives including socio-economic status, geographical location, cultural and linguistic background,

access to resources, opportunities and services among others, government commitment to women's health must take into account all these factors in order to formulate a meaningful health policy for women. As a roadmap to Western Australian Women's Health Policy, the following 10 points for action are planned for the next five years. Note that the plan of action is consistent but not identical with 10 point plan for Victorian Women's Health

1. Embed a **social determinants framework** in the approach and actions while formulating women's health policy. The strength of the social determinants framework lies in the fact that it has been proven effective because it takes into account multiple and broad range of factors e.g. socio-economic, cultural, environmental, geographical, biological and gender factors that impact on women's health.
2. Adopt **gender equality principles** with the help of gender impact assessment (GIA) tool, DHS gender and diversity lens and legislating gender equity requirements. WA publicly funded services (including health services) should plan for and integrate a reporting system which includes monitoring and evaluation on gender equality and diversity as outlined in this plan of action.
3. Use a **human rights based approach** that places freedom from fear, dignity and equality at the centre of women's health policy. Whilst all categories of women will benefit from such an approach more particularly, it will help to identify and prioritize the rights of groups of women at higher risks of poorer health and wellbeing, including those with multiple needs and suffering from numerous disadvantages.
4. Adopt a **pluralistic approach to women's health policy**. A pluralistic approach acknowledges the diversity and complexity of women's lives and health needs. Such an approach can easily be aligned with social determinants framework and social inclusion model to cater to the diverse and multiple needs while delivering services to diverse groups of women – Aboriginal and Torres Strait Islander women, immigrants and refugee women, women in metropolitan, regional and rural communities, women with disabilities and same-sex attracted women as well women in prison and other institutions.
5. Retain and increase funding to **women's specific services**.
6. Build up necessary **collaborative and cooperative support across government departments** via coordination and oversight by the Premier's office for the implementation of social determinants framework of women's health policy. This can be done with the help of GIA tools and gender and diversity checklist to measure the outcomes of policies and strategies of different departments.

7. Provide **new funding** to ensure that new initiatives and research that can realistically deliver required changes and improvements using GIA tool as and when necessary.
8. Establish a **clearing house for gender based data** across WA following the examples of the index; a model for health access to women's health and wellbeing data developed by Victoria ([www.theindex.org.au](http://www.theindex.org.au)). Like Victoria, from WA one could then access Women's Report Card, ABS statistics, Health and Wellbeing Surveillance data and all reports, papers and resource materials on women's health, socio-economic status and other relevant data. This will facilitate data coordination and help to collect and collate data from one source having necessary in-built linkages thus minimizing cost and time thereby optimizing resources.
9. Establish and resource mechanisms that ensure **consultative approach** to seek collective wisdom from women's health advocates by involving them in priority setting, service delivery and evaluation processes. Establishment of Women's Advisory Committees for the critical portfolio areas and diversity units across all government departments may be recommended as the initial steps in this direction.
10. Develop close **collaboration with other states and territories and the federal government** with regard to women's health policy and for sharing the resources and opportunities related to women's health and gender equality.

**Resource the following key priority areas and recommendations:**

- Adopting GIA tool and gender and diversity lens for achieving women's health and wellbeing (see Appendix 1 for a detailed analysis).
- Building women's capabilities through preventive, promotional and partnership approaches.
- Prevention of violence against women
- Addressing women's specific health needs and vulnerabilities
- Mental wellbeing and social connectedness.

## **Appendix 1: Translating 10 Point Plan on WA’s Women’s Health Policy into Action using GIA Tools and Gender and Diversity Lens**

### **GIA tool**

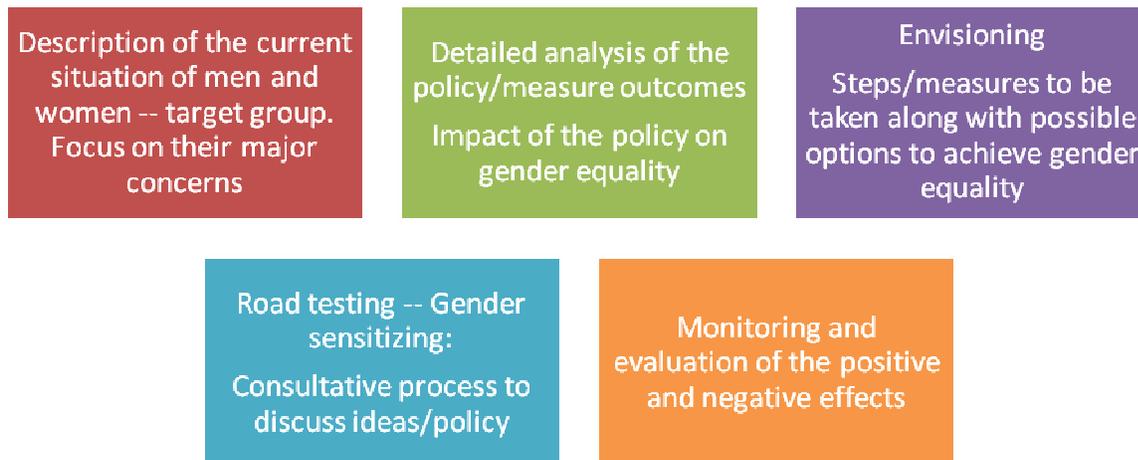
#### **Rationale**

Gender impact analysis is a tool that provides a practical, systematic method for ensuring that gender considerations form part of the development of policy, program and service design.

- Enables more precise targeting and maximum outcomes for policies, programs and services;
- Enforces gender equality through development of adequate intervention strategies based on identification of potential policy impact;
- Promotes gender equal opportunity through verification of planning quality and carefully selecting priority and issues on which planning choices to be based; and
- Ensures gender mainstreaming principle by contributing to overall policy evaluation.

“Gender-based analysis acts like a camera lens, filtering distortions and inaccuracies that are not immediately obvious” (Donner, 2003) and at the same time providing opportunity to pursue a planned approach to policies, programs and services that will provide better outcomes for women and men.

As a tool GIA can be used for an agency as a whole, to review a specific program or to review a specific set of policies within an agency e.g. policies related to assessment of clients with co-morbid AOD and mental health problems. **GIA is a step-by-step analysis** in the process of policy formulation that involves several steps as follows:



### Major checks

At every stage however, it is important to have in-built check mechanism so that the purpose of GIA is not defeated. According to Moser (2005: 11) three concepts – evaporation, invisibilisation and resistance provide the basis for gender mainstreaming assessment at the implementation stage. These concepts can be defined as follows:

Evaporation – When good policy intentions fail to be followed through in practice

Invisibilisation – Monitoring and evaluation criteria fail to document or inadequately document what’s happening on the ground; and

Resistance – When GM is blocked for political reasons rather than technocratic procedural constraints.

A ranking scheme may be useful to perform these checks. Following Department for International Development’s experience (DFID) (Moser, 2005: 12) ranking may be done as follows:

3: Highest score to be given to projects/ programs that aims either at removal of gender discrimination or promotion of gender equality

2: Second highest score for projects/programs where the above objectives are integral and mainstreamed. E.g. Equitable access to services and equitable benefits to new resources.

1: A non-targeted score or lowest score to projects/ prgrams that do not fit the above categories.

### Matrix for Policy Analysis using GIA tools

Standard 1.1: Assessment and planning are undertaken at the agency and consumer levels to ensure policy objectives are linked to gender equality.

Evidence question	What this means	Some (but not limited to) examples of evidence
Whether and how the policy objectives are linked to gender equality	<p>How the agency understands and is responsive to gender equality</p> <p>Which parts of the policy address the direct, indirect and gendered concerns</p> <p>Do the planning assumptions adequately reflect constraints on (i) women's, (ii) men's and (iii) people with diverse sexuality, sex and or gender (DSG) participation in the program</p>	<p>Reports of staff consultation process.</p> <p>Public documents e.g. values, vision, mission statements and agency's policy that states agency's goals in regards to gender equality and to address gender inequalities.</p> <p>Policy/Program objectives and strategies help ensure gender equality. Policies/strategies that ensure equity of access to services by addressing barriers to service access e.g. lack of child care, poor transport facilities may have home visits to overcome the barriers.</p> <p>Gender disaggregated data collection in place.</p>

		Reporting incorporates gender analysis. Budget allocation is adequate to ensure equitable participation of men, women and DSG group.
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Standard 1.2: Assessment and planning are undertaken at the agency and consumer/community levels to take into account specific gender concerns while formulating policy.

Evidence question	What this means	Some (but not limited to) examples of evidence
How does program/policy take into account specific gender concerns	<p>The processes, systems and mechanisms the agency has in place is gender sensitive:</p> <ul style="list-style-type: none"> <li>• for data collection and evidence base;</li> <li>• identify and prioritize needs of the service providers and different consumer groups; and</li> <li>• documentation, updating and evaluation of program/policy</li> </ul> <p>How and to what extent the program/policy guarantees gender preferential access and benefits to consumer groups</p> <p>Whether the program develops different strategies and services for different consumer groups e.g. women with dependent children, DSG clients.</p>	<p>Annual plans and program/project specific plans</p> <p>Gender specific data is collected and a gender analysis done</p> <p>Evidence of processes (including for selection and use of data sets, trend analysis, indicators and standards for presentation of data) to monitor emerging needs, trends and potential priorities of the clientele group. Reports have contributed to or produced looking at specific health issue with a gender analysis. Stakeholders' consultation activities, internal performance data, safety and quality monitoring. Gender analysis and gender sensitivity of the report.</p> <p>Policy and procedures for consumer assessment, care planning and review. Membership of, and/or reports of networking with, agencies that represent different groups including ATSI, key cultural, multicultural, DSG group, special needs agencies and advocacy groups. Consumer consultation and feedback reports.</p> <p>Registration information disaggregated by gender, age, disability, etc. All programs have provision for</p>

		<p>consumers' feedback.</p> <p>Budget allocation to ensure differential strategies and services for different women's groups</p> <p>Differential impact analysis is incorporated in gender analysis.</p> <p>A regular system of reporting and evaluation of project/program activities for different groups of men and women and DSG clients.</p>
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Standard 1.3: Assessment of the policy/program at the agency and consumer/community levels for any potential negative impact on gendered concerns and gender equality.

Evidence question	What this means	Some (but not limited to) examples of evidence
Whether policy/ programs have any negative impact on gendered concerns and gender equality	<p>How far the programs are consistent and coherent with policy goals</p> <p>Whether there is any monitoring mechanism to identify and assess if the agency's policies have any negative impact on different client groups, or indirectly discriminate against any particular client group. For example women with dependent children may not be able to access services if child care facilities are not available.</p> <p>Review mechanism within the agency and across Stakeholders'/ partners' agency to examine if there is any potential negative impact or unintended consequences from the policy/ program.</p> <p>Agency's response mechanism to reduce/eliminate negative impact. How staff collect and use information to develop and review service and program plans and models</p>	<p>Reports of staff consultation process.</p> <p>Policy and procedures for consumer assessment, care planning and review.</p> <p>Reports of stakeholders and partners' consultation process.</p> <p>Program/service manager and staff reports.</p> <p>Documented service and program plans to address identified needs.</p> <p>Program/activity evaluation report.</p> <p>Reports from internal performance data e.g. service and program reviews, feedback from consumer groups, safety and quality monitoring.</p>

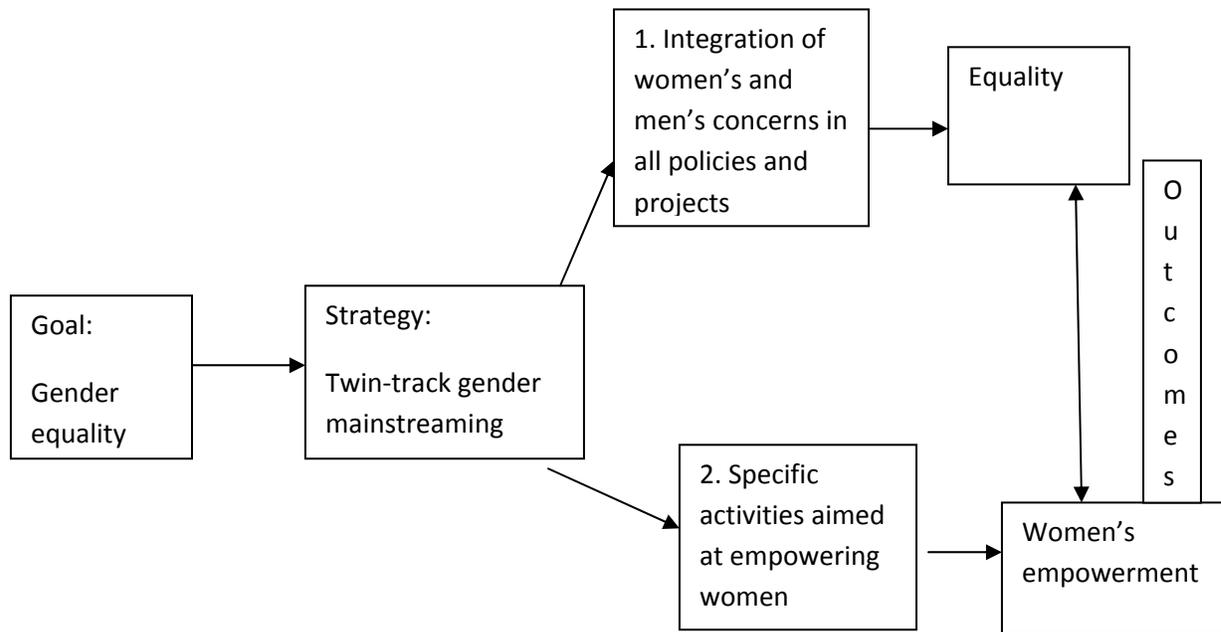
Standard 1.4: Assessment of the policy/program at the agency and consumer/community levels to ensure flexibility and confidentiality around gender sensitive issues e.g. domestic violence.

Evidence question	What this means	Some (but not limited to) examples of evidence
<p>Whether the program/policy ensures flexibility and confidentiality around sensitive issues e.g. domestic violence</p>	<p>How the agency maintains relationship with ATSI groups and other cultural groups in the community in order to ensure cultural safety.</p> <p>How the agency uses this knowledge in service and program design, and to ensure cultural safety and confidentiality as well as consumer rights and responsibilities</p> <p>The training and other forms of education that are provided to staff, so that they are aware of, and show respect to, needs for consumer and cultural safety.</p> <p>How existing services/programs are designed/redesigned to meet diverse group of consumers' needs better</p> <p>How new services or programs are designed, planned and implemented to meet identified needs or trends</p>	<p>Membership of, and/or reports of networking with agencies that represent different groups including ATSI, key cultural, multicultural, special needs agency and advocacy groups.</p> <p>Minutes of meeting with different organizations that helps the organization to keep in touch with different groups.</p> <p>Policies and procedures relating to confidentiality, diversity and cultural safety.</p> <p>Staff profile and records of cultural competency training and professional development programs and participation including DSG training, disability training.</p> <p>HR policies and procedures to support diversity and cultural safety e.g. recruitment of the staff to match the culture or language of the clientele groups, use of interpreters and translators</p> <p>Reports from internal performance data e.g. service and program reviews, feedback from clientele groups, safety and quality monitoring.</p> <p>Proposals and implementation plans for new programs, services or resources to address identified needs and priorities Service agreements, partnerships and MOUs, funding submissions Consumer services/program plans</p>

## Examples of GIA as used in some institutions' policies

1. Gender mainstreaming strategy of the Department for International Development (DFID), UK

Figure 1: Department for International Development (DFID), UK Gender Mainstreaming Strategy (adapted from Moser, 2005: 10)



## The gender and diversity lens (GDL)

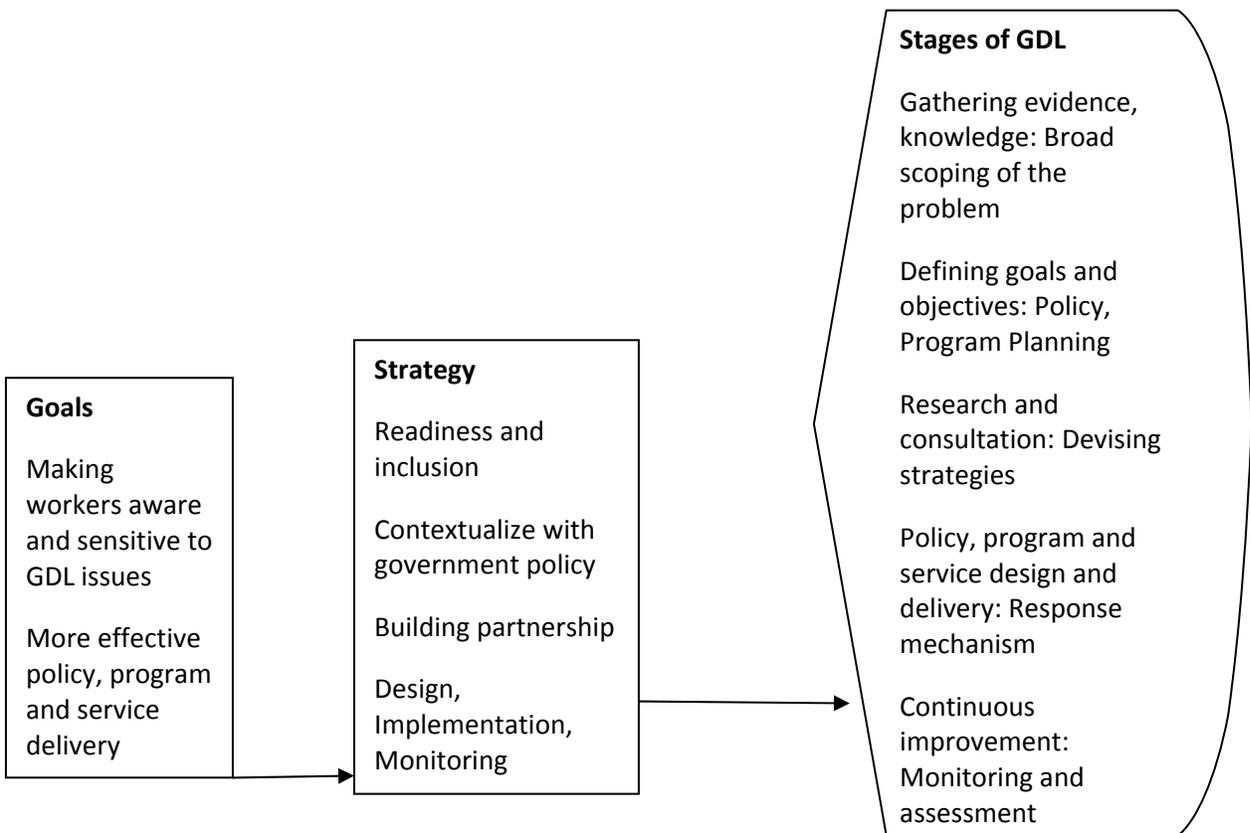
### Rationale

The GDL links gender analysis to an agency's planning cycle. It looks at 'gender' as "the first filter of analysis and overlays a diversity lens to assess issues for particular group of women and men". It thus helps broadening the agenda and the scope of work and also eliminates negative implications of a particular policy, program and/or project.

Figure 1 provides a framework outlining the rationale, strategy and the application of GDL in the policy planning and program design and service delivery. Note that unlike GIA the scope of which includes both broader and specific contexts, application of GDL is specific to a particular project/program in a given time period. Experiences from specific projects accumulate over time and can potentially make the agency more sensitive to the interaction of gender, diversity and disadvantages. It may not be wrong to describe GDL as a handy user manual for implementing a particular program/service e.g. improving health and wellbeing of diverse group of women. According to the Victoria Women's Health and Wellbeing Strategy,

*GDL is essentially a quality improvement resource designed to identify – hidden assumptions and values which may sustain inequality and contribute to discrimination; the possible consequences and impact of initiatives and service gaps and research in areas which require further work.*

Figure 1: Gender and diversity lens: A framework for programmatic application (after Department of Human Services, Victoria, 2010)





**Outputs**

- Better practice models
- More informed policy
- Mainstreaming gender equality
- Specific planning tools and resources
- Training
- Data collection

**Potential Outcomes**

- Better designed program
- Better result e.g. improved health and well-being
- Improved access to services
- More capable workforce

**Matrix for Policy Analysis using GDL Lens**

At the strategy level GDL matrix can be used as a tool for ensuring QIC standard as shown in the following table.

Standard 1.1: Assessment of whether gender issues have been systematically considered in the planning, implementation phases and evaluation of a program e.g. health and well-being for a diverse group of women.

Evidence question	What this means	Some (but not limited to) examples of evidence
Whether the program ensures gender and diversity considerations	<p>Whether the staff members have adequate understanding of the gender relations and gendered patterns of behavior, which affect women’s and men’s health and well-being.</p> <p>Whether the staff members understand how personal bias and expectations can influence individual activity</p>	<p>Public documents e.g. values, vision, mission statements and agency’s policy that states agency’s goals in regards to gender equity and diversity goals. Budget and time allocation are adequate to ensure gender and diversity analysis. Staff profile and records of cultural competency training and professional development programs and participation including DSG and disability training.</p>

		<p>HR policies and procedures to support diversity and cultural safety e.g. recruitment of the staff to match the culture or language of the clientele groups, use of interpreters and translators</p> <p>Job descriptions, service contracts and performance appraisals adequately reflect responsibilities for gender equity objectives</p> <p>Consumer/client registration information disaggregated by gender, age, aboriginality, ability/disability, culture, language, religion and belief, sexual orientation, care responsibilities, geographic location, housing security, educational standard, paid/unpaid work</p>
	How far the program is consistent and coherent with government's current policy directions, priorities and familiar with policy setting	<p>Reports of staff consultation process</p> <p>Reports of interactions and frequency of with government</p> <p>Timing of the policy and program development is consistent with contemporary government policy</p>
	Whether the agency has developed a shared vision and consensus on gender and diversity objectives with key stakeholders	<p>Membership of, and/or reports of networking with, agencies that represent different groups including ATSI, key cultural, multicultural, special needs agencies and advocacy groups.</p> <p>Reports of stakeholders and partners' consultation process.</p>
	How the agency maintains relationship with ATSI groups and other cultural groups in the community to ensure their participation in the program?	<p>Membership of, and/or reports of networking with, agencies that represent different groups including ATSI, key cultural, multicultural, special needs agencies and advocacy groups.</p> <p>Consumer consultation and feedback reports</p>

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