



womens health & family services



Department of Health



Women's Ten Point Plan of Action

PROJECT REPORT

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Partners



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Executive summary

Introduction: Background to the Ten Point Plan of Action

As early as 2004, Western Australian women's health centres and service providers together with other interested women in the community and women working in government, have been conducting workshops aimed at improving the health status of women throughout WA. A Steering Group formed out of these workshops with a membership from a range of women's health and related services. After a comprehensive consultation process the need for a collaborative, co-ordinated and cross-sector approach to improving women's health and well-being was identified. To create models, programs, and methodologies that will improve health and well-being the full spectrum of the determinants must be considered. It was on this basis that principles for action emerged.

In 2011, Western Australia's women's health centres put together 'Women's Health Matters – a Ten Point Plan of Action'. The Ten Point Plan of Action is the first of its kind in WA, although not nationally or, indeed, internationally. The Plan drew from the knowledge and experience of local, national and international women's health sectors. In 2006, for example, Victorian Women's Health Services developed a comprehensive document, *Women's Health Matters: From Policy to Practice – Setting the Agenda for Victorian Women's Health 2006-2010* that included a Ten Point Plan. The 2006 document was influential in driving priority setting for women's health within government, and in developing a common set of agreed priorities and collaborative processes across the women's health sector. A new Ten Point Plan was developed in 2010.

It is evident from the Victorian and Canadian experiences that the successful implementation of a process to facilitate the realisation of an action plan to improve women's health outcomes requires co-ordination and leadership from the women's sector and the support of key stakeholders.

The women's health sector in Western Australia understands that the WA Women's Ten Point Plan of Action requires a process that depends on its own capacity and, essentially, community and stakeholder input. The 'second phase' of funding from Lotterywest was to gather information from research and community and stakeholder consultation to ensure that the Plan of Action is evidence based, informed by evidence of best practice and conversant with external events, trends and relationships that have potential for constraining or enabling the development of the Plan of Action. This report emerged from the 'second phase' of research and consultation. Information for the report was collated from the following sources:

- Desktop and literature research
- Interviews with key stakeholders
- Community forums/workshops
- A webinar
- An online survey

The purpose of this report is to:

- Place the Ten Point Plan in the context of current diverging, converging and interacting research, policies and strategies.
- Present two examples of processes and applications of the social determinants of women's health that have improved the health and wellbeing of women, their families and communities.
- Present the findings from community consultations (community feedback) on the Ten Point Plan of Action.
- Briefly assess the capacity of the non-government women's health sector to begin to deliver the Ten Point Plan through action on the social determinants of women's health and wellbeing.
- In the light of research and community consultations, outline possible next steps for the non-government women's sector to build their capacity to assist women to attain and maintain good health and mental health through enhanced collaboration and inter-sector and inter-agency linkages.

This report is part of the process of collecting, analysing and distributing information for the purposes of developing the Ten Point Plan of Action in the light of converging, diverging and interacting external factors. Effective planning also requires information on internal organisational factors. Information gathered from research, the community, government representatives and the women's health sector provides a perspective of the operating environment (external events, trends and relationships) in which the Plan will need to develop. This will assist in formulating the next steps towards the creation of a preferred future. The 'description of the present' provided in the report, and the process undertaken, is a modification of the 'environmental scanning' methodology.

Literature review: The understanding of health motivating the Ten Point Plan of Action

The World Health Organisation defines health as a state of complete, physical, mental and social well-being, which is created and lived by people in the setting of their everyday lives – where they learn, work, play and live (World Health Organisation 1986). Here, health is more than a matter of medical care. A complex set of interactive factors (which can be negative or positive) play a vital role in determining a person's health and well-being.

The weight of evidence indicates that social determinants of health (i) have a direct impact on the health of individuals and populations, (ii) are the best predictors of individual and population health, (iii) structure lifestyle choices and, (iv) interact with each other to produce health (Raphael 2003). Raphael argues that biomedical interventions and lifestyle choices are a small factor in whether individuals stay healthy or become ill (Raphael 2003). Best estimates are that only 10-15 per cent of increased longevity since 1900 is due to improved health care (Raphael 2003). The determinants of health and wellbeing are overwhelmingly social.

A World Health Organisation working group identified ten social determinants of health:

1. The social gradient
2. Stress
3. Early life
4. Social exclusion
5. Work
6. Unemployment
7. Social support
8. Addiction
9. Food
10. Transport (cited in Raphael 2003:36)

Raphael used more practical, tangible concepts to give further depth to the 'list'. He included:

- Social support networks
- Income and status
- Employment and working conditions
- Physical and social environments
- Healthy child development and services
- Personal practices and coping skills (Raphael 2003:36)

The social determinants of health have been the focus of a three-year investigation by an eminent group of policy makers, academics, former heads of state and former ministers of health. Together they comprise the World Health Organisation's Commission on the Social Determinants of Health. The focus is on improving quality of life and life chances and choices through broad-based interventions – such as urban development, the creation of supportive social and physical environments, early intervention and prevention, employment, housing and education – that have synergy with 'micro' level services, programs and projects delivered by, for example, the community and non-government sectors (WHO 2007).

Gender: A basic social determinant

Considerable research has demonstrated that women's life circumstances and lived experiences are different than men's (see, for example, Benoit and Shumka 2009). On average women earn less income than men and are more likely to be poor, especially during their senior years or if they are sole parents (Women's National Health Policy [WNHP] 2010). Women's burden of illness is often different to men's, and communities and families tend to place different social expectations on women (WNHP 2010). Women are more likely to experience violence (WNHP 2010). These and other factors, like cultural background, genetics and education, interact with gender and sex to affect health. This offers a broader view of the pathways to disease prevention and health promotion without losing sight of the fact that gender inequalities

are often based on sex-based differences. Sex and reproductive health should, of course, always remain a primary concern in health research, policy and practice.

Also, some women and girls are especially vulnerable to social disparities and inequities and deserve special consideration. Aboriginal and Torres Strait Islander women, for example, have poorer physical and mental health in almost every dimension than non-Aboriginal and Torres Strait Islander women (NWHP 2009). Aboriginal and Torres Strait Islander status can also impact on women's use of health services, particularly primary care (NWHP 2009). Aboriginal and Torres Strait Islander women have their own words, their own agendas, and their own solutions to bring forward on these issues and must be enabled and supported to do that. Women with disabilities, it should be noted, are one of the most excluded, neglected, isolated and vulnerable groups in Australian society. As a group, they experience many of the recognised markers of social exclusion – socio-economic disadvantage, social isolation, multiple forms of discrimination, poor access to services, poor housing and denial of opportunities to participate actively in society (Women With Disabilities Australia 2012).

Research and service provider wisdom understands that social determinants constrain and enable an individual's or populations' capacity for good health and wellbeing. At their best women's health centres provide services and programs that 'empower' individual women – often with complex needs – to 'move on' to be well functioning citizens and parents. It is also well understood that maintenance of improved health and wellbeing depends on the day-to-day presence of positive social determinants such as a violence-free household, secure and affordable housing, a safe and supportive community, good employment and working conditions, affordable goods and services, parenting supports and so forth. The WA Women's Ten Point Plan of Action requires a process whereby inroads can be made into the social determinants of health (by incorporating social determinants as a core aspect of organisational business, for example). Non-government women's health services do, of course, impact on social determinants in the process of practising a social model of health. However, if women's services are to meaningfully and purposefully participate in delivering outcomes in the area of social determinants (through, for example, leadership, collaboration, joint stakeholder projects and initiatives), then it is essential that they build their capacity to do so.

Examples of best practice

Models of best practice – applicable to the Western Australian context – are presented in chapter two of the report. The women's health sector in Canada and in Victoria (which follows the Canadian model) demonstrate the productiveness of government support for grassroots services that use research and evidence of best practice and community outreach and consultation to create programs and services that deliver better outcomes for women. The women's health sectors in Canada and Victoria built their capacity to provide innovative services and programs to women and their families, and to initiate research used to improve service provision and inform government policy making and implementation. They also built their capacity to provide leadership on issues affecting women and to initiate shared care and collaboration and to facilitate stakeholder participation on projects and initiatives promoting joined-up responses to ongoing and emerging issues affecting women.

It may be more accurate to say that the capacity of the women's sectors in Canada and Victoria were built in the process (the steps and actions) taken to promote better outcomes for women, their families and their communities. Canada and Victoria emphasise the productiveness of connective infrastructure, and the confluence of governance, research and practice. Furthermore, they have built their capacity by insisting on research-based best practice in service provision, professional development, strong networks, shared resources, knowledge and skills.

Community consultations

Extensive community consultations occurred throughout Western Australia to collect feedback on WA Women's Ten Point Plan of Action and to identify priority issues for women. The first phase of consultations consisted of intensive face-to-face interviews and teleconferences. During these consultations with key stakeholders (often more than an hour in duration) interviewers' questions followed a set format. However, questions were open enough for interviewees to discuss aspects of the Plan of specific pertinence to their organisation or the constituency of women they were representing. The themes that emerged from these consultations formed the basis (that is, the choice of speakers and topics of discussion) of community workshops conducted in Perth, Busselton and Karratha. Feedback on the Plan collected from Webinar discussions and an internet survey were collated together with the information gathered at the community forums. The findings from consultations are presented in chapter four. To present a comprehensive picture of the community environment data collected by the Western Australian Women's Advisory Council was (with kind permission) included in the report.

The issues to emerge from the consultations will be of no surprise to most readers and they are themes that emerged during the wide consultations for the 2010 National Women's Health Policy. What is significant for the WA Women's Ten Point Plan of Action is participants' frustration at the lack of a process to effectively intervene – in the long term – in ongoing and emerging issues affecting women, their families and communities. It is evident in the data that because women have lower average incomes than men, are more likely to head sole parent households, experience precarious labour-force attachment, have less superannuation and take on greater caring responsibilities, that they are more vulnerable to housing stress and rising rental costs. Interestingly, mental health was not identified as a priority issue per se, but *all* of the themes that emerged from the consultations were regarded as a priority primarily *because* of their impact on women's mental health. This seems to emphasise the necessity of a social determinants approach to health and wellbeing.

A comprehensive consultation with two women working in a remote aboriginal community in Western Australia was particularly compelling. Its urgency demanded the inclusion of an extended description of the issues of remoteness. In remote aboriginal communities, women's experiences of sexual abuse; domestic and family violence; poor housing; food insecurity and availability, and; limited medical attendance, are entitled to more impassioned and creative responses. There is also an onus on the women's health sector to assist the many remarkable women working in these communities with professional development services and enhanced networking and information and knowledge sharing.

Next steps: Building the capacity to implement WA Women's Ten Point Plan of Action

Recommendations for possible 'next steps' in the process of building the capacity of the non-government women's sector to develop effective collaborative practice to intervene in the social determinants affecting women's health and wellbeing include:

- The non-government women's sector to provide a map of existing 'joined-up' approaches and collaborative efforts aimed at improving women's health and wellbeing into the future (that is, beyond client/service interaction).
- The non-government women's sector to initiate intensive networking, dissemination of information and professional development towards representation in government forums as a single voice.
- The non-government women's sector to forge links with relevant sectors and other community service bodies to increase the overall understanding of, and response to, women's complex contextual issues and impediments to good health and wellbeing.
- The non-government women's sector to play a leadership role and initiate action on the social determinants of women's health and wellbeing by, for example, facilitating inter-agency and cross-sectoral projects and initiatives to address social determinants.
- Non-government women's health services to incorporate social determinants into written organisational/service documents.
- The non-government women's sector to cultivate strategic partnerships to co-ordinate a state-wide approach to women's issues.

A plan of action to address the priority issues affecting women's health and wellbeing will require a commitment from the State Government to:

- Actively support the Development of cross-sectoral coordination across WA to address the social determinants of women's health and wellbeing – housing being the first priority.
- Actively support the efforts of the non-government women's sector to evolve a coordinated **model-of-action** to jointly assess, plan for and accommodate the diverse housing needs of women.
- Collaborate with the non-government women's sector to develop a sustainable model for WA of ongoing coordination/collaboration for implementation of the Ten Point Plan.

1. Introduction: The state of Western Australia

Western Australia's framework of support

In the State Government's *Delivering Community Services in Partnership Policy* it is stated that the not-for-profit sector plays an important role in the wellbeing of the state and drives social innovation. It goes on to say that the not-for-profit sector 'adds immeasurably to the quality of life and social fabric; and that the Government has an important role to play in supporting and building the capacity of the not-for-profit sector by facilitating and assisting the work they do (Department of Finance 2011).

The non-government women's health sector in Western Australia has a strong base in translating women's voices and experience into advocacy for a better health outcome for women and their families. The non-government women's health sector is resourceful, committed, enduring and capable of achieving significant change toward improving the health and wellbeing of women, and their families and communities. The Government appreciates the service provision value of women's health services and supports partnerships with the women's sector to achieve better health outcomes for Western Australian women. This partnership could be further enhanced and more fully realised in the interests of women, children and communities if the Government were to draw on the experience and expertise that already exists in the women's health sector to ensure that policies offer the best opportunities for health.

A gendered approach to health or health within a social context is endorsed by state government documents; and government policy frameworks and strategies acknowledge a range of social determinants. *The Draft Western Australian Women's Health Strategy 2013-2017*, for example, endorses the WA Women's Ten Point Plan of Action and has goals to achieve population health and overlaps with a woman-centred holistic approach. However, the social determinants approach to health and wellbeing focuses less on promoting healthy lifestyle choices and low-risk behaviours and more on tackling the risk factors such as housing security and affordability, or investing in the real health promoters such as early childhood development, income equity and social and environmental infrastructure.

WA Women's Ten Point Plan of Action is about achieving and sustaining good health and wellbeing for women and their families through shared objectives and accountability across all policies. Tackling social determinants, or promoting good health and wellbeing through investing in social determinants, should be a core part of the business of health.

Table I below presents a selection of national and State Government documents and bodies which are consistent with and could potentially assist the non-government women's health sector's efforts to make inroads into the social determinants of women's health and wellbeing. The strategic document recently prepared by the Western Australian Women's Council for Domestic and Family Violence has also been included in Table I below. Table I presents a policy and strategic infrastructure with the potential to assist with the development of the WA Women's Ten Point Plan of Action.

Table 1: An overview of the Western Australian framework of support

| Document/body | Description |
|---|---|
| <p>The Women's Advisory Council (WAC) (State Government)</p> | <p>The WAC advises the Minister of Women's Interests on matters pertaining to women's issues and interests, which are determined through community consultation.</p> |
| <p>WA Women's Report Card (Office of Women's Interests – State Government)</p> | <p>The Report Card provides key indicators on the status of women in areas such as public life and leadership, health, education and safety, policing, violence, crime and imprisonment. It is a tool for indicating where women are making progress and where policies and services can be improved and are in place to provide the support women need to ensure equitable social and economic outcomes.</p> |
| <p>COAG National Plan to Reduce Violence Against Women and their Children (2010-2022) (Federal and State Governments)</p> | <p>This is the first plan to co-ordinate action across jurisdictions. It is also the first to focus on working to increase gender equality to prevent violence from occurring in the first place. The Plan recognises Domestic Violence and sexual assault are gendered crimes, so strategies to address them must be gender specific and gender sensitive.</p> <p>The Plan states that more rigorous equality is necessary to prevent women from falling into poverty and to improve outcomes for the most vulnerable women and their families. Improving equality between men and women requires coordination across governments and sectors to support women's economic security, safety and status.</p> |
| <p>Western Australian Strategic Plan for Family and Domestic Violence (2009-2013) (State Government)</p> | <p>The Strategic Plan recognises that family and domestic violence is a complex problem requiring a multi-agency response across both State and Commonwealth Government departments and community sector organisations. It supports an integrated and holistic response underpinned by effective legislation.</p> |
| <p>The Women's Council for Domestic and Family Violence Services (WA) Strategic Plan 2012-2015 (non-government peak body)</p> | <p>Its objective is to facilitate and promote policy, legislative and programmatic responses relevant to women and children who have experienced domestic and family violence. The Strategic Plan supports a gendered analysis of all legislature, policy and program responses to DFV. The Strategic Plan makes specific reference to the WA Women's Ten Point Plan as an important initiative for Western Australian women.</p> |
| <p>Western Australian Draft Women's Health Strategy 2013-2017 (State Government)</p> | <p>This Strategy is a whole-of-health policy framework that aims to make changes for better health outcomes for women. The central approach of the Strategy is based on gender as a determinant of women's health. The Strategy supports the application of a gender analysis process to research and policy to highlight and promote the specific needs of women in service delivery. The focus is primarily WA's health policy framework and planning context. Importantly, the Strategy specifically endorses the WA Women's Ten Point Plan of Action.</p> |

| Document/body | Description |
|--|---|
| <p><i>National Women's Health Policy 2010 (adopted by COAG)</i></p> | <p>The first priority set forward in the policy is a focus on prevention and targeting specific health conditions that can have the greatest impact over the next twenty years.</p> <p>The second priority is addressing the inequalities in the social determinants,</p> |
| <p><i>National Aboriginal and Torres Strait Islander Women's Health Strategy 2010 (Federal Government)</i></p> | <p>The Strategy endorses a social determinants perspective; recognising that the social determinants of health intersect (particularly gender, culture and socio-economic conditions). Special mention is made of minority group status and gender as major social determinants of women's health and wellbeing.</p> |
| <p><i>Gender Equality for Women Program (FaHCSIA) 2011 (Federal Government)</i></p> | <p>This Program aims to improve gender equality through co-ordinated whole-of government advice and support for women's economic security, safety and leadership. It aims to implement strategies in priority areas to achieve gender equality. The priority areas include: reducing violence against women, demonstrating Australian government leadership on gender equality, increasing opportunities for women to contribute to Australian Government decisions, increasing opportunities for women to undertake valued leadership roles and creating business and workplace cultures that deliver better economic choices and outcomes for women.</p> |
| <p><i>Women's Interest Strategic Directions 2011-2015 (State Government)</i></p> | <p>An understanding of social determinants is embedded in this document. There is a recognition, for example, that issues such as violence and sexual assault/harassment apply to girls and women in a specific way; and that there are issues specific to women such as the impact of unpaid caring, interrupted workforce participation and casual and part-time employment on superannuation savings and the gender pay gap.</p> |
| <p><i>National Women's Health Alliances (announced 2010 - Federal Government)</i></p> | <p>Six national women's alliances are each receiving \$200 000 per year for three years. The objective is to ensure that the voices of as many women as possible are heard, especially those who in the past found it difficult to engage in advocacy and decision-making.</p> <p>The alliances comprise of three issues-based groups:</p> <ul style="list-style-type: none"> • Economic Security 4 Women • Equality Rights Alliance • Australian Women Against Violence Alliance <p>And three sector-based groups:</p> <ul style="list-style-type: none"> • National Regional Women's Coalition • National Aboriginal and Torres Strait Islander Women's Alliance • Australian Migrant and Refugee Women's Alliance <p>The alliances bring together women's organisations and individuals from across Australia to share information, identify issues that affect them identify solutions and engage actively with the Australian Government on policy issues.</p> |

| Document/body | Description |
|--|---|
| <p><i>Women’s Health Policy and Projects Unit (WHPPU) (Department of Health - State Government)</i></p> | <p>WHPPA has a whole-of-health mandate to promote excellence in health care for women, children and their communities. It endorses the social model of health and focuses on the following areas:</p> <ul style="list-style-type: none"> • Women’s health centres • Regional sexual assault services • Female Genital Mutilation and African Women’s Wellness • Family and Domestic Violence |
| <p><i>Delivering Community Services in Partnership Policy (State Government)</i></p> | <p>The policy promotes a more collaborative approach between not-for-profits and Government/corporate/clients for the achievement of positive social outcomes. The policy states that the Government’s role is to support and build the capacity of non-for-profit organisations; which it recognises are the experts in service provision – particularly to vulnerable and marginalised groups.</p> |
| <p><i>United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) Recommendations</i></p> | <p>It is clear from the Recommendations that elimination of discrimination does not only mean removing the barriers to participation or including women’s voices, it means the adoption of positive measures that change how things are done.</p> |
| <p><i>Social Inclusion Policy 2009 and National Statement: A Stronger, Fairer Australia</i> <i>(Federal Government)</i></p> | <p>A Social Inclusion Board, supported by the Social Inclusion Unit in the Department of the Prime Minister and Cabinet has been established to ensure that ‘all Australians ... [are] able to play a full role in Australian life, in economic, social, psychological and political terms’ (Australian Government 2009). The policy establishes a commitment to building joined-up services, whole-of-government solutions, stakeholder partnerships and community capacity; evidence based practice; early intervention and prevention.</p> |
| <p><i>Australian Women’s Health Network (AWHN) – non-government</i></p> | <p>AWHN plays a central role in helping women’s health services and groups to communicate across the country, share information and resources, promote women’s involvement in issues and policies affecting health, act as a ‘watchdog’ on emerging issues that impact on women’s health and to keep abreast of current discussions and debates applicable to women’s health and wellbeing.</p> |
| <p><i>The Social Determinants of Health Alliance 2013 (officially launched February 2013) – non-government</i></p> | <p>Founding members include: Catholic Health Australia; St Vincent’s Health Australia; St Vincent de Paul Society; the Australian Council of Social Services (ACOSS); the Heart Foundation; the Australian Nursing Federation; Indigenous Allied Health Australia; the Doctors Reform Society of Australia and; the Public Health Association of Australia.</p> <p>The aim of the newly formed alliance is to work with state, territory and federal government to reduce health inequities in Australia.</p> |

The principles and objectives underpinning the WA Women's Ten Point Plan of Action also have synergy with other State Government (and COAG) objectives – such as, social inclusion and social innovation and early childhood intervention. Also, COAG initiatives such as the *National Framework for Protecting Australia's Children* are compatible with the WA Women's Ten Point Plan of Action. The Framework moves on from seeing 'protecting children' as merely a response to abuse and neglect to one of promoting the safety and wellbeing of children. Non-government women's health services (particularly the ones that are actively inclusive of children, young people and families) are part of the objective of enhancing the variety of systems that can be used to protect children. Leading practitioners in Australia and elsewhere have suggested that applying a public health model to care and protection will deliver better outcomes for children, young people and their families. It is stated in the document thus: 'Just as a health system is more than just hospitals, so a system for the protection of children is more than a statutory child protection service.' (COAG 2009:3). Early intervention strategies focused on families, communities and other social determinants are the focus of prevention strategies.

Government actions do not necessarily adhere to the commitments articulated in their documents. For example, no action has ever been taken to build in health impact assessments that would evaluate policies or programs as possible causes of inequities in women's health. Importantly, WA does not have a women's policy, and no resource centre or clearinghouse (with sex disaggregated data and evidence of best practice), which services, universities and governments can readily access. There is no gender impact statement – where the impact of all policies and programs on women are considered at every stage of the policy or program cycle to determine whether they promote, for example, the social and economic inclusion of women. One of the key policy messages to come out of the OECD was the need to increase both the quantity and quality of data by gender and improve the evaluation of public policy (OECD 2012: 19).

The *Gender Equality Blueprint* states that the non-government women's services are not adequately funded to provide policy advice to government (Australian Human Rights Commission 2010). It recommends resourcing women's grassroots organisations and representatives to participate fully in local, national, regional and international policy and decision-making processes; and be included in policy development and meaningful and ongoing consultation.

In a submission to the National Women's Health Policy, The Royal Australian and New Zealand College of Psychiatrists (RANZCP) states:

Providing well integrated services to a population with widely differing and complex needs is inherently difficult and resource intensive. However, the alternative is likely to be a set of interventions that focus on symptomatic rather than causal factors, perpetuates service gaps, cost shifting pressures and ineffective commitment of resources (RANZCP 2012:10).

Joyce and Bambra argue that policy makers should manage the complex nature of health inequalities by developing up-stream macro-strategies alongside more targeted interventions (Joyce and Bambra 2010). As Whitehead observes, individually focused interventions are much more likely to be effective when implemented in conjunction with other types of intervention like programs to stimulate community interaction and cohesion and broader schemes aimed at enhancing working and living conditions (Whitehead 2007). Proportionate interventions avoid inequity in access and take-up of these resources. The non-government women's health sector is well-placed to further participate in delivering better outcomes for women and their families by building its capacity to facilitate partnerships and joined up approaches or linkages to address the socially determined barriers to good health and mental health. It is reasonable to expect macro-level activity to be informed by the 'micro' and support evidence based efforts to generate better outcomes for women in the areas that are impacting on their health and mental health and putting their children and families 'at risk' of poor outcomes in the areas of health and mental health, also.

2. Literature Review

Research methods

The research methodology incorporated the following elements:

- Desktop research
- Electronic database searches
- Literature review of national and international journal articles, reports and writings on the social determinants of health
- Review of 'grey literature' and policy documents, strategies and guidelines

Current international and national trends: The social determinants of health

The World Health Organisation defines health as: 'a state of complete physical, mental and social wellbeing and not merely the absence of disease, injury or infirmity' (cited in SACOSS 2008: 2). The term 'wellbeing' encompasses much more of the human experience and describes our ability to respond to or take control over everyday challenges and changes (SACOSS 2008:2). In Western society the social gradient is particularly significant in determining health and wellbeing. Social determinants, such as access to resources, in turn determine the extent to which one can or cannot avoid a range of risks that epidemiologists link to increased morbidity and premature mortality, and the general inability for a person to attain their health potential. According to Rachlis, a 'particular population's health status is as unique to that society as fingerprints are to an individual' (Rachlis 2004:304). Multiple factors – social, structural, genetic, biological, and environmental – that operate outside of individual control and serve as the basis upon which differentiations within a population can be found (Benoit and Shumkn 2009: 2).

To acknowledge and investigate the influence social and environmental factors have on the health of individuals and groups is not a recent phenomenon. Advances in medical treatments and in the human lifespan over the last 150 years have been greatly influenced by improved living and working conditions in the Western world. Recently, however, momentum has been building around the concept of the social determinants of health. *The Social Determinants of Health – The Solid Facts* was first published by the World Health Organisation (WHO) in 1998. The goal was to promote awareness, informed debate and action on the social determinants of health.

In 2006, the World Health Organisation charged commissioners with developing understandings of the social determinants of health and determining how those understandings might be applied in practical actions to improve population-wide health equality and equity. By 2008, scientific understanding of the association between social determinants and health had progressed, and important examples of good practice had emerged (Irwin et al. 2006:751). The seminal publication that emerged from the research has made a compelling argument for the inclusion of population-wide health matters in all government policies that influence the lives of people, including housing, education, law and justice, and social and environmental infrastructure with

the report describing how gaps in health outcomes are indicators of policy failure (McQueen et al 2012).

The commission's key findings and final overarching recommendations were categorised into the four distinct but interlocking areas of:

1. Improving daily living conditions.
2. Addressing inequities in the way in which society is structured and organised.
3. Addressing Health in All Policies.
4. Measuring and understanding the problem and assessing the results of action. (WHO 2008).

Significant, was the world conference on the social determinants of health in Rio de Janeiro on 19-21 October, 2011. It was organised by the WHO and its focus was on turning policy into practice with regard to the social determinants of health. The constituent parts of the social determinants approach that it recommended be adopted were:

1. Governance to implement action on the social determinants of health to make inroads into health inequities.
2. Promotion of participation and community leadership for action on social determinants.
3. Advancing the role of the health sector, including public health programs, in reducing health inequities.
4. Global action on social determinants, which aligns priorities and stakeholders.
5. Monitor progress (with measurement and analysis) to inform policies and build accountability on social determinants. (See McQueen 2012).

Up until Australia's domestic response to the World Health Organisation's Commission on Social Determinants of Health report 'Closing the Gap within a Generation' it is difficult to identify any specific government response to the relevant WHO reports. Notwithstanding, the 1999 Department of Health and Ageing commissioned study on the social determinants of health titled *Socio-economic determinants of health: towards a national research program and a policy and intervention agenda* (Turrell et al 1999). The report aimed to: review Australian research pertaining to health inequalities; research capacity and suggested policies and interventions; and to make recommendations for a research program and intervention agenda. More recently, reference was made to the social determinants of health and inter-sectoral action in *Taking Preventative Action – A Response to Australia: the Healthiest Country by 2020 The Report of the National Preventative Health Taskforce* (The Department of Health and Ageing 2010).

The language of social determinants certainly has currency at both a national and a state level; however, 'it is evident that there is not a policy understanding of the approach to health equity through the social determinants of health. Catholic Health Australia (CHA) argues that two key factors are missing from the Australian landscape: coordination and accountability' (CHA 2012: 4). With the recent domestic response to WHO's *Closing the Gap in a Generation* there may be some movement towards developing a national approach to action on the social determinants of health (as there has been in South Australia, Tasmania and, at least up until the recent election, in Queensland).

There is evidence that at both a national and a state level Australia is taking action on the social determinants of health but it is fragmented and uncoordinated. For example, in the *Discussion Paper for the Development of a National Aboriginal Health Plan*, Social determinants of health are a key consideration and opportunity to improve health and well-being (Department of Health and Ageing 2012). National and state governments and territories are increasingly embracing the concept of social determinants and do undertake initiatives that address different aspects of social determinants of health. *The Fourth National Mental Health Plan: An agenda for collaborative government action on mental health 2009-2014* acknowledges that many of the determinants of good mental health and of mental illness are influenced by biological, social psychological, environmental and economic factors; and that mental health is not just a health sector issue. A suite of cross-sectoral indicators will measure how progress towards the implementation of the Plan has changed (or not) the lived experience of people with a mental illness. However, generally, there is not a systematic approach that embeds, monitors and evaluates progress on the social determinants of health and wellbeing.

In May 2012, Catholic Health Australia commissioned the National Centre for Social and Economic Modelling (NATSEM) to write a report considering the costs of inaction on the social determinants of health (NATSEM 2012). The report showed that a collection of societal factors – the different access to household goods and services, to healthcare, schools and higher education, conditions of work and leisure, housing and community resources – will play out over an individual's lifetime and will be expressed through their health and health behaviours (NATSEM 2012). The NATSEM report estimates the enormous savings that could be made with a new approach to health policy that does not just fall within the ambit of the health system and where health and wellbeing are not just the responsibility of the formal health system (NATSEM 2012).

The NATSEM study goes on to argue that poor health outcomes continue (at a massive cost) because the social determinants of health are not being addressed and the World Health Organisation's recommendations on the social determinants of health are being ignored. The WHO Commission gives greatest emphasis to policies that address 'upstream' structural and

infrastructural determinants of health, and policies that are good for health, rather than 'downstream' action more focused on individual risk factors or the performance indicators on narrow health-care policy. This is because the evidence strongly suggests that health inequities are not caused by lifestyle choices or risky behaviours, but by deliberate public policy choices and systems that, with intentional action, and alternative societal arrangement or policy decisions, might be avoided, diminished or ameliorated. Catholic Health Australia argues that the fact of group health differences resulting from unequal social positions caused by considered policy decisions and societal arrangements taken up and implemented by governments has not been acknowledged sufficiently in Australian health policy (CHA 2012:8).

Popay, Whitehead and Hunter talk about 'lifestyle drift' and silo-based practice which is 'the tendency for policy to start off recognising the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual, lifestyle factors' (CHA 2012: 26). Consequently, populations will drift towards, and place considerable pressure on, secondary and tertiary services (CHA 2012:26). Furthermore, a silo-based approach to considering the impact of social determinants of health means accountability for it can get lost and in the end there are no accountability mechanisms for action (CHA 2012: 27). According to Catholic Health Australia, the maintenance and promotion of a population's health is only partly achieved by public investment in health services such as hospitals, physicians, and advanced medical technology. More fundamental in the long run would be to modify social determinants in the interests of better individual and population health and wellbeing (CHA 2012). This would require the health sector to positively engage with other sectors to ensure sustained action on the social determinants of health. WHO refers to this as a 'Health in All Policies' (HiAP) approach (McQueen et al 2012).

In the report from the international meeting on Health in All Policies, Adelaide, 2010, there emerged a commitment to moving towards shared governance for health and wellbeing (The Adelaide Statement 2010). HiAP starts from the recognition that the determinants of health lay in the policy domains of all sectors of government. South Australia adopted a Health in All Policies (HiAP) approach to improving health and reducing inequities; whereby government is central to the process of improving health and reducing inequities (The Adelaide Statement 2010). Tasmania, building on the experiences of South Australia, is also moving toward adopting a HiAP approach (CHA 2012:11).

Gender: a basic social determinant of health

Social determinants provide the context for understanding population health and women's health in particular. A woman's social position is based upon societal features such as gender. As a health determinant, sex can influence how females and male bodies 'respond differently to alcohol, drugs, and therapeutics due to the differences in bodily composition and metabolism, as well as differences in hormones' (Benoit 2009: 6). However, patterns of group differences in health result more from just biology (or lifestyle choices). Group differences in health develop in great part from the acceptance of social inequalities in a system that produces unequal social positions which in turn determine an inequitable distribution of resources (Whitehead and Dahlgren 2006). With issues such as domestic violence and sexual assault, gender is a basic social determinant. And public policies, such as income and housing, interact with gender to influence the social determinants of women's health. Women, due to their generally lower incomes (relative to men), and care-giving responsibilities within their families, are especially susceptible to adverse public policy decisions (see, for example, Bryant 2009). Employment equity, publically funded parental leave, the organisation of child and elder care, all have a significant influence on reducing inequities between the genders (see, for example, Benoit et al 2005; Johnson 2007).

Gender differentiation and subsequent health inequalities between men and women are constituted within a socio-economic-political context that is not static but varies historically and cross-culturally. Gender is an 'upstream' factor that influences whether people have a chance to be healthy and stay healthy (Bryant 2009:2). Due to women's specific experiences of social determinants it is necessary to incorporate a gendered approach to health promotion work that focuses on women. Intervention to reduce inequality and improve health outcomes will be more effective and equitable if gender is recognised as a key social determinant.

Two best practice approaches to the social determinants of women's health

In Western Australia, the non-government women's health sector already contributes to addressing the social determinants of health and is often more innovative and responsive than government programs can be. However, currently the effort is not coordinated or directly aimed at addressing the social determinants of health (CHA 2012: 13). Catholic Health Australia argues that locally based entities (networks, centres and so forth) can advocate for and support policies, strategies, programs and action plans that address social determinants of health for their constituencies or within their own catchment areas (CHA 2012:13). The non-government women's health sector could forge links with service providers and advocacy groups who share

their philosophy of empowerment. And also establish a solid evidence base for their work with particularly vulnerable and hard to reach women that will inform their advocacy role.

The women's health movements in Canada and Victoria are committed to using all of the knowledge at their disposal to ensure success and have built capacity through collaboration, shared resources and alliances that reliably lead to better outcomes for women and their families and communities. Like Canada, Victoria argued for a new approach integrating women's health policy with other areas of government policy in a co-ordinated way, embedding gender in the 'social determinants' approach to health policy and practice (Women's Health Victoria 2009).

Victorian approaches to women's health

Victorian women and Victorian women's health services have a notable history of successfully advocating for and working to improve, women's health outcomes. Upon the expiry of the four year Women's Health and Wellbeing Strategy launched in 2002, a group of women's health providers collaborated to write a new policy proposal: *Women's Health Matters: From policy to Practice – Setting the Agenda for Victorian Women's Health 2006-2010* that included a 10 Point Plan (Women's Health Victoria 2006). This was endorsed by almost 30 women's health and community groups. In 2011, Women's Health Victoria released a second 10 Point Plan for the period 2010-2014, which builds upon the 2006 document and suggests policy directions, including increased funding for women's services (Women's Health Victoria 2011).

The model of the Victorian Women's Health Program has enabled women's health services to share knowledge and capacity, to establish broad networks and to develop high levels of expertise in the area (Victorian Women's Health 2011: 4). Women's health services receive funding from the Victorian Government, but are largely independent, incorporated associations. They focus on improving the health of Victorian women by working within a health promotion framework and with sectors that impact on women's health and wellbeing. They also engage in mainstream sectors to create policy, programs and services that are responsive to the needs of women. Victorian women's health services have worked towards shared goals and priorities to achieve significant outcomes for women, their families and communities.

In addition to strategic health promotion and advocacy work to improve health outcomes for women, Women's Health Victoria encompasses women's health services and associations across Victoria and provides a number of direct services. The Table below provides an overview of the infrastructure that emerged in the process of building the capacity of the non-government women's health sector.

Table 2: An overview of the capacity of the Victorian non-government women’s health sector

| Service | Description |
|--|--|
| <i>Women’s Health Victoria</i> | <p>Women’s Health Victoria is a not-for-profit, state-wide women’s health promotion, information and advocacy service. The service works with health professionals and policy makers to influence and inform health policy and to improve service delivery for women. The work of the service is underpinned by a social model of health and commitment to reducing inequities in health which arise from social determinants. WHV works for women-centred approaches to policy, programs and services. It incorporates:</p> <p>The Clearinghouse A collection of current women’s health resources housed at WHV. The service identifies, collects and provides access to published women’s health information. The Clearinghouse supports the work of WHV and assists others to incorporate a gendered approach to health.</p> <p>The Index The Index is an online gateway to evidence-based health and wellbeing data on Victorian women. The data assist those working in policy development, planning, research and service provision to build a detailed picture of women’s lives. The data collected extend beyond traditional biomedical model of health, incorporating over 70 health and wellbeing indicators relevant to the social model of health.</p> |
| <i>Women’s Health Association of Victoria (WHAV)</i> | <p>WHAV is the peak body for women’s health services funded under the Victorian Women’s Health Program. There are nine regional and two state-wide member services. WHAV builds links and partnerships within the women’s sector. Its core functions are networking, information and knowledge sharing, policy development and advocacy. It provides opportunities for members to:</p> <ul style="list-style-type: none"> • Develop sectoral responses to issues arising from government and the external environment. • Initiate collaborative action on issues related to women’s health and wellbeing. • Encourage the health system to respond better to diverse women’s needs. • Promote the social model of health. |
| <i>Victorian Women’s Health Program</i> | <p>The objective of the Victorian Women’s Health Program is to improve the health and wellbeing of Victorian women (with an emphasis on the most at risk) through the dissemination of health information and research and through the provision of community and professional education. Twelve regional and metropolitan women’s health services – which work within a social context – are funded by the program. The program ensures a consistent approach to women’s health across the state, which includes the translation of knowledge into practice.</p> |
| <i>The Office of Women’s Policy</i> | <p>The Office of Women’s Policy provides policy advice to the Victorian Government. By working across government, the Office coordinates and monitors government policies and programs that impact on women and their families.</p> |

Through sustained collaborative effort the women's health sector in Victoria built its capacity to develop and implement a long-term plan of action and broad objectives independent of government. It was an effort to move beyond individual services undertaking advocacy and plan across population, policy and legislation; and to promote cross government action on women's health. It changed funding requirements to free up the capacity to work differently with its resources.

The infrastructure that the women's health sector created in Victoria enables a coordinated whole-of-government approach to issues such as the prevention of domestic violence as a women's health issue.. The Victorian Government gives effect to *The COAG National Plan to Reduce Violence Against Women and their Children (2010-2020)* through concerted leadership and collaborative effort. Responsibility for prevention and early intervention and response is spread across a range of portfolios. This co-ordinated, whole of government approach incorporates Ministers from across portfolios, state-wide and regional committees and action groups and community sector organisations. This demonstrates a concern for broader issues that influence health that moves beyond a focus of health-care and 'shop-front' service delivery.

According to Marilyn Beaumont (who played an important leadership role in building the capacity of the Victorian women's health sector), change and making governments responsive to women's perspectives and concerns, depends on having resources to undertake research, analysis, and advocacy both in and outside government (Beaumont 2008:4). The layers of what makes healthy public policy, she goes on to argue, includes having robust processes in place to listen to diverse groups of women in developing women-responsive service models, and providing the resources needed to take concerted action over a long period of time to achieve change. In Victoria, the women's sector has had considerable success in building a positive partnership with key government stakeholders and provided leadership in cross-sector approaches to issues such as domestic and family violence.

Canadian approaches to women's health

The women's health movement in Canada developed both parallel to and as part of the women's movement as a whole (Morrow et al. 2007). One of the key defining features of the women's health movement in Canada is that

women's health is about much more than particular reproductive organs and secondary sex characteristics ... It is defined by, and shaped in, social, psychological and economic environments and relationships ... This means that health is a social issue and a social contract rather than simply a medical and technical problem to be addressed by experts (Armstrong 1998:247).

The Canadian women's health movement established that health had to be understood holistically and that addressing the social determinants of health, such as poverty, racism,

experiences of violence, and other forms of social inequality was critical (Morrow et al. 2007). Thus women's disproportionate poverty and experiences of violence came to be regarded as serious health issues. Women lobbied for governments and health care professionals to address poverty so that women – including lone mothers, elderly lone women, Aboriginal women, and women with disabilities – could have their basic needs met for maintaining health and wellbeing. Thus issues such as violence were firmly established as a health issue.

In Canada, the importance of social and economic conditions such as education, housing, environment and gender on a person's health status is generally well recognised. This broadened approach to health reflects a profound change in thinking that can be credited, in part, to the women's health movement in Canada. Throughout the 1970s and 1980s, women in Canada organised many local, provincial, and national groups and organisations to fill critical gaps in health services for women or to lobby for services (Boscoe et al 2004).

The women's health movement formed partnerships with other groups who shared their issues:

- Consumer groups and self-help groups dealing with issues such as mental health;
- Anti-racism groups and those working on equity and access issues;
- Environmental groups;
- Disability rights activists;
- Medical reform groups; and
- The legal community (Boscoe et al 2004).

The endurance of the women's health movement in Canada is in large part due to this network that put gender up front and centre as a critical determinant of women's health (Morrow et al 2007). This network fought for, and finally got, greater participation of women in all levels of the health care system including policy making (Morrow 2007). Table 3 below sets out important components of the women's health sector in Canada, which accounts for its sustainability, comprehensiveness and impact on the social determinants affecting women's health and wellbeing.

Table 3: An overview of the capacity of the Canadian non-government women’s health sector

| Service | Description |
|---|--|
| <i>The Women’s Health Contribution Program</i> | <p>The Women’s Health Contribution Program supports community-academic partnerships in the dissemination of policy research and information for women’s health. The Program currently supports:</p> <ul style="list-style-type: none"> • Centres of Excellence for Women’s Health • Canadian Women’s Health Network • Working groups and other initiatives that address specific policy issues in women’s health. <p>The overall goal of the Program is to improve the overall health status of women in Canada by enhancing the health system’s understanding of, and responsiveness to, women’s health issues.</p> |
| <i>Centres of Excellence for Women’s Health</i> | <p>Health Canada’s Centres of Excellence for Women’s Health represent a unique multi-disciplinary partnership among academics, community-based organisations and policy-makers.</p> <p>The aim of the regionally based Centres of Excellence is to inform the policy process and generate knowledge about the determinants of women’s health, including gender and diversity.</p> <p>The Centres continuously ask (see, for example p. 17 in Waves):</p> <ul style="list-style-type: none"> • What program changes need to be made as a result of this research? • Who needs to do what differently now that we know what we know? • How should policy be different, based on the evidence? • What information is missing? • What does it all mean for the way that we conduct further research? • With whom do we need to share the findings of this research? <p>Research can reveal how to change practice and questions current practice when the evidence indicates it is in the interests of women’s health.</p> |
| <i>The Canadian Women’s Health Network (CWHN)</i> | <p>The Canadian Women’s Health Network (CWHN) has a co-ordinating committee that includes regional representatives and women committed to the interests of specific sectors – women with disabilities, immigrant women, women of colour, Aboriginal women, lesbian women, older women, and young women. CWHN facilitates national networking of women’s health organisations, to communicate the research findings of the Centres of Excellence and other initiatives, and act as a clearinghouse for women’s health information. The CHWN website is a major source of women’s health information in Canada and it manages the database of the Centres of Excellence.</p> |

| Service | Description |
|--|---|
| <p><i>Women’s Centres CONNECT!</i></p> | <p>In Nova Scotia, non-government women’s centres (which are not strictly health centres) collaborate to provide leadership in bringing agencies together (connecting them) to work on major community development initiatives such as affordable housing for women. They also participate in developing and strengthening community networks that support and strengthen communication and cooperation within the community service network, therefore improving services for women.</p> <p>By connecting services and agencies, the women’s sector ensures that initiatives and networks are working towards filling gaps in services (as they concern women in particular communities). Collaboration can take the form of: anti-poverty networks; employment equity committees; and interagency committees on family violence. Some examples of community initiatives are: Women and Non-Traditional Work, numerous housing and homelessness initiatives, a range of women’s health initiatives and community events. Government funds a part-time secretariat to co-ordinate activities around issues of concern.</p> |
| <p><i>Women’s Advisory Councils</i></p> | <p>Throughout Canada, advisory councils have been established under the Status of Women Act and the Advisory Council on the Status of Women Regulations.</p> <p>Advisory Councils educate the public and advise provincial governments on issues of interest and concern to women and to ensure that issues affecting women become part of the government plan.</p> <p>In the City of Toronto a Status of Women Committee has been dealing with ongoing issues concerning women in the City of Toronto. These issues range from access to childcare, recreation programs and services for diverse communities, health care services and equity at work. The City has been particularly concerned with preventing sexual harassment and violence against women and increasing community safety. Some of the issues the committee has been following include the handling of sexual assault and family violence investigations by the Toronto Police Service. The City’s budget process is also being monitored in order to identify any negative impacts on the delivery of programs and services for women and children (ref City of Toronto)</p> |
| <p><i>Institute of Gender and Health</i></p> | <p>IGH prioritises a lifespan approach to women’s health. Although IGH does not have an explicitly feminist agenda it has increased the capacity of researchers to investigate questions related to gender and health.</p> |

Three broad themes underpin the women's health sector in Canada: health status, health determinants and women-centred care. These themes are all pursued either through a population health or a health services and systems framework. The impact of socio-economic status, race, culture, age, sexual orientation, geography, ability and/or addiction on the health of women and girls has been the overarching concern in the work of the women's health sector. The ability or capacity of the sector to create innovative partnerships with a range of communities and sectors, across multiple issues affecting women's health and wellbeing, has been its key to success. Innovative partnerships with a range of communities and sectors produces research, new knowledge, policy advice, better practice guidelines, enhanced service delivery and ultimately better outcomes for women, families and communities.

Despite some serious cutbacks and setbacks, the women's health sector in Canada is a key player in women's health research and policy development throughout Canada and internationally. Significant, is the Women's health sectors' capacity to initiate inter-disciplinary research and action on social determinants affecting women's capacity for sustained, quality health and mental health and to use the findings to drive efforts to change policies and practices constraining women's ability to achieve and sustain good health and wellbeing.

3. The Project – Women's Health Matters: A 10 Point Plan of Action

WA Women's 10 Point Plan of Action

As early as 2004, women's health centres and other stakeholders have been conducting workshops aimed at improving the health status of women throughout WA. A Steering Group formed out of these workshops with a membership from a range of women's health and related services. After a comprehensive consultation process the need for a collaborative, co-ordinated and cross-sector approach to improving women's health and well-being was identified. Issues regarding enhancing communication as well as resource and information sharing across services to build capacity were also identified.

With funding from Lotterywest, Western Australia's sixteen women's health centres together with other interested women in the community and women working in government, put together *Women's Health Matters – a Ten Point Plan of Action*.

It is evident from the Victorian and Canadian experiences that the successful implementation of a process to facilitate the realisation of an action plan to improve women's long-term health outcomes requires the support of key stakeholders and collaboration across agencies and organisations providing services to, or advocating for, women.

The non-government women's health sector in Western Australia understands that the WA Women's Ten Point Plan of Action depends for its realisation on action on the social determinants of women's health and wellbeing. This is because the determinants of women's health and wellbeing include factors that lie outside of the health sector – such as the gender pay gap, access to affordable and appropriate housing, education, social and environmental infrastructure, transport and goods and services.

The 10 Point Plan of Action embeds gender in the social determinants of health and wellbeing and is consistent with the Victorian women's Health 10 Point Plan, which was influential in driving priority setting for women's health within government, and in developing a common set of agreed priorities across the women's health sector. The WA Women's Ten Point Plan is compatible with, and can assist in the development of, the following policy documents and strategic plans (for a full outline see Table 1):

- Policies/strategies
- National Aboriginal and Torres Strait Islander Women's Health Strategy 2010 (federal)
- National Women's Health Policy 2010 (adopted by the Council of Australian Governments)
- Gender Equality for Women Program 2011 (federal - FaHCSIA)
- Western Australian Strategic Plan for Domestic and Family Violence 2009-2013 (state)
- COAG National Plan to Reduce Violence Against Women and their Children 2011-2022

- Western Australian Draft Women's Health Strategy 2013-2017 (state)
- Equal Futures Partnership 2012 (federal)
- Women's Interests Strategic Directions (state)
- WA Women's Report Card 2012 (state)
- United Nations Convention on the all forms of Discrimination Against Women (CEDAW) - Recommendations
- National Framework for Protecting Australia's Children 2009 (state)
- Delivering Community Services in Partnership Policy (state)
- National Social Inclusion Strategy 2009 (federal)

A social determinants of health approach is essentially a holistic understanding of health that moves beyond the treatment of illness, and acknowledges the complex combination of factors that constrain and enable the capacity for quality health and wellbeing. In recognition of the social determinants of health, many women's health services already have multi-agency and multi-disciplinary care plans and teams engaged in joint service planning, provision and information sharing to facilitate effective referral pathways and continuity in care. To achieve real, long-term gains in health, this collaborative process needs to work towards a more integrated approach to the factors that influence health outcomes such as: early intervention and prevention, parenting supports, education, employment opportunities and conditions, housing, transport and community services.

The capacity of the WA non-government women's sector to lead the delivery of the Ten Point Plan of Action

The principles of the WA Women's Ten Point Plan of Action are embedded in the aims and objectives of the women's health centres in WA and reflected in service policy and operational objectives. The social model of health underpinning the service delivery of the women's health centres in Western Australia recognises that a sustained improvement in a woman's health and well being is context dependent. Collective service wisdom appreciates, and best practice evidence demonstrates that individual health and wellbeing is affected by social determinants such as insecure or unaffordable housing, domestic violence, geographical location, social exclusion, employment opportunities and so forth.

Women's issues are multi-faceted and require holistic, practical and sustained problem-solving support and services delivered by knowledgeable, skilled and competent staff. The services and programs offered by women's health centres enable women successfully to identify and address the complexity of issues and barriers they are experiencing, and to go forward in their lives. The centres provide a wide range of services to assist women build skills and use supports to achieve and maintain good health and wellbeing in their daily lives. This demonstrates a holistic

framework for the promotion and maintenance of good health within community settings, whilst responding to and meeting the changing and diverse needs of local communities and priority population groups. The service and program framework of women's health centres has three key components: Intervention, Prevention and Community Development. These three components are interdependent and contingent on a set of Core Services that focus on strengthening capacities at multiple levels: at the individual level, organisational level and broader community level.

Non-government women's health centres are a well respected cornerstone of the service network in their communities providing essential services for women that are not provided elsewhere and tailored for women who do not, for various reasons, access regular services. Programs and outreach activities are based on the identified needs of women within communities. Non-government women's health services are particularly good at providing for women (and families) by identifying women's, family and community needs, finding and reaching clients and for building capacity and ensuring service continuity which is flexible, informal and non-stigmatising. Clearly, the non-government women's health sector is an essential element in achieving good outcomes in the community.

According to White and Winkworth, siloed and single-disciplinary approaches fail to address multiple and interlinked issues faced by women and their families (White and Winkworth, 2012). Collaboration is seen as a way around the complexities and inefficiencies arising from the diversity of policy and practice across the various service sectors and organisations (White and Winkworth 2012). Collaboration between service providers and the delivery of 'joined-up' services are increasingly being seen as more successful at engaging with vulnerable women and their families and providing the multi-layered support that delivers better outcomes for women. Poor outcomes for women in terms of health, mental health, participation, substance- use and so on are due to deficits in several resource domains. Again, lack of resources (financial, physical, personal or social – that is, *external* factors) rather than inherent characteristics (*internal* factors) are largely responsible for poor health and mental health outcomes.

One of the strengths of non-government women's health centres is the breadth of their mandate and their multi-entry points. They are often seen by the formal health care system as part of the treatment plan. Other organisations and agencies see them as a critical adjunct to their own more specialised and narrower focus. The women's health centres play an essential role in their local service networks. A clear strength of the women's health centres is their unique focus on multiple entry points, working closely and cooperatively with other services to ensure women have access to services and programs they need, and providing an essential link in the service network through quality services and a high level of expertise. Therefore, this report encourages the Government to work with women's health centres to find creative ways to fully

account for and acknowledge the value of the investment that they have made and are making in the future of women and their families and communities. A key objective should be to support active engagement with government on policy issues as part of a better, more informed and representative dialogue between women and government. Canadian research demonstrates that collaboration across sectors and agencies generates better service delivery and improved health outcomes for women and their children and communities (Connect! 2003).

Considerable feedback on WA Women's Ten Point Plan of Action from key stakeholders and women and their representatives in the community was gathered and collated for the purposes of this report. Already comprehensive data was further enhanced by the inclusion of data collected in 2012 by the Women's Advisory Council (published here with kind permission). The following chapter presents the themes that emerged from wide consultations inclusive of: government and organisational representatives and key stakeholders and interested individuals from across the state – including remote Aboriginal communities. Participants in interviews, workshops, a survey and a webinar were encouraged to familiarise themselves with the WA Women's Ten Point Plan of Action to maximise their input.

The collection of feedback on the WA Women's Ten Point Plan of Action from key stakeholders and women in the community was an important aspect of this project due to the commitment of the non-government women's health sector to client participation in the development, planning and delivery of services.

4 Consultations and Data Analysis

This report on the WA Women's Ten Point Plan of Action had access to an extensive range of primary data¹ on women's health and wellbeing, namely:

- Workshops on the WA Women's Ten Point Plan of Action held in Perth, Busselton and Karratha between on November 2 and December 14, 2012
- Pre-workshop consultations which took place with representatives of approximately 13 community groups and key government agencies
- Webinar workshops on WA Women's Ten Point Plan of Action
- An online survey in response to the WA Women's Ten Point Plan of Action
- Data from consultations undertaken by the Women's Advisory Council (WA)

Overall, well over a hundred individuals and representatives of a diversity of women's and community services and the Government sector provided input into women's health and wellbeing in Western Australia.. The issues prioritised as serious determinants of women's health and wellbeing were:

- Mental health
- Housing
- Homelessness
- Domestic violence
- Low-income
- Economic independence
- Unpaid caring
- Access to essential goods and services
- Women raising grandchildren
- Women with disabilities
- Inclusive and innovative services
- Remote location

Participants articulated an understanding of these issues based on their own experiences and/or in their capacity as a professional in applicable areas. Almost without exception, workshop participants considered the above issues to be the key determinants of poor mental health outcomes for women. Housing stress – the lack of security, affordability and suitability – was identified as a huge barrier to women's ability to achieve and maintain health and wellbeing. Thus, it was suggested, better mental health outcomes will only be achieved through action across all sectors. Similarly the issues that emerged were generally identified as social inequities born of entrenched societal inequalities. Consequently, participants' main concern was the

¹ See Appendices 1, 2, 3 for full database

mechanisms available to intervene and take action on more than just a group or individual level and in way that will be sustainable into the future. Hence the support for a social determinants approach to problem solving.

Often, participants linked the emergence themes and suggested solutions to the WA Women's Ten Point Plan of Action, indicating for example:

- Housing will only be more available, affordable and appropriate for women if all government policies address the issue with key stakeholders.
- All of the issues affecting women require a more co-ordinated response due to the complex connections between factors such as mental health, local and family environment, access to services and so forth.
- It is important to bring Aboriginal and Torres Strait Islander women's voices to issues that they and their communities are facing; and also to build partnerships between the aboriginal and non-aboriginal women's sectors in Western Australia.
- The complexity born of the interaction of issues such as housing, mental illness, poor physical health, lack of superannuation, isolation, the cost of living and so on requires a comprehensive and integrated approach.
- The diversity of issues and significant gaps in service delivery suggest the need to build sector capacity through increased co-ordination between women's centres.
- The road to gender equality must include an assessment of the impact of current policies on women or the lack of an appropriate, targeted policy.
- The need to build the capacity of the women's sector to work together on issues such as domestic violence and collectively influence decision- making and policy.
- It is not easy to translate complex individual issues (the range of social determinants) into the broad conceptual framework that is the 10 Point Plan.
- Given the diversity and complexity of on-the-ground issues, it was suggested that the Plan be translated into more specific goals to be achieved.
- Strategic approaches such as linking in with the national women's alliances – coordinating strategies, sharing research resources, assist in building each others' capacity, building momentum around particular issues.
- Local projects and initiatives in the lead up to national and international events.
- Need an effective mechanism to highlight emerging issues in the women's and community sector and to advocate and lobby government and other relevant stakeholders on policy issues.
- An Action Plan would facilitate the process needed to be undertaken to 'de-silo' current models and funding development.

Overall, participants were despondent about the lack of creativity and innovation around addressing urgent issues affecting women and their children. There was a shared concern regarding the short-term impact of 'business as usual'. It was variously articulated amongst

participants that quality health and mental health outcomes for women and their children into the future will only emerge from positive social determinants. 'Government policies,' a participant argued, 'are playing an active part in shaping women's life chances and choices. Governments need to be accountable for what they do and what they fail to do'.

The qualitative data gathered from extensive consultations supports the evidence that gender is an important determinant of health and wellbeing. Therefore, women need healthcare, social support, programs, services and policies that are tailored to their specific needs and social position or roles. The data highlight the importance of responding to women's needs to improve their physical and mental health while addressing the social determinants that determine social position and the distribution of opportunities and important resources that are fundamental to quality health and wellbeing into the future. A key determinant of women's mental health is housing – the stress around it is exacerbated by other priority issues such as low-income and the cost of essential goods and services. It is stark, too, the evidence that women are particularly vulnerable to the crisis in the housing and rental market at exceedingly difficult, even harrowing times of their lives – fleeing domestic and family violence, after separation and divorce or acquiring a disability. Unfortunately, it is the children of these women who are also suffering from the lack of timely policy responses.

5 Concluding remarks

Building the capacity of WA's non-government women's health sector to promote action

There is growing acknowledgement around the world of the social determinants of health, which is reflected in the language currently being used in National and State policy documents, frameworks and strategies. Central to the social determinants approach is the axiom that the health status of a population is improved at least as much by addressing factors in the social environment which impinge on health (including mental health) as it is by investing in medical technology. According to MacDonald:

What we see and live through now is rooted in the past, in human actions. By the same token, these social determinants are amenable to change by us – they are a call to action in the present (MacDonald 2010:35).

In the vocabulary of another time this complexity was taken up by the Primary Health Care Conference of Alma Ata and its endorsement of 'inter-sectoral' collaboration with other sectors such as education and housing (WHO 1978).

When discussing the factors that affect health, it is necessary to recognise gender as a key social determinant. Although both women's and men's health is affected by social and economic factors the interaction of gender with other determinants of health creates different experiences of health and illness for women and men. A key finding of this report is that although medical advancement, quality health care and access to services are important to health, factors such as low-income and lack of control over one's life chances and choices are major determinants of health. To create models, programs, and methodologies that will improve health, the full spectrum of the determinants must be considered. With the acceptance that the social determinants of women's health and mental health are complex, and by definition multi-faceted in nature, policy responses should encompass both upstream (income distribution, improved living and working conditions and so forth) and appropriately or proportionately targeted downstream initiatives and interventions (Bambra et al. 2009). This necessitates a cross-sectoral response with action orchestrated at all levels and across all sectors. Ideally, this would involve partnerships and collaboration between the government and the non-government sectors and stakeholders applicable to each particular issue (or social determinant).

With appropriate support and resources, the non-government women's health sector has the capacity to facilitate a joined-up approach to the social determinants of women's health and wellbeing that promotes sustainable outcomes for women and benefits their children, families and communities. We know from the Marmot Report that good health and wellbeing requires a whole-of-government approach. The Health Department and health service providers cannot, for example, provide the education and training required to give women control over their lives (this being central to good health and good well-being). It is not purely about Government policy, although that is key, it is also about how agencies work together in partnership to deliver

the objectives necessary to the achievement of good health and wellbeing. The design and implementation of policy needs to recognise the importance of all policies to health. Thus the policies significantly affecting women's health and wellbeing, such as housing, income equity and education should be a priority as should the resources and effort invested in them. The link between policies and health and the ways to deliver these policies in order to achieve the maximum health benefit must be clearly established.

Putting women and housing on the agenda

Throughout consultations across Western Australia housing was identified as a priority issue for women; highlighting the centrality of affordable, appropriate and secure housing in enabling women and their families to attain and maintain good health and mental wellbeing. It is clear from the data that housing is a gender issue worthy of a place on the political agenda. The data presented in this report provide clear evidence of the need for a gender-based housing focus whereby the diverse housing needs of women are assessed, planned for and accommodated. The reality for many women and their families is that they will be less economically secure (due to the gender pay gap, responsibilities for caring for children, the elderly and family with disabilities, low income and less superannuation) across their lives and into old age if they do not have access to appropriate, secure and affordable housing and their housing needs are not met by the housing market or addressed in a systematic way.

The poor health and mental health outcomes for women experiencing (often acute) housing and rental stress is a compelling argument for a 'joined-up', cross-sectoral response to the housing needs of women and their families. This will require a comprehensive re-assessment of the housing circumstances of women and their families and a collaborative – government, industry, community – commitment to ensuring that housing is appropriate, affordable and secure. It is up to the women's sector, governments and the community generally to discuss the housing of women in WA and to determine solutions. The non-government women's health sector would like to play a leading role in this area and facilitate collaboration to build the capacity to determine principles that will inform actions into the future.

Recommendations

It is evident in the data that although many consultation participants did not speak explicitly about the social determinants of health, the conceptualisations of health that were being articulated were holistic, multi-faceted and complex. The cross-cutting issues to emerge from research and community consultations require alignments and assignments of responsibility between different government agencies, local governments and community sector organisations. Local collaboration, joining-up services and accountabilities have important policy implications. Sustained, co-ordinated attention to issues means breaking out of the 'silos' of sectoral service delivery. So far this type of collaboration has not been well resourced nor are there funding incentives. The State Government has created a better context for local collaborative effort, but

there needs to be better incentives and rewards for joined-up efforts and collaborative strategy processes and planning that involve multiple participant agencies working towards target goals through a number of specific projects or innovations that can be joined-up to wider priorities and actions.

Action on the social determinants affecting women's health and wellbeing needs to be sustained and mandated; and it needs to be built more effectively into departmental structures. Currently, the responsibility to join things up gets pushed down to frontline service delivery agents and caseworkers, who have to manage ensuing tensions through their daily practice. Social determinants data needs to go into the information mix, and it needs to be related more closely to government and community priorities (see Marmot and Wilkinson 1999). Currently, there are program evaluations and monitoring; however, the challenge is to contextualise it to wider social determinant factors.

This report recommends action is taken to build the capacity to develop the WA Women's Ten Point Plan of Action and to respond to the key priority issue identified as a serious barrier for women in their efforts to attain and maintain health and wellbeing: housing. Recommended next steps include:

- The non-government women's sector to provide a map of existing 'joined-up' approaches and collaborative efforts aimed at improving women's health and wellbeing into the future (that is, beyond client/service interaction).
- The non-government women's sector to initiate intensive networking, dissemination of information and professional development towards representation in government forums as a single voice.
- The non-government women's sector to forge links with relevant sectors and other community service bodies to increase the overall understanding of, and response to, the social determinants of women's health and wellbeing.
- The non-government women's sector to play a leadership role and initiate action on the social determinants of women's health and wellbeing by, for example, facilitating inter-agency and cross-sectoral projects and initiatives to address social determinants.
- Non-government women's health services to incorporate social determinants into written organisational/service documents.
- The non-government women's sector to cultivate strategic partnerships to co-ordinate a state-wide approach to women's issues.

A plan of action to address the priority issues affecting women's health and wellbeing will require a commitment from the State Government to:

- Actively support the development of cross-sectoral co-ordination across WA to address the social determinants of women's health and wellbeing – housing being the first priority.
- Actively support the efforts of the non-government women's sector to evolve a co-ordinated **model of action** to jointly assess, plan for and accommodate the diverse housing needs of women.

- Collaborate with the non-government women's health sector to develop a sustainable model for WA of ongoing co-ordination/collaboration for implementation of the WA Women's Ten Point Plan of Action.

Government has a core, ongoing role to sustainably provide resources to address social determinants of women's health and wellbeing otherwise local partnerships and collaboration can become just another element in a wider program of 'social inclusion' which ensures everyone's participation without ensuring the promotion of good health and wellbeing for women and their families.

Appendices

APPENDIX 1: PRE-WORKSHOP CONSULTATIONS

In the lead up to the workshops on the WA Women's Ten Point Plan of Action held in Perth, Busselton and Karratha between on November 2 and December 14, 2012, consultations took place with representatives of approximately 13 community groups and key government agencies. Data from these interviews were broken down to specific responses made by the participants around three of the areas probed (i) interviewees' overall reaction to the 10 Point Plan (a total of n=33 discrete comments was offered); (ii) current critical issues for women (n=40 discrete comments); (iii) considerations for the implementation of the Plan (n=61 comments).

The following analysis orders the responses from strongest to weakest themes along with several sample interviewee statements for each theme.

Reactions to the WA Women's Ten Point Plan of Action

Most of those interviewed were very positive about the directions of the WA Women's Ten Point Plan of Action with a small proportion of responses expressing some concern about its accessibility (mainly regarding its length and complex language).

A gendered approach

This was the strongest single theme emerging from responses to the WA Women's Ten Point Plan of Action, with almost half the comments underlining the importance of a gendered approach to women's health and wellbeing. Those interviewed expressed concern that women's issues are not being addressed, especially at a policy level. Comments included the following:

There is greater clarity around the gendered determinants and experiences of health issues such as chronic illness and mental illness. People understand the gendered nature of domestic violence and reproductive health, but are often not sure why other health issues require a gendered focus

People will ask why there is the need for a specifically women's health plan when they are afforded all the same opportunities as men; through education they can access better paying jobs etc. The Plan seems to be saying, and I agree, that it is harder for women to make full use of these opportunities.

It is good to see a gendered approach to women's health services – quite a gap in Western Australia.

Women's issues are simply not being addressed in WA. In policy there is no serious attempt to address issues as they are experienced by women. The feminist activism that was present in the public service is largely absent and fragmented. There is no real organised attempt by women to infiltrate the policy making process. A gendered analysis is not being applied to any policy area.

The reality is, how women can operate is constrained, but people don't readily see this because there is equal opportunity.

Gender equality has not yet been achieved, but we seem now to be in maintenance mode. This could be to do with a loss of a sense of urgency.

Supportive of the Plan

Just over one in four responses to the WA Women's Ten Point Plan of Action simply stated their support for the document and its relevance to other State-level and National health directions, without isolating any specific aspects, for example:

The Plan is comprehensive and ambitious and highlights that there is significant scope for continuing improvement in women's health outcome.

The Plan is very broad, but encompasses some of the key issues women have to deal with./It is good that the Western Australian strategy endorses the 10 Point Plan (it shows that there is support for it and a sense that there is a need for it).

The ten points are agreed priorities across the community sector.

The Plan is compatible with national and state policies.

Social determinants

Support was also evident for the broad social determinants approach to addressing women's health and wellbeing with comments such as:

There is no doubt that social determinants are fundamental to health outcomes.

Women using health services present with mental health and health issues that are socially determined and specific to their gender roles, or attributable to their social and cultural experiences of being a woman

It is important to look at general issues around housing, unemployment ... social-economic drivers of disadvantage

The Plan is developed by the health sector, but all the issues - homelessness, income, family breakdown, family court matters all contribute to one's health and wellbeing.

Presentation

In these interviews, and again at the public forums, attention was drawn by some participants to the presentation of the document and the wording of the ten points in WA Women's Ten Point Plan of Action, for example:

Language and structure could be more consistent, coherent and less repetitive.

We could begin to 'normalise' the social determinants approach by using simpler language.

Language and structure could be more consistent, coherent and less repetitive.

Simplification is necessary for consumer accessibility.

Critical issues impacting on women's health and wellbeing

Housing/homelessness

Of the critical issues raised by those interviewed, by far the single most common theme was around housing and homelessness with over a third of the comments noting the vulnerability of certain groups of women relating to housing affordability and availability. One interviewee described it as a "wicked issue" for many women over 55 and in poverty. Other comments included:

Affordable, appropriate and secure housing is an urgent issue. The cost of housing severely impacts on household budgets. Housing issues (the lack of it and its sub-standard quality) use up most of [the agency's] resources. Refugee women – often widows with children or the primary carers of children with disabilities – urgently require affordable and appropriate housing.

Housing - efforts to address housing are quite fragmented. Women need to work together to share information and identify issues and solutions so that they can have a voice on policy.

At least 80% of our clients have unsuitable and overcrowded housing, so this takes up a lot of time and resources.

Current programs address housing industry rather than user needs.

Housing – there are huge difficulties in changing policy./In Western Australia not a lot of work is being done on women and homelessness. There are demographic changes of people turning up to [agency named] homeless day centre and financial counselling – lots of mothers with children.

Services can only assist their clients with the application process that will result in their names being added to a very long housing waiting list.

Specific health issues

Some comments were directed at specific health issues mainly sexual and reproductive health and chronic diseases, with both younger and older women being singled out, for example:

The stuff that's killing women are chronic diseases, e.g., what is causing death amongst women – breast cancer, heart disease – how it impacts on women (different from men), increasing obesity. All these are impacting on women in their older years.

The plan seems to suggest that women have moved on from merely sexual and reproductive health issues. However, better health and wellbeing outcomes for refugee women primarily rest on these two issues.

Barriers to women having a healthy pregnancy and capacity to parent are the critical issues. Clinical care takes up the least amount of time. Clients themselves insist that we focus on the barriers to a healthy pregnancy as a first priority.

Indigenous focus

Specific mention of Aboriginal and Torres Strait Islander health featured in many of the comments on current critical health issues, alongside the need to attend to health issues in culturally relevant ways for example:

In Aboriginal health, particularly mental health social and emotional wellbeing, forms part of the holistic view of health; recognising the importance of connection to land, culture, spirituality, ancestry, family and community and how these affect the individual.

The fallout of colonisation is more of an issue and its impact on how men and women live together in the community and their perceptions of themselves and their roles.

Culturally appropriate intervention, using the social and emotional wellbeing framework, is developing as a useful, 'bottom up' approach.

Essential goods and services

Along with the heavy focus on housing and homelessness, participants identified problems relating to access to essential goods and services, for example:

Research shows the day-to-day impact of the cost of housing on food budgets. The cost of living affects thousands of people across WA but you wouldn't address it the same way because how it plays out is not the same in different locations and for different groups of people.

Women and violence

Domestic and family violence continues to be a huge concern. Interviewees expressed a deep concern regarding the intractability of the issue given the severity of its impact on women and children in the community. Many comments emphasised the need for cultural change and the need for a population-based approach to prevention:

Much has been done in the DV [domestic violence] area, but not enough on why men are violent – until that's addressed; we are not going to fix the ongoing issue. Woman may leave the relationship, but man will still go on and violate someone else.

Choice and independence

A significant proportion of the comments related to the need for women to be more independent; something that was seen to have “*a lot to do with how we raise girls*”.

Women's capacity for independence and choice. If a woman's marriage breaks down it is almost impossible to find appropriate alternative accommodation. Girls are still not raised to think that they must train for an occupation that will sustain them financially and be satisfying.

Implementation of the Ten Point Plan

Unsurprisingly, throughout the conversations leading up to the November 27 workshop, many ideas were raised regarding the implementation of the WA Women's Ten Point Plan of Action, notably about its steering, sponsorship and how women's voices could be heard.

Peak group idea

The idea of something akin to a 'peak' group to take overall responsibility for the implementation of the WA Women's Ten Point Plan of Action emerged in almost a third of the comments. While most were supportive of the idea of a 'peak', some were qualified.

A peak women's body is an exciting prospect because women and their representatives could organise, collaborate and advocate around issues and educate.

A peak women's body (a united but diverse voice) that enables, encourages and supports the development of an Aboriginal perspective – which is not merely subsumed by or added on to a gender perspective – would be a great opportunity for Aboriginal women to envisage what sustainable change might look like and how it might be achieved.

A 'clearing house' (of research, best practice literature and sex disaggregated data) is an important component of an effective peak. I've become a bit cynical about Peak bodies in their role to solve social problems – but I can't think of an alternative. If we were to go down the path of a Peak body it would have to be really quite unique rather than a new layer on the work of other Peaks.

A Peak would have to be funded from the government public sector – but significantly well funded. It would need some unique, strong people. Without a loud public voice it would be difficult to make any significant gains.

A holistic, collaborative approach

Another strong message from these interviews was for a more collaborative approach that encompassed community organisations, Government and non-Government working together to resolve the range of underpinning social determinants impacting on women's health and wellbeing.

Holistic, locally based projects where communities are resourced to address their issues are usually the most successful. Each individual group needs their own voice.

Holistic, cross sector perspective is how to look at services.

When women effectively create community interest and support on an issue they will usually have an impact on policy.

Greater collaboration on women's issues would build the capacity of existing women's services and make them more sustainable.

If we want better health outcomes for women we have got to include men. This applies across the board – within the government and non-government sectors.

Grounded in the community

Comments also underlined the importance of having channels for women's voices to be heard and for policy directions to be grounded.

When women effectively create community interest and support on an issue they will usually have an impact on policy.

Ongoing community forums and policy clinics as well as a sustainable non-for-profit sector already gives community representatives opportunities to engage in policy planning.

The not-for-profit sector is best placed to foster broader engagement in policy and so should be involved in policy making upfront. Funding the non-for-profit sector builds the capacity to do that; the capacity to have the necessary discussions.

Funding/resourcing

A proportion on the interview comments on implementation directions was directed at funding and resourcing issues, with concerns expressed about disparity of resourcing of the health centres and agencies competing for limited funding. Comments also included:

There are stresses around reporting frameworks and resources for NGOs.

As long as this is not based on competitive funding the community could work together beautifully on something like this. When you take the competitive funding out of it the community sector works really well together.

If you pay peanuts you'll get monkeys. Still, it's a serious attempt to get women's voices heard at the decision-making level.

Top-down support

As well as the strong push for community action and involvement in the implementation of the WA Women's Ten Point Plan of Action, it was also recognised that high-level State and National sponsorship and push was needed, for example:

Success [in implementing the Plan] will be related to the Minister's commitment and leadership. Unless targets are set centrally and each Minister is made accountable for outcomes through Legislation or by the Premier, success will be limited

A state women's alliance might get good traction if they linked up with national alliances.

Good practice

Interviewees also commented on existing good practice they felt could guide the implementation of the WA Women's Ten Point Plan of Action, for example:

The Close the Gap Campaign, which has shaped government policy and seen a huge investment into Aboriginal health. Historic partnership approach indicates sustained improvements in Aboriginal health because it funds creative, context specific projects that start from the 'bottom up'. Victorian Women's Health has done a great job of advocating for, and improving, women's health outcomes by creating a strong women's health sector that works together and with other non-government services and stakeholders in the government and private sectors that can have an impact on women's health outcomes. They provide evidence for action and make recommendations to government based on their research and evidence. Their Index and clearing house is a very important resource.

At NATSIWA (National Aboriginal and Torres Strait Islander Women's Alliance) we are trying to build the public policy voice of Aboriginal and Torres Strait Islander women. We are aligned with the human rights Gender Equality for Women program.

APPENDIX 2: WOMEN’S ADVISORY COUNCIL (WA) CONSULTATIONS

This exploration of women’s health issues relating to the WA Women’s Ten Point Plan of Action also had access to data from consultations undertaken earlier in the year by the Women’s Advisory Council to the Minister for Child Protection, Community Services, Seniors and Volunteering and Women’s Interests. The following thematic analysis is based on 80 specific contributions (n=86) made by participants involved in the consultations. The data confirm the data in Appendix 1, while at the same time identifying several new directions. A final theme identifies positive comments made about things that are working well.

Table: Thematic analysis with percentage of comments per theme (n=86)

Theme

Areas of concern

Infrastructure & housing (16.3%)

- Severe housing shortage for disadvantaged groups
- Infrastructure and facilities in Karratha
- Having a local directory; cost of housing and rentals
- Lack of public transport in Albany
- Transport to Perth from country areas
- Access to social, recreational facilities
- Housing, schooling and food are priority needs ahead of health

Cross-cultural issues (16.3%)

- Low literacy of clients
- ESL, curriculum – need for specific, health-related language skills
- Communication skills for health service providers
- Exploitation of female workers
- Teenage girls and prostitution
- CaLD women and drivers licence

Medical access (11.6%)

- Lack of GPs and obstetricians in country towns;
- Access to female GPs especially in outlying areas
- Closure of maternity services in Katanning
- KEMH difficult to access from northern suburbs

Theme

Areas of concern

*Mental health
(10.5%)*

- Mental health a big issue in the Pilbara
- Impact of social isolation
- Need for more mental health support groups
- Need for more qualified staff around mental health issues
- Perinatal care to reduce post-natal depression

*Knowledge issues
(10.5%)*

- Lack of community knowledge of services
- Women's lack of confidence and knowledge to access the system
- Being 'in' the system to know it
- Health and nutrition education (early years and during pregnancy)
- Services providers lack of knowledge of other providers

*Research/Social
Impact focus
(4.6%)*

- Role for Centre for Social Impact Studies around women in the Pilbara
- Longitudinal study into impact on women of fly-in, fly-out work
- Need for more youth services for youth from single parent families

*Ageing issues
(3.5%)*

- More options for aged care noting impact on carers
- Women outside child-bearing age 'falling off the radar'

*Women's Health
Centres (3.5%)*

- Need for Women's Health centre in Karratha
- More sharing of resources and longer term funding

Child Care (3.5%)

- Child care is too expensive
- After-school and holiday care needed

*Drug and alcohol
(2.3%)*

- Drug and alcohol issues linked to mental health
- Drug and Alcohol rehabilitation services needed –

*Other issues
(7.0%)*

- Review needed of Family Day Care in the Pilbara
- More support/advocacy for people with a disability men and the general population
- Limited beds for respite
- Centrelink payments are low and cut off after a period
- Lack of a holistic approach to women's care

*Positives and what
is working well
(10.5%)*

- New Albany hospital
- Ishar Women's Health Centre Shared Care Anti-natal Model of care is working well
- Ishar CaLD Carer's exercise group
- Newly opened Pregnancy Problem House teenage mothers' group Lots of women's groups
- Newly formed depression support group

APPENDIX 3: OVERVIEW OF WORKSHOP AND WEBINAR CONSULTATIONS AND SURVEY RESULTS

These data bring together the range of consultations involving over a hundred individuals and representatives of a diversity of women's and community services and the Government sector participated in workshops, as well as data from a webinar and an online survey. The issues prioritised as serious determinants of women's health and wellbeing were:

- Mental health
- Housing
- Homelessness
- Domestic violence
- Low-income
- Economic independence
- Unpaid caring
- Access to essential goods and services
- Women raising grandchildren
- Women with disabilities
- Inclusive and innovative services
- Remote location

Participants articulated an understanding of these issues based on their own experiences and/or in their capacity as professionals in applicable areas. Almost without exception, participants considered the above issues to be the key determinants of poor mental health outcomes for women. Housing stress – the lack of security, affordability and suitability – was identified as a huge barrier to women's ability to achieve and maintain health and wellbeing. Thus, it was suggested, better mental health outcomes will only be achieved through action across all sectors. Similarly the issues that emerged were generally identified as social inequities born of entrenched societal inequalities. Hence participants' main concern was the mechanisms available to intervene and take action on more than just a group or individual level.

The data have been ordered to indicate, for each issue, a description of the issue, the groups most affected, the impact on women, and suggested solutions.

The issue: housing availability, affordability and security

Description of the issue

- Many women are unable to find appropriate accommodation within their price range and in their area of choice (near family and schools, for example). Rental and mortgage stress is seriously exacerbated by the rising cost of essential goods and services.

- Housing affordability and sustaining home ownership is disproportionately felt by women (over-represented in 'at risk' groups – low-income, low superannuation savings, caring responsibilities, sole parents, victims of domestic and family violence – see Security 4 Women, 2008).
- Women's health is highly contingent on the place where they reside.

Women identified as being most affected

- Aboriginal women
- Sole parents
- Women with disabilities
- Separated and divorced women
- Women seeking accommodation due to domestic violence
- Older, single women
- Migrants and refugees
- Women with significant caring responsibilities
- Women caring for grandchildren
- Women exiting prison
- Low income earners
- Private renters

Identified impact on women

- Poor mental health
- The cost of rental accommodation makes it extremely difficult to meet the costs of essential goods and services.
- Overcrowding (known to severely impact on mental health)
- Due to the lack of available rental accommodation (and, so, little choice about where to live), women and their children are often forced to move away from their families and communities.
- Many women exiting prison see returning to prison as a safe alternative.
- Often, women in low-paid employment take on second jobs to meet high rental costs.

Suggested solutions

- Further investment in the supply of suitable public and social housing.
- Housing policy that addresses sustaining people in home ownership.
- More housing programs to assist women to sustain or enter home ownership post-divorce, relationship breakdown or loss of a partner.
- Increase in Commonwealth rent assistance for women in the private rental market facing escalating rents and insecure housing.

- More capacity is needed within Supported Accommodation Assistance Program and current system response.
- More research to determine what is and what is not working for women in terms of housing.
- A government strategy that identifies and provides pathways into safe, secure and affordable housing for women and their children.
- Better education and employment opportunities for girls.
- Educate girls to plan for their future and possible eventualities, and to be financially independent and literate in the areas of finance.
- Ensure that girls' choices are educated ones and not limited by gender roles and stereotypes.
- Tenant advocacy services dedicated to individual and systemic advocacy.
- Address the gender pay gap.
- Facilitate (meaningful) workforce participation for women with children and unpaid carers.
- The women's sector needs to work with stakeholders in the government and housing sector to ensure that recommendations for affordable housing include a focus on accessible housing as well as a gender focus. The precarious income and housing situations of sole parent families is primarily a women's issue.

The issue: homelessness

Description of the issue

- Gender is a key social determinant in experiences of homelessness (that is, it affects women in a specific way and they are susceptible to homelessness for reasons specific to their gender).
- Many women and girls are homeless due to domestic and sexual violence and abuse. Single women over the age of fifty may be homeless due to interrupted workforce participation due to caring and so little superannuation.
- Homelessness is particularly dangerous for women and girls and puts them at risk of violence, sexual abuse and exploitation.

Women identified as being mostly affected

- Very young women
- Women fleeing domestic violence and unable to access refuge accommodation due to the age of their male children
- Young, single mothers

- Women leaving their homes due to domestic violence
- Very young women
- Older, single women
- Women evicted from their homes (as a consequence of 'three strikes and you're out')

Identified impact on Women

- Poor mental health (depression, anxiety)
- Social exclusion
- Heightened anxiety and fear due to a lack of a safe space
- Drug use
- Self-harm

Suggested solutions

- Improve the access of women and children to women's refuges.
- Provision of transitional housing services for women in crisis.
- Inter-agency collaboration and practical support for people who are homeless or at risk of homelessness.
- Replacing the 'three strikes and eviction' policy with a more responsible approach that is more effective in the long-term (preventative, early intervention measures to ensure that eviction due to issues such as overcrowding do not reach crisis point. This may mean working with families at risk of eviction).

The issue: access to essential goods and services

Description of the issue

Many participants expressed concern about the impact of the cost of living on women on low incomes or Centrelink payments. Women on low incomes are unable to afford decent housing, a good diet and transport and are having to keep their electricity, water and telecommunications to a strict minimum. 'Mental well-being,' one participant said, 'depends on financial well-being.'

In the Pilbara region there is no reliable public transport, so women (particularly sole-parents and the elderly) are relying on taxis to get around, which is expensive. It is difficult to access available services without reliable transport. Many women cannot afford to get their licenses and to buy their own car. Inadequate access to reliable transport affects one's ability to be self-sufficient and to access local services and networks. Concerned participants stressed that if transport is not addressed then it will be essential to develop mobile health services.

Women identified as being most affected:

- Sole-parents
- Women experiencing housing stress
- Elderly women
- Women living in rural and remote areas.
- Women on Centrelink payments
- Women on low-incomes
- Women with disabilities

Identified impact on women

- Poor mental health
- Inability to meet housing costs
- Homelessness
- Social isolation
- Health damage due poor home and work environments

Suggested solutions

- Avoid the tendency to focus on one type of intervention (usually at the individual or group level), which tends to be specific-sector focused. Intervene in the inequitable distribution of resources through a multi-sector focus.
- Connect intervention program inputs to intended outcomes.
- Tackle the prevailing macro-economic or cultural environment that affect women's social position and standard of living.

The issue: women caring for people with a disability, mental illness, chronic illness and age related issues

Description of the issue

- The majority of primary carers are women.
- Many of the issues that are currently of concern for many women (mental health, housing, superannuation savings) impact more severely on women whose primary role is unpaid caring.

Women identified as being mostly affected

- All women can become carers at any time. However, unpaid caring has a particularly detrimental impact on women who are from low-socio economic backgrounds and poorly educated.

Identified impact on women

- Poor mental and physical health
- High stress levels
- Poor workforce participation and little or no superannuation savings
- Social exclusion
- Stigmatisation (if caring for someone with a mental illness)
- Isolation

Suggested solutions

- Crisis advocacy for carers
- Co-ordinated inter-agency response to issues as they affect carers.
- Recognition of carers across all services, not just health and disability.
- More effective outreach and projects to facilitate inclusion and participation.
- Flexible working conditions.

The issue: domestic and family violence

Description of the issue

- Despite the resources invested into the issue of domestic violence it remains a serious and urgent problem with a devastating impact on women, children and the community. Out of all of the states, Western Australian women are currently fairing the worst.
- Efficacy of violence restraining orders.

Women identified as being mostly affected

- Aboriginal women
- Women with children
- Women with disabilities
- Pregnant women

Identified impact on women

- Poor mental health
- Physical harm
- Emotional distress
- Social exclusion
- Depression
- Anxiety disorders
- Loss of self-esteem and decision making ability

Suggested solutions

- Women's services are currently working in silos – each usually unaware of what the other one is doing. Greater service co-ordination would potentially improve service delivery and outreach.
- Women's services could actively work with the National Plan to reduce violence against women and their children.
- Violence education and support for young men.

The issue: inclusive and innovative services

Description of the issue

It was acknowledged that non-government women's services fill the gaps in mainstream services and are more accessible ('user-friendly'). It was also recognised and appreciated that women's health services were relatively accessible and responsive to the needs and contexts of a diversity of women and families in the community; and that they filled the gaps in mainstream services. However, women continue to fall through service gaps because (a) the issues they present with do not fall within any specific service or program, and (b) they are unaware of existing services or lack the confidence to initiate contact.

Various workshop participants suggested that gaps in services go unrecognised because of a siloed approach to service provision. Consequently, resources are used for service duplication rather than to enhance service delivery or to tailor services and programs to a new client group.

It was the view of several participants that services had a responsibility to identify, engage with and provide services to women who would benefit from an appropriate service, program or activity.

Women identified as being most affected:

- Women with disabilities (particularly with children)
- Women with complex needs or co-morbidity
- Women who are service resistant
- Vulnerable and disadvantaged women
- Aboriginal women

Identified impact on women:

- Un-addressed mental health issues or other unidentified issues that are impacting on women and also their children and communities
- Women continue to fall through service gaps all through the gaps in the service sector
- Women in need of services are sometimes the least likely to receive them.

Suggested solutions:

- Improved outreach strategies to ensure that women and children who could benefit from services are aware of them and can easily access them.
- Women's services should engage in creative promotional and outreach initiatives and recurrent community consultation.
- Promotional strategies need to consider literacy issues
- Regular community networking events
- Soft or multi-entry points (no 'wrong door' policies)
- Joined-up or de-siloed services
- Develop partnerships with local government to promote what resources and services are available to women.
- Flexible and collaborative service delivery
- Meet women where they are most comfortable via outreach services.
- Actively attend places where vulnerable women (and their families) would be.

The issue: Women raising their grandchildren or with significant care-giving responsibilities**Description of the issue**

Women increasingly have responsibility for their children's children. Balancing the needs of grandchildren with domestic labour, paid work, caring for elderly parents and their own personal time is a challenge.

Australia has amongst the lowest public expenditure on early childhood services across the OECD nations (OECD, 2008). A substantial proportion of grandmothers are filling the shortfalls of formal childcare without much support.

There are gender inequalities associated with doing grandchild-care, which impact on the lives of older women, particularly in relation to experiences of paid work, leisure time and expectations to provide care.

Women identified as being most affected

- Women with adult children and living in low socio-economic areas.

Impact on women affected

- Inadequate support
- Inadequate acknowledgement of the contribution they are making (legally or by Centrelink, for example).

The issue: Women living in remote Aboriginal communities

Description of the issue

Rural and remote settings are almost inevitably areas of unmet need. Medical staff and healthcare workers are often non-aboriginal and inexperienced. This can lead to a situation where a significant number of medical graduates are employed. This can introduce additional cultural and language issues, which may be particularly accentuated in relation to sexual health, contraception and pregnancy related issues. Women's mental health services need to be community based and available where needed in the areas of high-risk population. The significant burden of disease makes this necessary (RANCZP 2012: 11).

Services ranging from essential water, power and sewerage supply to telecommunications, health and community infrastructure are daily issues affecting women's health and wellbeing. The health status of women living in remote Aboriginal communities, for example, does not compare well with women living in the inner city. The connection between place and health is especially evident when we consider the differences between urban and remote settings.

Women in remote Aboriginal communities face significant challenges to the full enjoyment of their human rights. Aboriginal women in remote communities lack access to adequate healthcare and education and face disproportionately high rates of poverty and are subjected to violence, such as domestic violence and sexual abuse. The poor health of women living in remote communities due to a lack of appropriate and timely services is not just a policy issue; it is an ethical issue and a matter of social justice, which government has the capacity to mitigate.

As part of the consultation process, consultants specifically sought feedback from two women working in a women's health centre in a remote Aboriginal community. A lengthy teleconference ensued. One participant was new to the field; the other had had twelve years'

experience working in remote Aboriginal communities in Western Australia and the Northern Territory.

It was expressed by an interviewee, that there is sometimes reluctance within aboriginal communities to address the gender dimensions of their community's because to do so can be seen as interfering with culture. Conversely, Aboriginal health workers often see gender analysis as a means by which to identify and address gender-differentiated needs in a more accurate and targeted way. Partnerships between Aboriginal and non-Aboriginal services is a 'Closing the Gap' recommendation.

Impact on women affected

- Access to a doctor on a fortnightly basis
- Limited access to essential goods and services
- Children with chronic ear infection and a failure to thrive
- Social issues
- Overcrowded housing (elderly women are particularly affected and are mostly the ones left to sleep outside - land tenure issues as it is a nature conservation zone)
- Sexual assault
- Domestic and family violence
- Alcoholism
- Poor health and nutrition
- Food security in the home due to/ overcrowding and transiency (a particular concern for women with children)
- Personal safety

Possible solutions

- Regular access to a psychologist (as with GP)
- Mental health programs and supports
- Aged care supports
- Empowering Aboriginal women through health literacy and literacy in regards to their human rights (around housing security and personal safety, for example)
- Forming a women's group
- Resources to develop entrepreneurial skills
- Promoting a sense of responsibility in governments and the community to take urgent action on the issues facing women and their families
- Professional development and capacity building
- More active networking with other women's health centres, including remote health services in Western Australia and elsewhere.

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