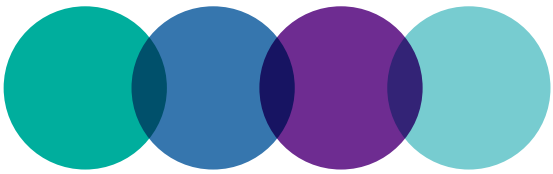
AUSTRALIAN WOMEN'S HEALTH NETWORK



WOMEN'S HEALTH: MEANINGFUL MEASURES
FOR POPULATION HEALTH PLANNING

2013

Australian Women's Health Network

Women Health: Meaningful measures for population health planning

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This position paper is available for free download at: www.awhn.org.au

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Executive summary

The Australian Women's Health Network (AWHN) identified the need to develop meaningful measures of women's health as an outcome of a series of position papers published in 2012 on women's health and wellbeing and women and health reform. The *Women's Health: Meaningful Measures in Population Health Planning* project was subsequently proposed to Minister for Health, Tanya Plibersek; with funding received for the project shortly after from the Department of Health and Ageing. With limited resources for the project, a think tank was convened on 31 July 2013 in Canberra as the most effective way to draw together the expertise required to meet the aims of the project.

What are meaningful measures? Meaningful measures provide a snapshot of the social determinants of women's health. These are the social and economic circumstances of women's lives (such as their socio-economic disadvantage). Such circumstances result from the inaccessibility to women of key requisites for a healthy life which can also be meaningfully measured (such as economic and social participation). In turn, this can expose women to health behaviours and/or risk factors for poor health (such as stress or self harm) that can result in a myriad of health problems (such as mental health issues) – all of which can be meaningfully measured.

In addition, meaningful measures throw a spotlight on the underpinning drivers of women's socio-economic positioning. These are the deeply entrenched structural mechanisms that stratify society along gender lines, and produce and maintain gender hierarchies in relation to power, prestige and access to resources that are the key requisites for a healthy life.

Meaningful measures are needed because Australian health policy and planning has tended to overlook the social determinants of women's health and continues to remain 'blind' to prevailing gender hierarchies and their resulting systematically inequitable distribution of power, prestige and resources between women and men. In Australia there exists a current opportunity to mainstream meaningful measures through various population health policy and planning activities of Medicare Locals, local governments (councils), and state and territory governments. There exists an opportunity, too, to influence an environment that can authorise the uptake of meaningful measures through state, territory and federal government departments of health (and their ministers) and peak health organisations, for example. The work arising from *Women's Health: Meaningful Measures in Population Health Planning* project (namely, this resource) is addressed to these primary intended users.

For the think tank, participants were asked to prepare a brief presentation against a set of questions. These were:

1. In targeting better health outcomes for women, what is critical to measure and make visible within each of the following levels of determinants that affect health outcomes?
   - individual level
   - intermediary factors, and
   - structural factors
2. What data sources could be accessed by population health planners within the areas to be measured?
3. What data gaps make this difficult?

Facilitation of agreement on a core set of meaningful measures first led to the development of a robust conceptual framework that shows four causally interlinked dimensions of women's health:

- the underlying structural mechanisms that stratify society along gender lines and produce and maintain gender hierarchies in relation to power, prestige and access to resources (including the key requisites for a healthy life);
- the social determinants of women's health (or women's social and economic circumstances, their daily living conditions, their lived experiences);
- women's exposure to health behaviours and/or risk factors for poor health; and
- the various health issues experienced by women, which must be understood in the context of the other dimensions.

The four dimensions of the conceptual framework are aligned with contemporary research on the social determinants of health, in particular the work of the World Health Organization's (WHO's) Commission on the Social Determinants of Health (CSDH)

(http://www.who.int/social_determinants/en/). CSDH makes an analytical distinction between the structural factors of health inequities (considered to be the most upstream of all determinants) and the social and economic conditions of daily life (cast as the more intermediary social determinants of health).

Aligned with CSDH, the conceptual framework for women's health conveys the message that any action to improve women's health cannot limit itself to the social determinants but must tackle the structural mechanisms that produce and maintain the inequitable distribution of power, prestige and resources between men and women in the first place.

The conceptual framework for women's health also includes a life course approach to show how the causal relationships between the structural drivers and the second, third and forth dimensions of women's health are experienced by women throughout the life course and in different ways.

Meaningful measures then emerged from the conceptual framework. Meaningful measures reflect the most critical elements of the conceptual framework necessary for health policy makers and planners to comprehend – *at a minimum* – so that their work does not continue to overlook the social determinants of women's health and/or remain 'blind' to the structural drivers of gender hierarchies and inequities that shape women's daily living conditions and their health outcomes.

The final agreed set of meaningful measures is presented in this report together with links to available data sources where these are currently known to exist. Fresh data sources will no doubt come into existence as data custodians, such as the Australian Bureau of Statistics, continue to expand their output of gender-based statistics. This means that the meaningful measures arising from the *Women's Health: Meaningful Measures in Population Health Planning* project are not static but rather a work-in-progress. This report concludes with a set of implementation steps to ensure the continued development of meaningful measures of Australian women's health.

1.0 Background and context to the work

1.1 About the Australian Women's Health Network

The Australian Women's Health Network (AWHN) is a community-based, non-profit consultative organisation with members in every state and territory across Australia who share the purpose of working to improve the health and well-being of Australian women.

AWHN works with policy makers, service providers and community to advance a national voice on women's health through disease prevention, health promotion advocacy and information sharing. AWHN recognises the social, economic, cultural and political factors that impact on women's lives and health.

AWHN has member networks in all states and territories of Australia, across all dimensions of the social determinants of health. AWHN's membership profile ensures broad reach as the majority of the organisation members are themselves member-based organisations, which between them have an estimated 12,000 individuals that AWHN communicates with on a regular basis. This includes rural and remote women, women with disabilities, Aboriginal and Torres Strait Islander (ATSI) women, migrant and refugee women, older women, young women, lesbian, bisexual, transgendered, same sex attracted and intersex women. Further information about AWHN can be found at www.awhn.org.au.

In 2012, AWHN produced the *AWHN Women and Health and Well-being* and *Women and Health Reform Position Papers* (www.awhn.org.au) which argued broadly for recognition of a number of principles essential to establishing a firm basis upon which to redress health inequities for women. The need for the development of meaningful measures of women's health was identified in these papers and promoted through advocacy for action on their recommendations. The *Women's Health: Meaningful Measures in Population Health Planning* project was proposed to Minister for Health, Tanya Plibersek following discussion on these recommendations, and subsequently received funding assistance from the Commonwealth Government with a Health Systems Capacity Development grant through the Department of Health and Ageing.

A think tank was convened on 31 July 2013 in Canberra as the most effective way to draw together the expertise required to meet the aims of the project, particularly given the very limited resources available. The total funding received for the project was $10,000 and it needed to be completed in a short time frame (from May to September 2013) with significant population planning currently underway.

The objective and target outcomes of AWHN's *Women's Health: Meaningful Measures in Population Health Planning* project were as follows:

Objective

Recognising that gender is a key determinant of health and is often invisible in data collections and analysis for health planning, the objective of the *Women's Health: Meaningful Measures in Population Health Planning* project was to create agreed national key performance indicators for women's health for inclusion in population health planning data collection and analysis.

Target Outcomes

1. Enhanced population health planning through recognition:
   - » that gender accounts for the fundamental differences between men's and women's health;
   - » of the importance of gendered social relations, social factors and conditions of living in determining health and illness outcomes; and
   - » that gender is an overarching social determinant of health.
2. Enhanced population health data which underpins prioritising service delivery initiatives and needs analysis for action.
3. Improved health and well-being for women through the inclusion of these key performance indicators in all Commonwealth, State/Territory and Local Government funded entity population health planning.

1.2 Why focus on meaningful measures?

'What gets measured is what gets done'. This is a key message of the *Women's Health: Meaningful Measures in Population Health Planning* project. Put simply, what gets measured is more likely to be prioritised by health policy makers and planners. Health measures enable evidence and facts to be gathered and used for sound health policy and planning: they contribute to setting the health agenda – nationally, regionally and locally. Once priorities are set, decision-makers can be held to account for their actions (or non-actions) on them. They can also monitor efforts against them through health measures and improve future actions on them. That is why it is important to have *meaningful* measures of women's health for population health planning – measures that truly reflect women's lived realities. The think tank was an opportunity to explore such measures – as well as any gaps in data collection and analysis.

What kinds of evidence and facts do meaningful measures of women's health collect?

Meaningful measures provide a snapshot of the social determinants of women's health. These are the social and economic circumstances of women's lives (such as their socio-economic disadvantage). Such circumstances result from the inaccessibility to women of key requisites for a healthy life which can also be meaningfully measured (such as economic and social participation). In turn, this can expose women to health behaviours and/or risk factors for poor health (such as stress or self harm) that can result in a myriad of health problems (such as mental health issues) – all of which can be meaningfully measured.

In addition, meaningful measures throw a spotlight on the underpinning drivers of women's socio-economic positioning. These are the deeply entrenched structural mechanisms that stratify society along gender lines, and produce and maintain gender hierarchies in relation to power, prestige and access to resources that are the key requisites for a healthy life.

Research that exemplifies 'what gets measured is what gets done' includes the Victorian Health Promotion Foundation's (VicHealth's) report on the health costs of violence against women, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence* (VicHealth 2004). This report shows that intimate partner violence was the leading contributor to death, disability and illness for Victorian women aged 15–44 years. Since the publication of the report, this meaningful measure has set the agenda for health policy and planning in Victoria at the statewide and local levels.

Meaningful measures therefore support and resource health policy makers and planners to undertake their work in ways that are encompassing of women's experiences and genuinely inclusive of the populations they plan for. More about women's socio-economic circumstances and the underlying mechanisms that stratify society along gender lines can be found in section 2.2 'The social determinants of health and the structural drivers of inequities' of this report.

Why do we need such an emphasis on meaningful measures of women's health?

Australian health policy and planning has tended to overlook the social determinants of women's health and continues to remain 'blind' to prevailing gender hierarchies and their resulting systematically inequitable distribution of power, prestige and resources between women and men. The traditional way of bringing data together does not always take into account the impacts of the social determinants and structural drivers on women *because* they are women; for example, the effects of women's financial insecurity on their health at different stages in the life course. As noted by one think tank participant, the public health field is poised for an analytical breakthrough of this barrier. The *Women's Health: Meaningful Measures in Population Health Planning* project is a contribution to this work.

In Australia there exists a current opportunity to mainstream meaningful measures through various population health policy and planning activities. The primary intended users of the work (namely, this resource) arising from the *Women's Health: Meaningful*

Measures in Population Health Planning project are:

1. entities mandated to conduct population health planning based on evidence and meaningful measures, for example:
   - 61 Medicare Locals;
   - local governments (councils); and
   - state and territory governments.
2. entities that can build an authorising environment for the uptake of meaningful measures of women's health, for example:
   - state, territory and federal government departments of health (and their ministers);
   - public health sector organisations like such as the Australian Institute of Health and Welfare;
   - entities responsible for data capture and distribution such as the Australian Bureau of Statistics and the Australian Women's Health Longitudinal Study; and
   - peak health organisations, such as the Public Health Association of Australia, National Mental Health Commission, and National Heart Foundation.

1.3 The think tank on meaningful measures

On 31 July 2013, AWHN convened a think tank in Canberra of experts in population health planning, data collection and analysis to explore meaningful measures of women's health.

In preparation for the day, participants were asked to prepare a 1–2 page presentation against a set of questions. The questions were:

1. **In targeting better health outcomes for women, what is critical to measure and make visible within each of the following levels of determinants that affect health outcomes?**

   Individual level
   - Lifestyle factors, particularly: diet, physical activity, smoking, alcohol and drugs; genetics; social connection; freedom from violence and discrimination; and access to income, opportunities for social participation and citizenship.

   Intermediary factors
   - Social and community factors, including the influence of: neighbourhoods; criminal incidents; unemployment levels; discrimination and racism; social exclusion and cultural influences.
   - Living and working conditions, including: educational attainment; access to health services; housing; employment conditions; unemployment; sanitation; air and water quality.

   Structural factors
   - General socio-economic factors impacting on health and well-being, including: levels of poverty and wealth and how income is distributed (i.e. the social gradient); cultural richness; educational opportunities; legal and political environments, policies and infrastructure.

2. What data sources could be accessed by population health planners within the areas to be measured?

For example, the Australian Institute of Health and Wellbeing Health Performance Framework includes the following:

Health status

- Mortality and life expectancy
- Prevalence of health conditions
- Human functions – disability and impairment
- Well-being

Determinants of Health

- Bio-medical – genetic, blood pressure, cholesterol, weight
- Community and socio-economic status – social capital, income, housing, education, employment
- Environmental – physical (urban design, open space, pools, gyms, community centres, libraries), chemical (air quality), biological (food, water)
- Health behaviours – smoking, alcohol, nutrition, immunisation, sexually transmitted infections, exercise, sun

Health system performance

- Accessibility
    i. Availability
    ii. barriers e.g. disability, low socio-economic status, cultural and linguistic diversity, ATSI, transport
- Continuity of care, effectiveness, efficiency and sustainability, responsiveness
- Safety from health care, falls etc.

3. What data gaps make this difficult?

For example, data is usually disaggregated by sex but insufficiently correlated with income to explain the nature of the social-health gradient by sex. Income is a key determinant of health for women. Women have far less access to economic resources than men and their health is a reflection of that social-health gradient.

Violence against women is the single biggest cause of poor physical and mental health among women but we have little longitudinal data about the long-term effects of violence against women on women's economic well-being and security, as well as health and well-being.

During the think tank, participants discussed the common themes and points of differences in the approaches and concepts used for their presentations. Facilitation of agreement on a core set of meaningful measures during the think tank first led to the development of a conceptual framework for women's health. Meaningful measures then emerged from the conceptual framework.

The conceptual framework and the meaningful measures are presented and discussed in the following sections of this report.

2.0 A conceptual framework for women's health

2.1 The ingredients for a conceptual framework

During the think tank, participants agreed that the most critical factor in identifying meaningful measures is the existence of a robust conceptual framework that can encapsulate Australian women's health in all its totality and interlinked complexity. Much of the discussion was subsequently spent sketching the contours of a conceptual framework, the final version of which can be found on p. 13 of this report. As the collective thinking unfolded, a distinction emerged between an uppermost causal level of structural drivers of gender hierarchies and inequities and a second-order level of social and economic circumstances expressed as women's lived experiences of the structural drivers.

The resulting conceptual framework is aligned with contemporary research on the social determinants of health, in particular the work of the World Health Organization's (WHO's) Commission on the Social Determinants of Health (CSDH) (http://www.who.int/social_determinants/en/). CSDH makes an analytical distinction between the structural factors of health inequities (considered to be the most upstream of all determinants) and the social and economic conditions of daily life (cast as the more intermediary social determinants of health). CSDH presents the different levels of causality in a framework for action on the social determinants of health – one that clearly shows the priority given to the structural determinants of health inequities in shaping a population's health:

A key aim of the framework is to highlight the difference between levels of causation, distinguishing between the mechanisms by which social hierarchies are created, and the conditions of daily life which then result. [...] The vocabulary of 'structural determinants' and 'intermediary determinants' underscores the causal priority of the structural factors (Solar and Irwin 2010: 4 and 6).

It is noted that VicHealth is also currently using CSDH's latest research on the social determinants of health by adapting and applying it to the Australian context, although the focus of VicHealth's work is not specifically on women's health. In addition, implementation of the conceptual framework for women's health should support country reporting against international conventions, such as the United Nation's *Convention on the Elimination of all Forms of Discrimination against Women* (CEDAW).

Think tank participants further recommended that the conceptual framework incorporates a life course approach, such as that utilised by the Ministry of Health in New South Wales. A life course approach has the benefit of focusing attention on the operation of the structural drivers of gender hierarchies and inequities throughout women's lives – from childhood and adolescence, to the young adulthood years, to the mid-life years, and to the older years and end-of-life – in recognition that this operation of structural drivers will be experienced and lived differently by women depending on their stages in the life course.

The following section describes in more detail the distinction between an uppermost causal level of structural drivers of women's health and a second-order level of social and economic conditions expressed as women's lived experiences of the structural drivers; and explains why this distinction is so important for a conceptual framework for women's health.

The conceptual framework is then presented and described in section 2.3 *'The conceptual framework: Four dimensions'*.

2.2 The social determinants of health and the structural drivers of inequities

2.2.1 The social gradient in health

It is understood globally by public health experts that the most powerful influences on a population's health are the social and economic conditions in which people are born, grow, live, work and age (CSDH 2008: 26).[1] Evidence shows a strong relationship between socio-economic disadvantage, on the one hand, and shortened life expectancies and increased morbidities, on the other. The health of any given population is not evenly experienced but is rather graded by differences in socio-economic circumstances. This is known as the social gradient in health.

The existence of a social gradient in health means that health policy makers and planners (and their partners) must take action on social and economic conditions that shape people's lives if they are to improve the health of everyone – especially those with the poorest outcomes. Effective health policy, for example, involves multi-sectoral effort to reduce levels of social exclusion, financial insecurity and economic disadvantage, thereby improving opportunities for all to be part of the social and economic life of their communities. As Marmot and Wilkinson write, "Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation" (Marmot and Wilkinson, 2003: 11).

2.2.2 Gender inequities

Inarguably, action on the social determinants of health is the basis of sound population health planning. But what is less well understood and less widely acknowledged in the public health field is the recognition that the social gradient of health is not gender neutral. The fact remains that within any given population, men and women are unequal in social and economic terms. The social construction of gender – or how we live our biological sex according to prevailing norms, values, expectations and behaviours as men and women – exerts an ever-present force on the unequal distribution of power, prestige and resources *between* the genders, including men's and women's differential access to the key requisites for a healthy life. This unequal distribution of assets stratifies society along gender lines and produces and maintains gender hierarchies and inequities. These in turn shape every facet of women's experiences in ways that are unique to them *as* women – although not always in the same ways (explained further below). Gender-based inequities are, in short, the structural drivers of the social and economic conditions of women's lives; and they influence the circumstances of daily living for women in a myriad of ways, including (but not limited to):

- the role women play in families and households;
- the relationships women have to others as carers and care givers;
- the pathways open to women for secure paid employment;
- the power and control exercised by men over women in private and public life;
- women's capacity to influence the course of public life;
- the voice women have in decision making;
- the ways in which women are valued; and
- the ways in which women are treated – including by the health system.

These unique circumstances of women's daily living – the social and economic conditions of their lived realities – then mean that women are more likely than men to be found lower down the social gradient in health with the accompanying exposures to poorer health that this positioning entails.

Economic participation, for example, is a key requisite for a healthy life. Gender norms and institutions define different employment expectations of men and women such that women are systematically disadvantaged in relation to their access to economic participation relative to men. Dominant beliefs about what counts as women's work are typically manifested in the daily life of women in Australia. This is through:

- the inordinate amount of unpaid work performed by women in households and families;
- women's often fragmented paid work trajectories and career paths;

[1] With health understood as a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity

- women's restriction to lower paid roles, occupations and sectors of employment;
- the poor working conditions often endured by women; or
- all of the above.

Moreover, these unique social and economic conditions reduce women's lifetime earning capacity and increase their exposure to economic disadvantage and/or poverty in adulthood and older age – both of which pose further risks to the health of women as a group compared to men.

With respect to a conceptual framework for women's health, then, explicitly naming the structural drivers that stratify society along gender lines and produce and maintain systemic gender hierarchies and inequities is both necessary and non-negotiable. So too is showing the relationships between these structural drivers and social and economic circumstances of women's lives, the health behaviours and/or risk factors that expose women to ill health, and the resulting health issues experienced by women.

2.2.3 A note on intersectionality

As stated, gender hierarchies and inequities shape every facet of women's experiences in ways that are unique to them as women, although not always in ways that are identical. Women's experiences as women are not always the same because social stratification occurs across multiple axes. Social stratification along the lines of gender always intersects with other lines of social hierarchy, such as racial privilege, ethnic privilege and hetero-normativity – to name but a few. This means that the distribution of power, money and resources can be unequal *within* women as a group, with some women experiencing the effects of compounded inequities because of their positioning through multiple axes of social stratification and systemic hierarchies.

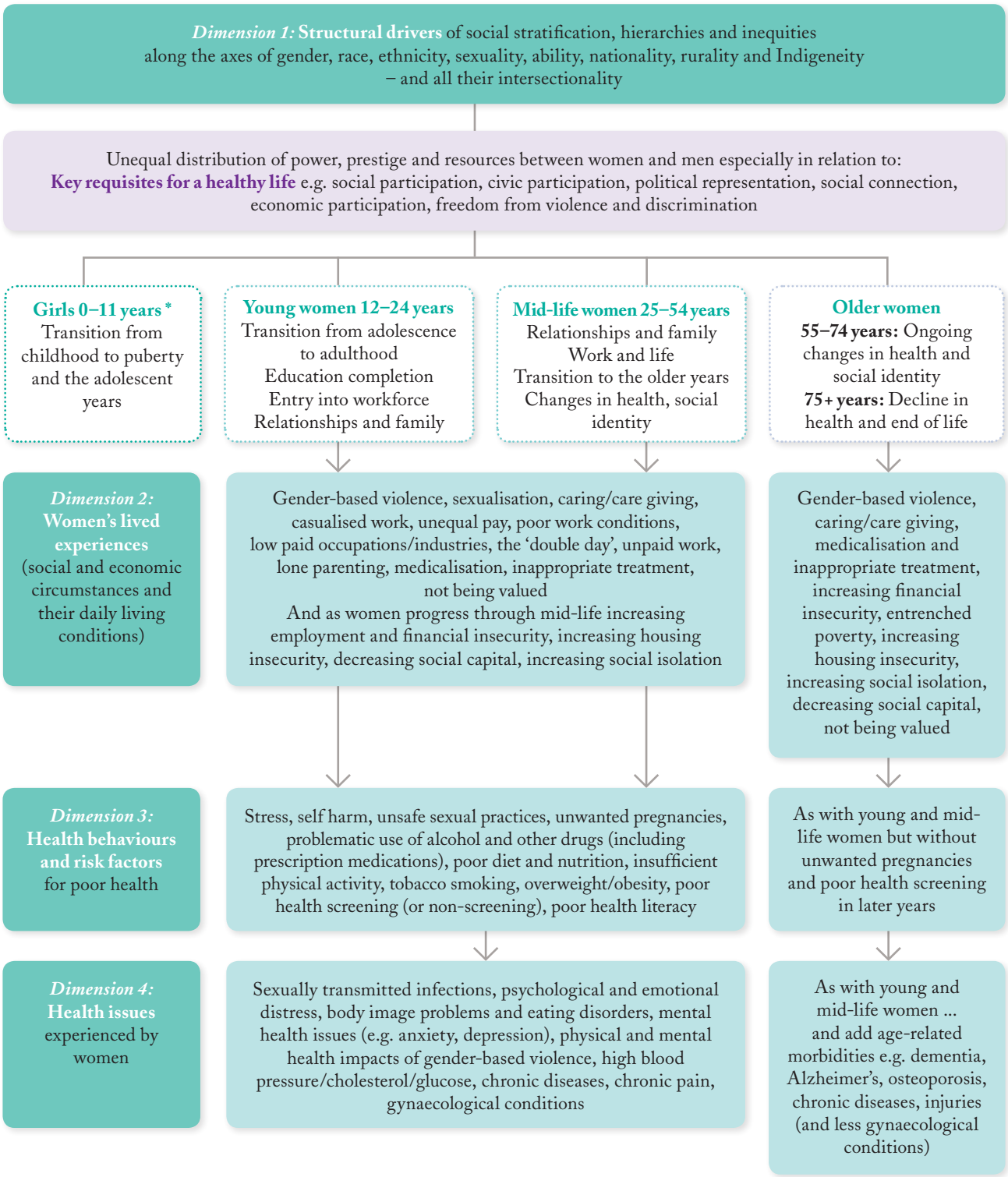
To the example of economic participation above, we can add that prevailing norms about culture and ethnicity typically define different employment expectations of Anglo-Australian women and women from non-English speaking backgrounds. As a result, women from non-English speaking backgrounds are systematically disadvantaged in relation to their access to economic participation relative to Anglo-Australian women. This differential access to economic participation between women is manifested in the concentration of women from non-English speaking backgrounds in lower paid jobs in blue collar occupations, which can expose them to poor work conditions such as long and/or inflexible working hours. Compared to their counterparts in white collar employment, women from non-English speaking backgrounds in blue collar work are consequently more exposed to reduced lifetime earning capacity and hence increased economic disadvantage and/or poverty. They are also more likely to be exposed to the stressors of poor working conditions and hence at increased risk of emotional and/or mental health issues. In short, the specific social and economic circumstances of women from non-English speaking backgrounds mean that these women are more likely than Anglo-Australian women to be found lower down the social gradient in health along with the exposures to poorer health that this positioning entails.

Of course, understanding the lived realities of other groups of women, such as Aboriginal and Torres Strait Islander-identified women, women with disabilities and sexuality and gender diverse women, demands similar attention to the intersectionality of different axes of social stratification and systemic hierarchies. Only then can health policy makers and planners grasp the social and economic circumstances of these women as the result of deep structural drivers of inequities.

With respect to a conceptual framework for women's health, it is therefore imperative that the structural drivers that stratify society along gender lines are shown together with other axes of social stratification that structure social hierarchies and inequities, and which in turn intersect with one another to influence women's social and economic circumstances, their health behaviours and risk factors for poor health, and the health issues that they ultimately experience.

2.3 The conceptual framework: Four dimensions

The conceptual framework for women's health comprises four dimensions that make explicit the totality and interlinked complexity of women's health. A life course approach and the key requisites for a healthy life are also part of the conceptual framework.



* Girls aged 0–11 years are shown in this conceptual framework for women's health to indicate that the structural drivers are at work throughout the life course. The conceptual framework, however, focuses on the causal linkages between the four dimensions and their effects on young women, mid-life women and older women.

2.3.1 The first dimension: Structural drivers of stratification, hierarchies and inequities

This level includes the deeply entrenched structural mechanism that stratifies society along gender lines and produces and maintains systemic gender hierarchies and inequities in relation to power, prestige and access to resources. The key requisites for a healthy life are part of this unequal distribution of assets between the genders. The structural mechanism responsible for this is the social construction of gender, or how we live our biological sex according to prevailing norms, values, expectations and behaviours as men and women. This particular structural mechanism intersects with other powerful drivers of social stratification that operate along the lines of race, ethnicity, sexuality, ability, nationality, rurality and Indigeneity, which each produce and maintain hierarchies and inequities that complicate even further the relation to power, prestige and access to resources for specific groups of women.

In keeping with the Commission on the Social Determinants of Health's causal prioritising of the structural determinants of health inequities, this first dimension of women's health is shown in the uppermost part of the conceptual framework for women's health.

2.3.2 Interlude: the key requisites for a healthy life and the stages of women's life course

Situated between the first and second dimensions of women's health, are the key requisites for a healthy life. The key requisites are part of society's resources that men and women have differential access to because of impacts of social stratification along gender lines. They include:

- social participation;
- civic participation;
- political representation;
- social connection;
- economic participation; and
- freedom from violence and discrimination.

The key resources for a healthy life are located between the first and second dimensions for a reason. Put simply, the structural drivers of stratification, hierarchies and inequities along gender lines mean women have less accessibility to the key requisites for a healthy life compared to men, and it is this inequity that is then 'lived' in women's socio-economic circumstances (the second dimension of women's health).

Also situated between the first and second dimensions are the stages of the life course approach. These are:

- childhood and adolescence (0–11 years);
- the young adulthood years (12–24 years);
- the mid-life years (25–54 years); and
- the older years and towards the end-of-life (55–74 years and 75+ years)

The stages of the life course approach are located between the first and second dimensions to show how the causal relationships between the structural drivers and the second, third and forth dimensions of women's health are experienced by women throughout the life course and in different ways (depending on the stage).

2.3.3 The second dimension: Social and economic circumstances of women

This level includes the social and economic circumstances of women (also known as women's daily living conditions or women's lived realities) that are shaped by the hierarchies and inequities in relation to power, prestige and access to resources as generated by the structural drivers. These social and economic circumstances are what public health conventionally understands as the social determinants of health; and in the conceptual framework for women's health (and in keeping with the latest research on the social determinants of health) these social determinants of health are a second-order priority insofar as they are the product of the deeper, underlying and entrenched structural determinants of health inequities. The conceptual framework for women's health thus conveys the message that any action to improve women's health cannot limit itself to the social determinants but must tackle the structural mechanisms that produce and maintain the inequitable distribution of power, prestige and resources between men and women in the first place.

The social determinants of women's health include a myriad of circumstances experienced by women on a daily basis including:

- employment issues: such as poor working conditions; fragmented paid work trajectories and career paths; unemployment; under-employment; casualisation; unequal pay; and restriction to lower paid roles and 'feminised' occupations/sectors of employment;
- financial insecurity, socio-economic disadvantage and entrenched poverty;
- housing insecurity and homelessness;
- poor social support, social isolation, social exclusion and low social capital (e.g. not having a voice in decision making);
- unpaid work (especially women's role as primary carers of children and care givers to other family members), carrying the load of the 'double day' (i.e. paid work and unpaid work), lone parenting and volunteering;
- gender-based violence (physical, sexual, emotional and financial) including intimate partner violence;
- sexual harassment in the workplace and stalking;
- discrimination and exploitation;
- sexualisation and objectification;
- inappropriate treatment by institutions (such as the legal system or the media) and services (including a health service system that medicalises women); and
- not being valued overall.

2.3.4 The third dimension: Health behaviours and risk factors for poor health

This level includes the exposures to individual health behaviours and/or risk factors for poor health that are connected to women's social and economic circumstances, such as:

- low self-esteem, stress and self-harm;
- poor diet and nutrition, physical inactivity, overweight and obesity;
- tobacco smoking;
- the problematic use of alcohol and other drugs (including prescription medicines);
- unsafe sexual practices and unwanted pregnancies;
- poor health screening practices (or non-screening); and
- poor health literacy.

2.3.5 The fourth dimension: Women's health issues

This level includes the myriad of health issues experienced by women that must be contextualised and understood according to the conceptual framework as a whole; that is, as framed by the preceding structural and socio-economic dimensions of women's health in their interlinked and causal chain of effects. Women's health issues include (and are not limited to):

- high blood pressure, high blood cholesterol and high blood glucose;
- mental health issues (e.g. depression, anxiety);
- body image problems and eating disorders;
- emotional health issues (e.g. stress);
- physical health problems (e.g. chronic pain, arthritis);
- gynaecological conditions;
- sexually transmitted infections;
- physical and mental health impacts of gender-based violence;
- preventable chronic diseases (e.g. diabetes, lung cancer, heart disease); and
- age-related morbidities (e.g. chronic diseases, osteoporosis, injuries from falls, dementia and Alzheimer's).

3.0 The meaningful measures

The conceptual framework presented and described above allows us to understand women's health in its full dimensions. Importantly, it enables us to identify the most critical aspects of women's health to be measured. This identification is important because 'what gets measured is what gets done' (see section 1.2 'Why focus on meaningful measures'?).

Not every aspect of women's health as shown in the conceptual framework need always be measured; salient elements are therefore the *prioritised* areas of the conceptual framework necessary for health policy makers and planners to comprehend – *at a minimum* – so that their work does not continue to overlook the social determinants of women's health and/or remain 'blind' to the structural drivers of gender hierarchies and inequities that shape women's daily living conditions and their health outcomes.

As this report makes clear, meaningful measures are specifically for use by population health planners and decision-makers, and the different emphases they will place on the different meaningful measures given the diversity of the populations they are planning for is acknowledged. The table and its contents are not meant to be an exhaustive set of measures of Australian women's health for health planners and decision-makers.

The following table includes the meaningful measures of Australian women's health that arose from the work of the think tank in prioritising certain elements of the conceptual framework. The table also includes links to available data sources for the meaningful measures, where these are currently known to exist. Fresh data sources will no doubt come into existence as national data custodians, such as the Australian Bureau of Statistics, continue to expand their output of gender-based statistics – particularly in the areas of women's experiences of violence and pay inequities. This means that the table of meaningful measures that follows is not static but rather a work-in-progress, to be continuously developed.

Salient element of women's health	As meaningfully measured by …	Data source
Demographics and diversity	Age distribution of women as a population group	Australian Bureau of Statistics Census Community Profiles Series, http://www.abs.gov.au/census Department of Immigration and Citizenship, Settlement Reporting Facility, https://www.immi.gov.au/settlement/
	Countries of birth of women and their age distributions	
	Aboriginal and Torres Strait Island identified women and their age distributions	
	Languages spoken at home and spoken English proficiency	
	Religious affiliation	
	Women with disabilities	Women's Health Victoria, The Index ('Demographics and diversity'), http://www.theindex.org.au/Data/DemographicsDiversity.aspx
	Same-sex attracted women	
Gender equality and women's empowerment	Meaningful measure requires further investigation; two possible options are: » United Nations Development Program's Gender Inequality Index, a composite measure reflecting inequality in achievements between women and men in reproductive health, empowerment and the labour market » OECD's Social Institutions and Gender Index, a composite measure of the root causes of gender inequality; for example, violence against women, access to public space, discrimination against women with respect to political participation	Data source requires further investigation; for the moment there is the Gender Inequality Index (data on Australia available) http://hdrstats.undp.org/en/indicators/68606.html and the Social Institution and Gender Index (Australia yet to be ranked) http://www.genderindex.org

Continued...

Salient element of women's health	As meaningfully measured by ...	Data source
Women in leadership	Ratio of women with seats in parliament compared to men (federal and state/territory)	Parliament of Australia, 'Representation of women in Australian parliaments', http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/2011-2012/Womeninparliament#_Toc318895764 Australian Bureau of Statistics, 'Gender indicators' http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4125.0main+features610Aug%202013
	Ratio of women at ministerial portfolios compared to men (federal and state/territory)	
	Ratio of women who are local government councillors compared to men	Contact the Australian Local Government Association, http:/www.alga.asn.au
	Ratio of women in executive and leadership positions in private, Government and Non-Government entities compared to men (and attendant remuneration received)	Equal Opportunity for Women in the Workplace Agency, Census of Women in Leadership, http:/www.wgea.gov.au Australian Bureau of Statistics, 'Gender indicators', http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4125.0main+features610Aug%202013
Social connection	Meaningful measure requires further investigation	Data source requires further investigation
Labour force status	Women's labour force status compared to men	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
	Women's mode of employment (full time or part time) compared to men	
	Women's occupations and industries compared to men	
Financial insecurity	Women's individual income compared to men	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
	Women's superannuation compared to men	Women's Health Victoria, The Index ('Economic and employment conditions'), http://www.theindex.org.au/Data/EconomicEmploymentConditions.aspx
	Current gender wage gap in Australia	economic Security4Women (eS4W) ('Gender pay gap measures') http://www.security4women.org.au
Unpaid work	Amount of time spent caring for dependent children compared to men	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
	Amount of time spent assisting a family member or other person with a disability compared to men	
	Amount of time spent on housework compared to men	
	Voluntary work undertaken by women compared to men	
Housing insecurity	Women experiencing homelessness and the reasons why	Australian Homelessness Clearinghouse ('Research and data') http://www.homelessnessclearinghouse.govspace.gov.au

Continued...

Salient element of women's health	As meaningfully measured by ...	Data source
Lone parenting	Number of female-headed households with dependent children compared to male-headed households	Australian Bureau of Statistics, Census Community Profiles Series, http://www.abs.gov.au/census
Gender-based violence	Population-based surveys on women's experiences of gender-based violence	Australian Bureau of Statistics, Personal safety survey, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/ =AA3C5529FE728CD3CA25794F0011DD51?opendocument Australian Longitudinal Study on Women's Health, http://www.alswh.org.au
Discrimination based on ethnicity, race, sexual orientation or disability	Meaningful measures for each of these forms of discrimination require further investigation	Data sources for each of these forms of discrimination require further investigation; for the moment, the Human Rights Commission Australia has research reports and publications, https://www.humanrights.gov.au/
Exposure to health behaviours/risk factors for poor health	Women's use of prescription medications Rates of smoking amongst women Rates of alcohol consumption and binge drinking	Australian Longitudinal Study on Women's Health, http://www.alswh.org.au
Morbidity experience	Years lived with disability (YLD) and their causes	Australian Institute of Health and Welfare, Burden of Disease http://www.aihw.gov.au Australian Longitudinal Study on Women's Health http://www.alswh.org.au
Sexual and reproductive health	Breast cancer screening participation rates Cervical cancer screening participation rates Human papilomavirus vaccination participation rates Abortion rates Fertility and infertility rates Communicable diseases Contraceptive use	Women's Health Victoria, The Index ('Sexual and reproductive health'), http://www.theindex.org.au/Data/SexualReproductiveHealth.aspx

4.0 Using the meaningful measures: Case scenario

Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation' (Marmot and Wilkinson, 2003: 11).

The following case scenario has been developed as a way of illustrating how the meaningful measures contained in this resource can be used for population health planning.

A population health planner in Melbourne's north is working with a range of partners on developing a strategy to promote the mental health and wellbeing of the local community. Drawing on evidence, they decide that a key action area in the strategy is to focus on enhancing pathways to economic participation for those who want to participate but experience barriers in doing so.

Using the meaningful measures table in this report, the planner builds a profile of the labour force status of men and women in the local area; and sees that a lower proportion of women participate in the formal labour force than men. These facts prompt her to consult with stakeholders (including community women) to find out more about what lies behind this pattern in labour force status.

The planner finds out that the local population has a relatively young profile, with many households that are families with dependent children. Moreover, in these family households, women have the primary role of caring for the children. The extent of this unpaid work means many women have not been able to return to paid employment since starting their families, even though they would like to resume their careers. The women believe that many employers will not offer the flexibility in working conditions they would need to re-enter the workforce. They also talk about how their work at home is not really valued by those around them, but rather expected of them; and that this is having a bearing on their sense of self and their mental health and wellbeing.

The planner finds out that the local population is diverse, too, with a sizeable group of newly-arrived women from non-English speaking backgrounds countries such as China, India and Sudan. She verifies this by using the meaningful measures table in this report to build a profile of newly arrived women. During her consultations with newly arrived women, she learns that discrimination is a common experience. Many have found it difficult to source employment and/or have their educational qualifications from their home countries recognised. Many feel they have not gained acceptance in the local community. The women talk about how all these factors combine to affect their self-esteem, confidence and overall mental health and wellbeing.

The planner reports these needs back to the partners she is working with on the mental health and wellbeing strategy. Together, they formulate a set of specific activities to enhance pathways to economic participation for community women, including:

- advocating for more affordable and accessible child care;
- promoting equal and respectful relationships between women and men that emphasise the value of shared parenting roles (rather than traditionally defined gender roles);
- running community education sessions on the Fair Work Amendment Act 2013 which strengthens employee rights to request flexible work if are caring for dependants;
- communicating messages that assist in empowering local women to ask employers for flexible working conditions; and
- implementing a best-practice micro-finance program involving the provision of short-term no-interest credit, small business training and financial literacy training to assist newly-arrived women from non-English speaking backgrounds to start up local enterprises.

5.0 Implementation steps

1. The AWHN *Women's health: Meaningful measures for population health planning* report will be disseminated through targeted distribution to its primary intended users with assistance sought from the AWHN membership, Australian Medicare Locals Alliance, Australian Local Government Association, Australian Health Ministers' Advisory Council and Commonwealth Department of Health and Ageing.
2. Population health planning experts will be asked to provide feedback to AWHN on their application of the conceptual framework and meaningful measures in this report, with particular reference to the questions below, to support their ongoing refinement:
    - How have you used the conceptual framework and women's health meaningful measures and was this effective?
    - Are there specific ways in which the conceptual framework and women's health meaningful measures can be improved? For example, are there other/different meaningful measures that should be considered as seminal to population health planning? Have you identified better examples of data sources for the meaningful measures?
3. Entities responsible for data capture and distribution will be asked to consider the data gaps for the meaningful measures identified in this report and provide feedback to AWHN on how these might be addressed.
4. Reported progress against the steps outlined above will be used by AWHN to support continuing promotion, refinement and improvement in women's health through population health planning.

To assist in the provision of feedback and AWHN's reporting of progress outlined in these implementation steps a questionnaire has been developed for use at Appendix A.

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Appendix A

AWHN Women's health: Meaningful measures for population health planning
FEEDBACK FORM

AUSTRALIAN WOMEN'S HEALTH NETWORK

Reported progress against the *AWHN Women's health: Meaningful measures for population health planning* resource's Implementation Steps (pg. 20) will be used by AWHN to support continuing promotion, refinement and improvement in women's health through population health planning. To assist in this work, population health planning experts and entities responsible for data capture and distribution are asked to answer the relevant questions below.

POPULATION HEALTH PLANNING EXPERTS

1. How have you used the conceptual framework and women's health meaningful measures and was this effective?

2. Are there specific ways in which the conceptual framework and women's health meaningful measures can be improved? For example, are there other/different meaningful measures that should be considered as seminal to population health planning?

3. Have you identified better examples of data sources for the meaningful measures?

ENTITIES RESPONSIBLE FOR DATA CAPTURE AND DISTRIBUTION

4. How might the data gaps for the meaningful measures identified in this report be addressed?

Please send your feedback to AWHN
by email to ceo@awhn.org.au or
by post to PO Box 188, Drysdale VIC 3222.

A Microsoft Word version of this feedback form is available for free download at: www.awhn.org.au