## *10 Point Plan Partners*

**Women's Health Matters: From Policy to Practice**
**10 Point Plan for Victorian Women's Health 2006-2010**

# Setting an Agenda

**10 Point Plan Partners thank** **for their support**

This paper and other information on women's health is available at:

Women's Health Victoria
Ph: (03) 9662 3755
Email: whv@whv.org.au
Website: www.whv.org.au

Women's Health Goulburn North East
Ph: (03) 5722 3009
Email: whealth@whealth.com.au
Website: www.whealth.com.au

WIRE Women's Information
Ph: (03) 9921 0870
Email: wire@wire.org.au
Website: www.wire.org.au

Women's Health West
Ph: (03) 9689 9588
Email: info@whwest.org.au
Website: www.whwest.org.au

Women's Health in the North
Ph: 03) 9484 1666
Email: info@whin.org.au
Website: www.whin.org.au

Victorian Women with Disabilities Network
Ph: (03) 9662 3755
Email: vwdn@whv.org.au

Multicultural Centre for Women's Health
Ph: (03) 9482 3299
Email: info@mcwh.com.au
Website: www.mcwh.com.au

Women's Health in the South East
Ph: (03) 9783 3211
Email: whise@vicnet.net.au
Website: www.vicnet.net.au/~whise

Women's Health Loddon Mallee
Ph: (03) 5443 0233
Email: lmwh@lmwh.net
Website: www.lmwh.net

Women's Health East
Ph: (03) 9845 8000
Email: health@whe.org.au

Women's Health Grampians
Ph: (03) 5322 4100
Email: adminb@whg.org.au
Website: www.whg.org.au

Gippsland Women's Health Service
Ph: (03) 5143 1600
Email: admin@gwhealth.asn.au
Website: www.gwhealth.asn.au

Royal Women's Hospital
Ph: (03) 9344 2849
Email: whic@rwh.org.au

Correspondence regarding this publication and copyright issues should be addressed to:
Women's Health Victoria
GPO Box 1160
Melbourne Vic 3001

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More information about Gendered Policy Framework is available at:
http://www.whv.org.au/health_policy/gender.htm

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# Women's Health Matters: From Policy to Practice
# Setting an Agenda for Victorian Women's Health 2006-2010

*"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology"*

**The United Nations Division for the Advancement of Women, 1995**[1]

## Introduction

Victorian women have a remarkable history in advocating for, and acting to improve, women's health outcomes.

In 2006 we celebrate 110 years of Victorian women's leading role in promoting women's health with Australia's first women's health service set up by women, for women, at the Queen Victoria Women's Hospital in 1896. Much of the women's health movement in the late 1960s and 1970s evolved in Victoria. We are also celebrating 21 years since the establishment of the Labor Government's Victorian Ministerial Women's Health Policy Working Group. The release of its groundbreaking report "Why Women's Health?" in 1987 resulted in the first Victorian Women's Health Program in 1987 and the establishment of statewide and regional women's health services.

And next year we mark 10 years since the demise of the National Women's Health Policy. Since the dismantling of the National Women's Health Policy in 1997 by the Federal Government, it is more important than ever that the State Government has a comprehensive and credible women's health policy, within a broader health policy that acknowledges the importance of gender as a determinant of health.

Despite some measurable progress here in Victoria over the past two decades, inequities remain in health outcomes and health service delivery, particularly for women experiencing social and economic disadvantage. This includes the one in five Victorian women who will report experiencing violence in their adult lives[2], and the 13,000 Indigenous women in Victoria[3] who continue to experience poorer health, social, and economic outcomes and life expectancy.

Women's health services and advocates across the State are committed to further improvements in women's health outcomes, and have developed this discussion paper to contribute to setting the agenda for a new women's health policy and strategy over the next five years from 2006-2010.

This paper complements and builds on the "10 Point Plan" developed in November 2005 *(see Appendix One).* Member associations of the women's health peak organisation Women's Health Association of Victoria (WHAV) have contributed to the development of the Plan. WHAV objectives include:

(a) The promotion of a social model of health which recognises the impact of social, economic and environmental factors on women's health.
(b) Encouraging the health system to be more responsive to the needs of women through a variety of activities including:
- Contributing to state and federal government policies and issues that affect women's health
- Promoting best practice in women's health

(c) Working to improve the health and well being of women with a focus on those most at risk.
(d) Working co-operatively with other women's health networks and services to advocate for improved health services for women at both state and national level.

Since November the Plan has been endorsed by 40 women's services and associated organisations. Progressively since January 2006 it has been sent to all Victorian Government Social Development Ministers and Parliamentary Secretaries, the Victorian Labor Party, the Victorian Liberal Party, the National Party and the Greens. Each has been asked to commit to the Plan in the lead up to the Victorian State election to be held in November 2006.

## Why 'Women's Health' Matters

Women are different from men and experience life differently, both in sickness and in health. Growing up, and as adults, women have different experiences based on both biological factors and gender roles. As well as the obvious anatomical differences, these include genetic, hormonal, psychological and social factors. In responding to women's health issues we must recognise and acknowledge these differences, without overshadowing or dismissing the commonalities they share with men.

There are some conditions that affect more women than men, such as arthritis, major depression, osteoporosis, eating disorders and the health impacts of family violence. There are also gender differences in relation to the presentation of heart disease, patterns of HIV infection and the susceptibility to alcohol related damage[4]. And there are some conditions that only affect women, such as pregnancy, childbirth and menopause.

However women's health is still too often seen by many as being just about women's reproductive health. While this view remains, particularly amongst those in decision making positions in government and in the health care system, women's health will continue to be compromised by policies and programs that simply don't respond to their needs.

Despite the growing international recognition of gender as a determinant of health, this awareness has yet to be incorporated into mainstream health policy, and in the design and delivery of programs and services. Victoria has made some progress in this area over the past 20 years, but not enough.

Better outcomes in women's health have benefits for individuals and their families, and for the broader community. Flow on benefits are extensive and include greater participation and productivity by women in the paid and unpaid workforce, and less demand for high cost health services to be funded by government.

These better health outcomes can only be reached by having 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.

### *The Current State of Play in Women's Health Policy*

The past three decades have seen a significant shift in the way women's health needs are treated by governments and communities across the globe. Following the 1975 International Women's Year conference in Mexico, there has been a growing acceptance in developed as well as many developing countries that women's health cannot just be seen as an 'add-on' to mainstream health policies (*See Appendix Two*).

In 1987, Victoria adopted a 'dual strategy' approach to women's health which involved the development of separate health services for women, alongside the reforming and re-orienting of existing health services. This approach successfully led to nine regional women's health services being established across the State delivering a wide range of services to Victorian women and three statewide services advocating for women's health issues. However it is arguable whether the goal of reforming and re-orienting other health services to better cater for the needs of women has been achieved.

Since the establishment of the Victorian Women's Health Program in 1987, there have been a number of women's health policies, each with their own priorities and action plans. Some have been implemented more successfully than others.

Most recently, the Victoria's Women's Health and Wellbeing Strategy (WHWS) was launched in 2002 and concludes this year. This Strategy outlined the government's commitment to addressing inequalities in the health and wellbeing of Victorian women, particularly those who are the most disadvantaged. The Strategy was developed following consultation with over 1100 women and identified five key action areas:

- Increase women's participation and leadership
- Increase access that embraces diversity
- Enhance women's safety and security
- Improve women's mental and emotional health
- Extend knowledge of women's health and wellbeing and promote ongoing improvements

Now that this strategy is coming to an end, it is critical that it is formally evaluated and a new plan put in place to continue some of the work started within the WHWS. It is also important that the new plan is based on consultation and input from Victorian women, women's health services and others with a stake in women's health.

The demise of the National Women's Health Policy in 1997 has resulted in a lack of any national leadership on women's health. This means that a progressive Victorian women's health strategy is more important than ever.

Working in partnership with government, the women's health sector, the general health sector and women of Victoria can develop a plan for 2006-2010 and beyond that will help improve the health outcomes of Victorian women, and set a long term goal of a healthier and more productive population.

## *The Current State of Women's Health in Victoria*

Despite living in a prosperous state and having access to a wide range of generalist and specialist health services, it is clear that there are still many areas of social, economic and health inequities faced by Victorian women. The following provides a snapshot of some of the difference, inequities and disadvantage experienced by women.

**Population**
In June 2001, there were 2,365,889 women in Victoria comprising 51% of the state population. Nearly a quarter were born overseas, 12,711 women identified as Indigenous, comprising 0.5% of the population.[5]

**Women's Health Outcomes**

- The life expectancy of females born in Victoria in 2002-04 is 83.3 years (compared to 78.5 years for males)[6].
- Unlike men who experience more fatal injuries and diseases, women experience higher prevalence and incidence of health problems that aren't fatal, which results in higher rates of disability burden for women. This means that even though women live longer, often more of their lives are lived in ill-health and disability[7].
- Estimated Indigenous life expectancy in Victoria is much lower than non-Indigenous at only 65.1 years for females born between 1996 and 2001 (and 60 years for males)[8] and Indigenous health outcomes are much worse than for non-Indigenous people in nearly all areas[9].
- The greatest burdens of disease for women in Victoria in 2001 were: heart disease, stroke, Alzheimer's and other dementias, depression, and breast cancer.
- In 2001 the leading cause of disability burden for both men and women in Victoria was depression.
- In 1999-2000, a study of people over 25 years found that nationally, 22% of women and 19% of men over 25 years are obese, while 30% of women and 48% of men are overweight[10].
- Even though in 2004 16% of Victorian women were daily smokers, compared to 19% of men[11], women experience different impacts from tobacco use to men.
- Despite Victorian women consuming lower levels of alcohol, with 40% reporting drinking alcohol daily or weekly, compared to 58% of men, binge drinking and risk taking behavior of men and women differ.

### Issues that Impact on Women's Health

Some examples of these issues are:

- 57% of women participate in the paid workforce (compared to 72% of men)[12].
- Victorian women working full time still only earn 86% of men's income[13].
- When both part time and full time work are included (representing the reality of women's working lives), women only earn 64% of men's income resulting in much lower lifetime earnings.
- Women make up 71% of the part time workforce[14].
- In the national pre-retired population, 78% of men had some superannuation, compared with 71% of women. Of these individuals who did have superannuation, men had more than double the total median amount of women - $13,400 for men and $6,400 for women[15].
- Fertility rates in Australia have remained stable for the past decade at 1.7 births per woman, which is less than the 2.1 per 1000 required to maintain existing population levels[16].
- Women are having children later in life, with the median age of mothers increasing from 27 years to 31 years during the period from 1984 to 2004.
- 71% of primary carers in Australia are women[17].
- Women account for 83% of single parents in Australia. Lone mothers have younger children living with them more often than lone fathers. In 2001, lone mothers were more than twice as likely to have at least one child aged 0-4 years living with them than lone fathers[18].

## A New Way Forward in Women's Health Policy

There are still many areas where women's social, economic and health outcomes need major improvements. Arguably this requires a new approach to women's health policy – one which is integrated with other areas of government policy in a coordinated way, and that incorporates gender as part of a 'health determinants' approach.

This will require a change of thinking for many, and a greater investment of resources in women's health. However it is also arguable that investment in women's health is an investment in the health of all the community, and will have significant benefits for the whole population.

### *Using a Health Determinants Approach*

Over the past few decades, there has been growing evidence of the relationship between gender and health, and an understanding of gender as an important determinant of health and wellbeing. Although the importance of gender to health outcomes is not news to most of us, it is still being discovered in many areas of health and is still absent from both policies and practices in many health services.

"**Gender** is used to describe those characteristics of women and men which are socially constructed, while **sex** refers to those which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles[19]"

However it is important that gender is considered as one of the many interactive factors that contribute to an individual's health status. The Canadian Women's Health Strategy developed a list of 12 health determinants[20] that could be usefully translated into a framework for a women's health policy here in Victoria:

- 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

Incorporating the social, economic and cultural factors of the determinants of health will ensure that the Victorian women's health policy takes a wholistic view – one that recognises the reality of women's lives and the pressures they face that affect their health. Using this health determinants approach will address inequities in health and enable women's (and men's) health issues to be considered as part of the mainstream approach to health policy and program setting.

'Gender mainstreaming' is a term that has gained a great deal of currency internationally, and is being used to ensure that women's health issues are not marginalised outside the mainstream health system. It is designed to ensure that inequality and discrimination in the allocation of resources and benefits or in access to services is identified and addressed. The United Nations describes gender mainstreaming as:

*"… the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making women's - as well as men's - concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programs... The ultimate goal is to achieve gender equality[21]"*

This approach has been embraced by international bodies such as the World Health Organisation, the United Nations, and the Commonwealth Heads of Government (*See Appendix Two*), and is supported by women's health advocates as long as it is complemented by the continued provision of a sustainable specialist women's health service system.

### *Gender Based Analysis as a Tool*

The Canadian Government has taken this gendered approach to policies and programs even further by developing and mandating the use of 'gender-based analysis' as a tool for looking at the effects of gender on health and healthcare[22]. It provides a framework that helps identify and clarify the whole range of differences experienced by men and women, and identifies how these differences affect their health status, and their access and interaction with the health care system.

The World Health Organisation acknowledges that "gender analysis in health often highlights how inequalities disadvantage women's health, the constraints women face to attain health and ways to address and overcome these".

Such a tool can be used to help distinguish the differences between women and men, the nature of their social relationships, their different social realities, life expectations and economic circumstances.

Using this approach, it is possible to identify a range of health issues that affect women only, some that are more common in women than in men, and special conditions that are related directly to gender roles:

| Some health issues that affect women only | Some health issues experienced differently by women | Special conditions related directly to gender roles |
| --- | --- | --- |
| • menstruation<br>• pregnancy<br>• complications of pregnancy<br>• menopause<br>• gynaecological cancers | • breast cancer<br>• heart disease<br>• osteoporosis<br>• depression<br>• hypertension<br>• arthritis | • sexual abuse<br>• domestic violence<br>• effects of prostitution<br>• anorexia/bulimia nervosa<br>• conditions related to poverty, particularly in older women |

Similarly for men, there are a range of health issues that only affect them (such as prostate cancer), that are more common to men (alcohol use, lung cancer, pulmonary disease, hearing loss) and that are related to gender roles (stress related to overwork, lack of social connectedness, suicide).

Other benefits of adopting a gender perspective in health policy, as identified by the World Health Organisation European Region[23] include that it:

- Recognises the need for the full participation of women and men in decision-making
- Gives equal weight to the knowledge, values and experiences of women and men
- Ensures that both women and men identify their health needs and priorities, and acknowledges that certain health problems are unique to, or have more serious implications, for men and women
- Leads to a better understanding of the causes of ill-health
- Results in more effective interventions to improve health
- Contributes to the attainment of greater equity in health and health care

As acknowledged in the Victorian Women's Health and Wellbeing Strategy 2002-06[24]:

> *"Gender is a significant factor affecting health and wellbeing. The impact of gender can result in different social, economic and political opportunities for women and men; affects access to resources and use of the health system, and can lead to different exposure to particular risk factors. The differences between men and women also affect the causes of illness and disease, and therefore determine the nature of interventions."*

While this commitment was welcomed, translating it from policy into practice still has a substantial way to go. A formal gender analysis tool would help in more clearly articulating and measuring this in the next women's health strategy.

***Overarching Values of Women's Health***

Health as a human right has been embraced by many agencies at an international level. Most Western countries, including the United Kingdom, Canada and New Zealand, have a national Human Rights Act or equivalent[25]. While Australia has no plans to introduce one, the Australian Capital Territory has enacted a Territory Human Rights Act, and Victoria is planning to introduce a similar Act.

In the absence of any Australian constitutional entrenchment of equality for women, moves by the Victorian Government to enact a *Charter of Human Rights and Responsibilities* - as announced late in 2005 - are welcome.

The implementation of a gender based analysis framework across Victorian government policy would complement the Charter of Human Rights and Responsibilities, and ensure that the gendered nature of rights and responsibilities within our community are promoted. In tandem, these will help ensure that Victoria is a place where women have:

- The right to live safely and free from violence and fear
- The right for women to fulfill their potential
- The right to informed and real choices

It must also be recognised that within the diversity of women that make up the population, there are some that face even greater disadvantage. In response to the specific health needs of these groups, it is proposed that in addition to a gender analysis framework, a diversity analysis is overlaid that considers factors such as race, ethnicity, geographic isolation, work/family responsibilities, level of ability, and sexual orientation.

## Priority Issues

Both nationally and at a state level, there are a number of demographic, social and economic trends likely to have a significant impact on the future health needs of women. Women's health advocates acknowledge that within limited resources there needs to be a prioritisation of health issues to pursue. From their practice experience over the past 20 years, and recent consultations with women's health consumers and advocates, the following areas are suggested as priorities over the next five years:

- Developing a **statewide reproductive and sexual health policy**, supported by funded programs

- Acknowledging **violence against women as the greatest burden of disease** for Victorian women and funding health promotion and prevention responses within the state's health policy framework and service delivery models

- Ensuring that **women's emotional and mental health needs are appropriately and adequately met**, by reviewing all existing policies and programs from a gendered perspective and promoting this approach at a Commonwealth level

- Developing and implementing a **gender based analysis framework**, and diversity analysis, for all health policies and programs starting with the State and National Health Priority Areas.

There are clearly strong links between the first three priority areas – and it is important that these links are articulated and addressed as part of the women's health policy.

As well as funding programs and initiatives in these priority areas, there should also be a commitment to fund research in identified women's health priority areas to continue the development of evidence based health policy - particularly research evaluating the translation of evidence into practice. Consultation to help identify the five key research areas should be undertaken with a broad range of women's health providers, researchers and consumer groups.

Some of the key elements that need to be taken into account in developing strategies in each of these priority areas are outlined below.

### *Sexual and Reproductive Health Policy*

Sexual and reproductive health is a fundamental issue for all Victorian women, affecting them at every life stage. Public debate on women's reproductive health has been reignited nationally in the past two to three years with a Federal Parliamentary debate on women's access to medical terminations. Women's control over their own bodies, through access to safe and appropriate health services and information, remains a central priority of the women's health movement. However from this recent experience it is clear that this belief is not universally shared.

The development of a statewide reproductive and sexual health policy, along with funded programs, becomes even more critical for women in this environment.

The issue of sexual and reproductive health is of particular relevance to young women, with the alarming increase in sexually transmitted infections (STIs) such as Chlamydia indicating that current approaches are failing completely. Chlamydia notifications from 1994-2004 rose by 550% (4422/783) amongst females and nearly twice that amount in males[26]. The number of Chlamydia cases detected in the state last year jumped to 8894 compared with 4846 in 2002. However this only tells part of the story, given that reported rates are likely to underestimate the real rates of many STIs and the implications these have for women's health, particularly reproductive health and fertility, must be addressed.

A new approach to sexual and reproductive health policy and programs – including education programs - is critical if we are to positively influence fertility rates, the capacity to negotiate safe sex (safe from STIs and the possibility of pregnancy), and give young women the best possible information about reproductive and sexual health issues and choices available to them. Obviously education for young men is also required.

The development of a new policy in this area requires a more coordinated approach to reproductive and sexual health policy within and across government structures. Currently for example, responsibility for STI policy rests within the Department of Human Services (DHS) Public Health Division, issues of reproductive health and birthing are dealt with across acute care and various committees such as those on perinatal and maternal mortality.

Under the current legislative framework, attempting to situate in vitro fertilization (IVF) within a broad reproductive health policy is difficult, as the 'social/ethical' dimensions (eligibility for treatment, genetic testing, surrogacy, etc) are regulated by statute which addresses the perceived social/ethical consequences of the technologies that have developed to overcome infertility. None of these really fits under the rubric of public health or health promotion in the conventional sense. There is no DHS focus on the health promotion of reproductive health.

There is no coordinated approach to teaching and promoting young peoples sexual and reproductive health across health and education.

Recommendations arising from the 2006 research report 'The Sexual and Reproductive Health of Young Victorians' encompass the need for significant improvement in monitoring, educating and service development. In particular this report reinforces service development to address social health and wellbeing and policy and program development that recognises the inter-relation of sexual and reproductive health rather than viewing these domains as distinct fields.[27]

***Preventing Violence Against Women***

It is important to understand current trends in the incidence of violence against women and its impacts to develop models for prevention. Some of the latest statistics show that:

- While women make up only 30% of homicide victims, they represent nearly 90% of reported rapes and 76% of reported sexual assaults[28].
- It is widely acknowledged that around 80% of sexual assaults go unreported[29].
- After financial difficulty, domestic violence is the leading cause of homelessness in Victoria, with women and children still being forced in the majority of cases to flee the family home[30].
- Nearly 20% of Victorian women report feeling unsafe in their local neighbourhood after dark, and around 18% say they never walk alone after dark[31].

A recent study undertaken by VicHealth on the health cost of violence against women shows that this issue demands immediate attention and action. In Victorian women aged 15 to 44, violence was found to be the leading contributor to death, disability and illness, surpassing the disease burden caused by a number of well-known preventable risk factors such as high blood pressure, smoking and obesity.[32]

The VicHealth report found broad consensus internationally that intimate partner violence is best addressed in the context of human rights, legal and health frameworks and through the development of multi-level strategies across sectors.

Access Economics has also undertaken a study on the economic costs of family violence, and estimate the national cost to be $8.1 billion for 2002-03[33]. The cost to Victoria has been estimated at $2 billion every year[34]. With one in five Victorian women experiencing intimate partner violence in their lifetime, the health costs are already enormous. And most importantly, family violence is to a large degree preventable.

Women's health services are already working in a range of ways to focus on the prevention of violence against women, utilising health promotion frameworks. Action on prevention of violence needs to be further developed in policy across government, including health and the role of health services in early identification of violence issues and early intervention.

A focus on preventing violence against women as a health promotion action is complementary to the work being done across government in reforming the family violence system, *Changing Lives: a New Approach to Family Violence in Victoria,* and in the state's forward plan for women, *Leading with Victorian Women 2004-07*[35].

### *Mental and Emotional Health Responses*

As identified in the 2002-06 *Women's Health and Wellbeing Strategy*, women's mental and emotional health requires special attention. This requirement has not diminished since the strategy was published in 2002. Not only does depression in women contribute more to the burden of disease than depression in men, women also experience more affective disorders (depression and bipolar affective disorder) than men.

Mental health and mental illness are determined by multiple and interacting social, psychological and biological factors and indicators of risk include poverty, low levels of education, poor housing and social exclusion. Women as a group experience high levels of all these risk factors.

Depression is the most prevalent cause of disability among women and is likely to be accompanied by other psychological disorders. The following data from Women's Health Victoria's Gender Impact Assessment on Depression[36] highlight the severity of the illness:

- Ten to fifteen percent of women suffer a major depressive episode shortly after childbirth.
- One in four women and one in six men in Australia will experience depression at some time in their lives.
- Women with depression are significantly more likely to be prescribed anti-depressant drugs than men with the same diagnosis.
- Despite women being diagnosed with depression at a higher rate, it is not necessarily the case that depression is well recognised in women among doctors, family and friends.

Many studies have demonstrated an inverse relationship between depression and social networks and women are particularly more vulnerable than men to the effects of reduced social support[37].

With mental health attracting significant new funding by the Commonwealth government recently, it is important that state contributions and future policy directions take into account the gendered nature of mental and emotional health so that more appropriate services and responses are provided.

### *A Gendered Approach to the State and National Health Priorities*

It is also important that the agreed National Health Priorities[38] (set by the Commonwealth and state/territory governments) are approached from a gendered perspective. Currently they are identified as:

- Asthma
- Cardiovascular health
- Cancer control
- Diabetes mellitus
- Injury prevention and control
- Mental health
- Arthritis and musculoskeletal conditions

These priority areas account for almost 80% of the national burden of disease and injury and are critical in directing health funding for research and service provision. Many of these diseases and conditions have differential rates for men and women and contain gendered perspectives that should be acknowledged and addressed within a women's health policy, and within broader health frameworks.

As a starting point for implementing a gender-based analysis of all health policy, these National Health Priorities should be subjected to a gender analysis, to ensure that existing approaches are most effectively targeting and treating women and men. Similarly, as state health priorities are set there should be a requirement for these to be considered from a gendered perspective.

## Principles for Effective Implementation of a New Women's Health Policy

As well as developing a sound framework and strategic priority areas, it is important that a new women's health policy is implemented in a way that achieves optimal results for all involved – including government as funders, health services as providers and women as consumers.

The following represent a proposed set of principles for effective implementation:
- High level cross-government leadership
- An inclusive approach
- Honesty and transparency
- Adequate resourcing and accountability
- Retaining and enhancing women specific services
- Supporting collaborative frameworks

### *High Level Cross-Government Leadership*

The Victorian Government has demonstrated a strong commitment to adopting a whole of government approach to key issues, most notably in the social policy area. Both *A Fairer Victoria*[39] launched in April 2005 and *Better Pathways: an Integrated Response to Women's Offending and Re-Offending*[40] released late in 2005 are recent examples of this 'joined-up' approach by government.

The process in developing the *Better Pathways* project was particularly impressive as it acknowledged the gendered nature of women's offending. It also recognised that women prisoners and offenders represent some of the most disadvantaged members of the community, and that this cycle of disadvantage could be tackled in a coordinated way involving both government and community agencies. With $25.5 million committed over the four year life of this strategy, *Better Pathways* represents an excellent model for a whole of government approach to women's health.

Given that women's health outcomes are influenced by so many different economic, social and cultural factors, it makes sense for a cross-government approach to be taken in developing and implementing the women's health policy, led by the Minister for Health.

Other appropriate areas of government to be included in a high level government taskforce on women's health are:

- Victorian Communities
- Education
- Justice
- State and Regional Development
- Employment
- Transport
- Housing
- Community Services
- Police and Emergency Services
- Corrections
- Industrial Relations (including Workcover)
- Aged Care
- Aboriginal Affairs
- Multicultural Affairs

Consideration could also be given to establishing Ministerial Women's Advisory Committees within each of the relevant portfolio areas, in order to provide advice directly to individual ministers and their departments.

Cross portfolio collaboration is critical to the success of a new women's health strategy.

***An Inclusive Approach***

Successful implementation of a new women's health strategy will depend on developing strong partnerships and a shared sense of purpose with all critical stakeholders. This in turn will rely on involving all key players in its development.

Women's health services and advocates must be involved in setting priorities, developing policies and leading practice changes. There is currently a great deal of interest and goodwill from women's health services, as well as across the broader health system, in building on the achievements of the first *Women's Health and Wellbeing Strategy*, and this should be harnessed in the development of the next phase.

Others that should be involved in a partnership approach include:

- Members of Parliament
- Government departments and statutory bodies
- Non government organisations (women's health services, VicHealth, peak community groups)
- Indigenous leaders
- Professional bodies
- Intergovernmental organisations (Commonwealth Health Ministers Council, Commonwealth Women's Ministers Council)
- Public health sector (hospitals, bulk billing GPs)
- Private health sector (private hospitals, GPs, specialists)
- Academia (health researchers, women's health specialists, and medical and allied health educators and students)

An inclusive approach would also benefit from a strategic communications plan being developed to ensure that the goals of the strategy are widely communicated, along with monitoring and reports on progress throughout the life of the strategy. The new InfoHub based at the Queen Victoria Women's Centre should be included as an integral way of communicating with the broader community of Victorian women.

### *Honesty and Transparency*

In order to develop and maintain support for the new strategy and its initiatives, it is critical that honesty and transparency are built into the process through which it is developed, implemented and monitored.

Processes of engagement with partner organisations and community members must be inclusive and transparent. Where promises are made to include external parties in review and consultation throughout the life of the strategy, these should be honoured.

In recent years there has been a blurring of definition between consultations, information or education sessions and community forums. Given the resource constraints of all parties, particularly those in the non-government field, it is important that people are fully informed about the purpose and planned outcomes of forums they are invited to and where the information gathered at public forums will be made visible.

Good public policy relies on adequate and appropriate consultation. At the very least, those involved in consultation processes should be provided with the following:

- A brief and simple statement of purpose
- A summary of policy proposals to be considered
- A proposed implementation date where known
- Contact details for input
- A point of contact for questions and information on the process
- Feedback on outcomes of the consultation process
- Regular feedback on progress of the policy and outcomes

Even though they are all valid processes, consultation is not the same as forums for information sharing or capacity building, and these distinctions should be clear.

### *Adequate Resourcing and Accountability*

Resourcing for the new women's health strategy needs to be considered in light of the cost savings to government that can be created. For example, the estimated cost to the Victorian community of violence against women is around $2 billion per year.

*Better Pathways* attracted an investment of $25.5 million over four years to respond to the growing women's prison population, which rose from 116 to 257 between June 1995 and June 2001, a significant increase of 112.9%[41]. This funding model had a strong emphasis on preventing imprisonment and re-offending. A similar case can be made for investing money in preventing women's ill-health rather than pouring more money into treatment services.

One of the most cost effective elements of the new women's health strategy would be to invest in the development of a gender based analysis tool for use across government, to help identify approaches that are most responsive to the needs of women. Given the substantial international experience in this area, such a tool could be developed within the Office of Women's Policy.

The women's health strategy could then be used as an accountability tool for government departments to implement gender-based analysis in their policy, planning and funded service agreements.

Using this tool would also help ensure that other key social policies, such as *Growing Victoria Together* and *A Fairer Victoria*, are more effective and cost efficient.

Accountability for the implementation of the women's health strategy should rest not just with the Minister for Health, but for all ministers whose decision-making impacts on women's health outcomes. As with the first Women's Health and Wellbeing Strategy (WHWS), annual action plans and reporting on these plans will be critical. While the first few years of the WHWS resulted in timely and meaningful progress reports, it was disappointing to see that this was not sustained throughout the life of the strategy.

With internet-based reporting now commonplace across government, there should be no resource or other reasons why such reporting is not undertaken at least annually.

### *Retaining and Enhancing Women Specific Services*

Women's health services in Victoria continue to play a key role in the development and implementation of women's health policies and programs.

The philosophy, skills and expertise developed over the past two decades in working with women in both women only and mixed gender groups uniquely places women's health services to work with over services to facilitate gender responsive practice[42]. Women-specific health services have developed into a trusted, and vital, part of the broader health service system giving women health care providers and consumers a voice that they would never otherwise have had.

As well as improving the general health system through introducing gender based analysis into policy and practice, it is critical that women are given the choice to seek their health advice from other women, and from women-specific services.

In the context of a new women's health strategy through to 2010, it is important that government renews its commitment to women-specific services and the development of Centre's of Excellence, as well as further developing the roles of statewide and regional women's health services. This will help build on the existing intersectoral collaboration between these services and all other settings within which health is impacted – including the workplace, the general community, institutions and the family home.

### *Collaborative Frameworks*

As demonstrated by the current government, collaborative approaches and frameworks can be highly successful in achieving results for individuals and communities. The focus on initiatives that help build communities and promote social inclusion within the Department for Victorian Communities could successfully be translated into new initiatives, and better policy outcomes, in the area of women's health.

Primary Care Partnerships (PCPs) are one example where closer collaboration has been achieved between the many different players in the health service field. Many women's health services have actively participated in this new model, and believe that

their involvement can be even more worthwhile if the PCPs took on a gender based analysis of their activities, rather than seeing women's health as an add-on.

In implementing a new women's health policy, it is critical that government maintain and adequately fund specialist women's health expertise so that they can work effectively in these collaborative frameworks that work across health promotion settings and environments and health treatment services in primary and acute care.

## Conclusion

This discussion paper proposes a new way forward in the development of a women's health policy and strategy for 2006-2010. The basic elements of this are summarised in the "10 Point Plan" *(Appendix One).*

Essentially it is argued that investment in health policy and programs across Victoria could be managed more effectively and deliver better outcomes by adopting a health determinants approach which acknowledges gender as a determinant of health. Mainstreaming gender issues in policy and practice would result in better health outcomes for both women and men.

Alongside this long term goal of gender mainstreaming (which may take several years to implement), it is proposed that four inter-linked priority areas are focused on immediately with action plans developed to enact them over the next five years of the strategy:

- Developing a statewide reproductive and sexual health policy, supported by funded programs

- Acknowledging violence against women as the greatest burden of disease for Victorian women and funding health promotion and prevention responses within the state's health policy framework

- Ensuring that women's emotional and mental health needs are appropriately and adequately met, by reviewing all existing policies and programs from a gendered perspective, implementing this at the state level and promoting this approach at a Commonwealth level

- Developing and implementing a gender based analysis framework, and diversity analysis, for all health policies and programs starting with the State and National Health Priority Areas.

Principles for effective implementation have been articulated, and are aimed at ensuring maximum involvement and input from those directly affected – women, women's health services, and the broader health service system. The goal is to achieve a better health system, and health status, for all Victorians.

## Appendix One

***Women's Health Matters: From Policy to Practice***

***10 Point Plan for Victorian Women's Health 2006-2010***

The 10 point plan outlines a vision for women's health in Victoria over the next five years. It recognises the impact of gender in health and health inequalities and seeks to address these.

### *Endorsed By (as at October 2006)*

Arthritis Victoria
Australian Institute for Primary Care
Australian Women's Health Network
Carers Victoria
CASA Forum (Centre Against Sexual Assault Forum)
Centre for Culture Ethnicity and Health
City of Yarra
Country Women's Association of Victoria Inc
Darebin City Council
Domestic Violence Victoria
Eastern Domestic Violence Outreach Service Inc
Elizabeth Hoffman House Aboriginal Women's Service
Family Planning Victoria
Gippsland Women's Health Service
Health Issues Centre
Immigrant Women's Domestic Violence Service
Key Centre for Women's Health In Society
Moreland City Council
Multicultural Centre for Women's Health
Municipal Association of Victoria
Public Health Association of Australia (Victorian Branch)
Queen Victoria Women's Centre
Royal Women's Hospital
Tweddle Child and Family Health Service
Union of Australian Women (Victoria)
Victorian Aboriginal Community Controlled Health Organisations
Victorian Alcohol & Drug Association
Victorian Community Health Association
Victorian Council of Social Services
Victorian Local Governance Association
Victorian Women and Mental Health Network
Victorian Women with Disabilities Network
WIRE Women's Information
Women's Domestic Violence Crisis Service
Women's Health Association Victoria
Women's Health East
Women's Health Goulburn North East
Women's Health Grampians
Women's Health in the North
Women's Health in the South East
Women's Health Loddon Mallee
Women's Health Victoria
Women's Health West

# Women's Health Matters: From Policy to Practice
# 10 Point Plan for Victorian Women's Health 2006-2010

## ***Why do we need a new way forward?***

Women are different from men. Their social experience of that difference, expressed as 'gender', impacts on every area of their lives.

- Victorian women's average weekly earnings are 20% lower than those of Victorian men[43].
- The average earnings of employed women are still substantially lower that those of men[43].
- 15% of families with children under 15 are one-parent families. Of these 83% have a female head of family[44].
- Even when employed women are still largely responsible for looking after their homes and families.
- 20% of Victorian women speak a language other than English and close to one in five women living in Victoria is an immigrant[45].
- The number of Victorian women who identified as Indigenous in the 2001 census was 14,047[46].
- Women constitute a particularly large segment of the older/senior population[47].

There is growing evidence of the relationship between gender and health and understanding of gender as an important determinant of health and wellbeing. Although the difference is not news to most of us, it is still being discovered in many areas of health. Often, health has been dispensed as a 'one size fits all' model. However women need health care tailored to women's bodies and mindful of women's social roles[48].

There are some conditions that affect more women than men, such as arthritis, osteoporosis and eating disorders. There are some conditions that affect women differently than they affect men. Heart attacks and HIV/AIDS are two of the more serious conditions that doctors sometimes overlook in women, because the signs and symptoms look different than they do in men. And there are some conditions that only affect women, such as pregnancy, childbirth and menopause. Too often, reproductive health is what 'women's health' is seen to be. But women's health is much more than this.[48]

Despite the growing international recognition of gender as a determinant of health, this awareness has yet to be incorporated into mainstream health policy and the design and delivery of programs and services.

An investment in women's health is an investment in the health of all the community.

# 10 Points for 2006-2010

***What are the fundamental elements?***

**1. Social Determinants of Health Approach**

There is a need to create a comprehensive Victorian women's health policy that focuses on social, economic and cultural risks using a health determinants approach. This approach recognises that many factors in addition to access to health care services determine the health status of an individual. One of these factors is gender. Health should be promoted from the agreement that the twelve highly interactive determinants of health are:

- 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, and
- Culture[20]

**2. Gender as a Determinant of Health**

A new framework should encompass the components of gender based analysis. The components include gendered data, gender impact assessment and gender awareness raising. It requires that legislation, policies and programs are responsive to the evidence base regarding sex and gender differences and women's health needs. A lack of gendered data leads to ineffective service planning and reduced cost effectiveness of outcomes. The strategic use of women's health services to inform planning processes is thus essential.

The gender based analysis framework should be overlaid with a diversity analysis that considers factors such as race, ethnicity, geographic isolation, level of ability and sexual orientation.

A good example of a gender based analysis application is 'Better Pathways: An Integrated Response to Women's Offending and Re-offending'[40].

**3. Overarching Values**

Most Western countries, including the United Kingdom, Canada and New Zealand, have a national Human Rights Act or equivalent[25]. And although human rights laws operate within the jurisdiction of the Australian Capital Territory, Australia is the only Western country without a national Human Rights Act. In addition, Australia has no plans to ratify the UN Convention on the Elimination of All Forms of Discrimination Against Women and

is the only developed nation to not be a signatory. In the absence of any Australian constitutional entrenchment of equality for women at the federal level, moves by the Victorian Government to enact a Bill of Rights are welcome.

In implementing a gender based-analysis framework, it is recommended that human rights underpin the overarching values of this framework. It is recommended these include the creation of a society within which women have

- The right to live safely and free from violence and fear
- The right for women to fulfil their potential
- The right to informed and real choices

**4. Priority Issues**

Priority issues for action over the next five years should be:

- Statewide reproductive and sexual health policy and funded programs
- End violence against women
- Emotional and mental health

There should be a commitment to fund research in five identified women's health priority areas.

***How can this be implemented?***

**5. High Level Cross-Government Leadership**

Establish new Ministerial Women's Advisory Committees within each of the critical portfolio areas, including women's health, and develop a mechanism to achieve cross-portfolio collaboration.

**6. Inclusive Approach**

A process should be established which involves women's health advocates in priority setting and investment in translation of knowledge into policy development and health system and practice change.

**7. Honesty and Transparency**

Build honesty and transparency into consultation processes and turn consultation into action. When government is consulting with women it should be made clear from the outset where the results of the consultation will be visible, or whether the consultation is an information session, or whether it is an education session or other specific purpose.

**8. Resourcing and Accountability**

Allocate resource responsibility for carrying forward the gender based analysis approach in the women's action plan or health plan and make accountability for moving a women's agenda forward shared and visible.

The women's action plan or health plan should be an accountability tool for government departments to implement gender-based analysis in their policy, planning and funded service agreements.

Within Victoria currently, the apparatus in government for accountability to move a women's agenda forward is not clear. For example:

- G*rowing Victoria Togethe*r is not gendered.
- *Challenges in Addressing Disadvantage in Victoria* data analysis is not even sex disaggregated on those areas which inform the report such as school leavers unemployed, behavioural risks and socio-economic status, family violence reports and, unemployment. This is the paper which outlined the nature, extent and distribution of disadvantage in Victoria and led to the policy document *A Fairer Victoria*. The result is that *A Fairer Victoria* is not gendered. Visibility for accountability for moving a women's agenda forward is further diminished now that the *Forward Plan for Women* and the *Victorian Women's Health and Wellbeing Strategy* have been rolled into *A Fairer Victoria*.

**9. Women's Specific Services**

The authentic place of standalone specialist women's health services and programs ensures that research, policy and practice address the economic, social and cultural obstacles that prevent women from reaching their potential.

Renew commitment to women-specific services and centres of excellence and further develop the roles of statewide, regional women's health services for intersectoral collaboration between the settings within which health is impacted.

**10. Collaborative Frameworks**

Maintain and properly fund specialist women's health expertise while supporting those collaborative frameworks that women's health services are currently in, or could potentially work in. These work across health promotion settings and environments and health treatment services in primary and acute care.

## Appendix Two

***Developments in International and Australian Women's Health Policy***

### International Developments

1975 marked a turning point in the approach towards women's health, with the United Nations International Women's Year conference in Mexico establishing the move to an equity model, rather than a traditional welfare/poverty approach, to women's health.

UNIFEM (United Nations Development Fund for Women) was established in 1984 to recognise the importance of gender equality in international development projects including many health initiatives, with the General Assembly instructing UNIFEM to "ensure women's involvement in mainstream activities".

In 1995 the landmark UN World Conference on Women (Beijing) officially adopted "gender mainstreaming" – i.e. the application of gender perspectives to all legal and social norms and standards, policy development, research, planning, advocacy, development, implementation and monitoring.

The Beijing Platform for Action that resulted from this conference has helped drive women's health policy over the last decade, including an emphasis on health as a basic human right and the importance of women to be free from violence in order to maximise their health outcomes. A key statement from the conference was:

> *"Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men… The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."*

1995 also marked the formal adoption of a 'Gender and Development' approach by the Commonwealth Heads of Government in Auckland which recognised that many inequalities were created by society, and therefore need to be rectified by society[49]. It also recognised that both men and women needed to be involved in developing solutions to these gender based inequalities.

The UN Beijing +5 Women's Conference (2000) further strengthened the concept of gender mainstreaming in its resolutions. By adopting the Beijing Platform for Action, governments throughout the world - including Australia - effectively committed to effective integration of a gender perspective throughout all their policies, programs and service delivery. Their performance in delivering in each of these areas is subject to regular reviews, and Australia's performance is reliant on reporting by both federal and state/territory governments.

### Australian Developments

A National Women's Health Policy[50] was launched in 1989 under a Federal Labor government, with gender recognised as an organising principle for both policy and practice. It contained seven key policy areas:

- Reproductive health and sexuality
- Health of ageing women
- Women's emotional and mental health
- Violence against women
- Occupational health and safety
- Health needs of women as carers
- Health effects of sex role stereotyping

In June 1992, a steering committee was appointed to evaluate the program, and in 1993 an evaluation report was released showing overall positive results that attracted funding for another four years. However in 1997 after a change of government, the program was discontinued and women's health issues were subsumed into general funding streams with no specific strategy to set priorities or directions.

This policy shift was strongly condemned by women's health advocates. At a time when many other national governments and international bodies have been embracing gendered health frameworks, it has left Australia without a coherent approach to women's health. Several state governments have filled the gap with their own policies, but without national coordination or agreement on priorities, funding for women's health priorities and research has not flowed from the Commonwealth to states and territories.

Women's advancement has also stagnated in many other areas over the past decade, including their access to economic opportunities. The gender wage gap has increased, more women are now employed as casual workers without any job security, and responsibility for women's policy has been removed from a central agency into the Family and Community Services portfolio.

Other key issues that continue to compound women's relative disadvantage include:

- The market failure of a privatised child care system, resulting in further barriers to women's involvement in the paid workforce
- A family tax benefits system that penalises dual income families
- New industrial laws that further weaken women's ability to negotiate family friendly workplace conditions
- Refusal to institute a national paid maternity leave scheme, leaving Australia as only one of two OECD nations without this basic entitlement
- New welfare to work rules penalising single mothers and people on disability support pensions commencing in July 2006

## Appendix Three

### *Women's Health Policy and Services in Victoria – a Potted History*

| | |
|---|---|
| 1896 | Queen Victoria Hospital established in Melbourne – Australia's first health service by women for women |
| 1974 | Melbourne Women's Health Collective established |
| 1975 | UN International Year of Women<br>First National Women's Health Conference (Brisbane)<br>Women's Health Collective forced to close when funding not forthcoming |
| 1977 | Working Women's Health established (initially as 'Action for Family Planning' and later as 'Women in Industry: Contraception and Health) |
| 1983 | Women's Health Resource Collective shopfront opens<br>Victoria establishes a regionalised health system |
| 1984 | SA develops first women's health policy in Australia |
| 1985 | NSW develops a women's health policy<br>Victorian Ministerial Women's Health Working Party formed |
| 1987 | Ministerial Women's Health Working Party report released<br>Victoria develops a Women's Health Policy |
| 1988 | Victorian Women's Health Program (VWHP) established<br>HealthSharing Women, Women's Health Service for the West and Loddon Campaspe Women's Health Services established |
| 1989 | Barwon South West Women's Health Service established<br>National Women's Health Policy released by Federal Government (and funded for 4 years) |
| 1990 | Outer East Women's Health Service established |
| 1991 | Wellcoming Women's Health Service (Grampians region) established |
| 1992 | Gippsland Women's Health Services, Women's Health in the South East and Goulburn North East Women's Health Service established |
| 1996 | Healthsharing Women's Health Resource Service becomes Women's Health Victoria |
| 1997 | National Women's Health Policy abandoned – States and Territories now responsible |
| 2002 | Victorian Women's Health and Wellbeing Strategy 2002-2006 released |
| 2006 | Victorian Women's Health Services develop a "10 Point Plan" to help set the agenda for the next Women's Health and Wellbeing Strategy 2006-2010 |

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