A Gender Agenda
Planning for a Diverse and Inclusive Community

A Resource Kit for Health Professionals
July 2002
A Gender Agenda: Planning for an Inclusive and Diverse Community

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Introduction
This kit aims to stimulate thought, discussion and debate about positioning gender as a central concept in understanding health and illness, and the impact of gender on the health of women and men as a central concern. This is for individual agencies and particularly for Primary Care Partnerships in their important roles in community health planning.

Many working in the health sector may feel that ‘gender’ has already been dealt with, in terms of women's issues in health that were put on the agenda commencing in the 1970s. Women's Health Services through their dual strategy continue to provide direct services to disadvantaged women and work with other health service organisations to improve the responsiveness of health services to the needs of women. Others may feel that men's health issues have been neglected, and need to be focused on now. This paper is based on the premise that whether the focus is on women and men, or specifically women or men, gender analysis and attention to gender in planning, implementation and evaluation will assist in better targeting and more responsive health campaigns and services.

The resource kit aims to raise questions about how gender, health and illness are related, without providing definitive answers to health issues. These must be sought in context specific situations, with a focus on particular groups and involving women and men in those groups.

Both biomedical research and research on social inequalities from the social determinants of health perspective have until relatively recently overlooked gender. Contemporary research findings and examples are used in the paper as illustrations of work that has had a focus on gender, drawn from studies and research in Australia, the United States, the United Kingdom and other countries.

The elements of a gendered approach are compatible with many of the current influences on health services and community health planning and promotion, including the emphasis on the rights of consumers, cost effectiveness, and quality in delivery of services.

Gender analysis is an important process to assist in planning and designing interventions promoting health in a diverse society. Gender analysis requires commitment, care and community based work. It may not mean a lot of ‘extra work’ for those already under pressure - but it does require consistent attention through all stages of planning, service delivery and evaluation. At this stage in the development of primary care partnerships and community health planning, there are many opportunities for greater attention to gender.
The Project
Planning for an Inclusive and Diverse Community proposal was developed by Women's Health West (WHW) to focus on the three Primary Care Partnerships (PCP) in the Western Metropolitan region of Melbourne. The three PCP's include Brimbank/Melton, Moonee Valley/Melbourne and WestBay. The proposal was funded by the Department of Human Services (DHS) as a Best Practice Service Improvement Initiative in the Gender Sensitive Service Delivery Practice funding round of December 2000.

The project focus was on the development of a gendered framework and planning tools for PCPs to assist and enhance gender-sensitive practices in community health planning. Community health plans are complex documents that have three main components: partnerships, service coordination and service planning. The focus of the project has been on two components: partnerships and integrated service planning components. The service coordination component was outside the scope of the project.

A project reference group comprising representatives from the WestBay, Melbourne/Moonee Valley and Brimbank/Melton PCPs and Women's Health Services in Melbourne met during the project life.

Project activities included a high profile forum held in November 2001, production of the resource kit materials, and presentations to several PCP working groups.

Overview of the resource kit
The kit includes:

Part One: Gender Analysis
This section provides a description of gender analysis including: key concepts, a framework and required data. It examines gender in relation to projects and programs, policy and organisations. This section forms the foundation for the remainder of the resource kit.

Part Two: Gender and Health
This section examines how gender relations influence health and illness. The interaction of biological (sex) differences and social (gender) factors, biomedical research, gendered exposures to risk factors, experience of injury and illness, diagnosis and treatment, and gender sensitivity in health services are covered. The later part of the section looks at gender issues in relation to the social determinants of health, including research on social inequalities, gendering the concept of social capital and implications for health promotion.

Part Three: Women's Health Policies
This section provides an outline of various initiatives and milestones in Victorian and Federal Government policy on women's health. The section starts with the beginnings of the women's health movement in the 1960s and 1970s. It includes information on the formation and development of the Victorian Women's Health Program and concludes with a description of the current Victorian Women's Health and Wellbeing Strategy.
Part Four: Primary Care Partnerships and Community Health Plans
This section covers three areas. The first area outlines the Primary Care Partnership strategy and the Department of Human Services requirements and expectations of PCPs. The second focuses on Community Health Plans, data and information used to date, PCP planning priorities and health promotion issues. The third is consumer, carer and community participation in the partnership component of community health plans.

Part Five: Key issues for PCPs in Developing a Gendered Approach
This section summarises the key points made in Part Four. It outlines four key conceptual foundations for PCP capacity building in relation to gender analysis and gender planning. In addition it identifies areas where PCPs can take action to plan from a gender perspective in the partnership and service planning components of community health plans.

Dipping in...
The resource set is a collection of a number of short discussion papers and may best be dipped into rather than read from beginning to end for those short of time or with particular interests. While Part Three can be read as a stand-alone section, Part One provides foundation for Parts Two, Four and Five.

If you are interested specifically in gender analysis:
Part One: provides the theoretical introduction,
Part Two: looks at how gender influences health,
Part Five: makes suggestions about how a gendered approach can be strengthened in primary care planning.

If you are interested in health promotion, look at:
Part One: including the headings: relationship between gender and other social identities, gender and social change;
Part Two: most of the section, the social determinants of health, health promotion and intersectionality.
Part Four: implications for health promotion.

If you are particularly interested in research and the evidence base:
Part One: data and information requirements, inclusive research,
Part Two: sex, gender and health, research and the evidence base, gender bias in medical research and researching gender inequalities in health.

If you have an interest in consumer and carer participation:
Part One: indicators of gender equality in Australia (including the box on gendered responsibilities and multiple roles), gender and other social identities, gendered organisations
Part Two: consumer, carer and community participation in PCPs.

For those concerned specifically with PCPs and primary care planning, it is suggested that Part One be read in conjunction with Part Four. Part Five provides a summary of key areas where PCPs can take action to promote gendered planning.
Resource materials
There are two types of resource materials included in the Kit. First there are three short research papers on gender and three relevant health issues. The issues are: smoking, depression and cardiovascular disease. Second there are 17 specific analytical and practice tools to assist practitioners and planners with gender analysis, planning and evaluation.

Gender and Health Concerns
The three research papers on gender and three health issues, are designed to challenge common assumptions and identify areas where gender issues could be further considered. They are not intended to provide an up to date summary of current knowledge or the latest research, but rather provide a basis for discussion and further attention to gender aspects. It is of interest that even in these three national health priority areas in Australia there are many aspects of the influences of sex and gender on risk factors, disease prevalence, diagnosis, experience of illness and treatment/recovery are not well researched or initially examined.

Tools
The tools in the Kit have been selected as good examples of practical tools developed and used by a range of organisations to improve attention to gender issues and promote gender analysis in their own work. They provide a starting point for those involved in the primary care sector to look at how to focus on gender more systematically. A tool is best designed for a particular purpose and developed with the involvement of those people who will use it. It is hoped that agencies and PCPs will be able to adapt some of these to suit their particular purposes.

Some of the tools can be used for carrying out an overall assessment of organisational practice - a gender audit - of agencies or Primary Care Partnerships themselves. Others provide guidance in policy development and in consumer and carer consultations and participation. Many of the tools are applicable to the design, implementation and evaluation of health projects and programs.

Some of the tools focus on women, others address both women and men. Most of those that have a primary focus on women could be adapted to include similar questions about men.

A range of other gender tools and resources are available in various publications, and the Internet has a wealth of resources available relating to gender, including gender and health issues. Some of these are listed in a section on useful websites at the end of the kit.

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<table>
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<th>Participation and Consultation</th>
<th>Project and Program Planning Cycle</th>
<th>Quality Improvement</th>
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<tbody>
<tr>
<td>InterAction - Checklist for Gender Integration in Programming and Management</td>
<td>*</td>
<td>* participation and consultation strategies section</td>
<td>* program, projects, activities and procedures</td>
<td>* Building capacity section</td>
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<tr>
<td>Juliet Hunt - Understanding Gender Equality in Organisations: A Tool for Assessment and Action</td>
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<td>NOVIB - Organisational Gender Diagnosing</td>
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<td>SIDA - Organizational Change and Equality between Women and Men</td>
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<td>Sue Dyson/Women's Health in the South East (WHSE) -</td>
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<td>Sue Dyson/WHSE - Diversity Snapshot</td>
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<td>United Nations Development Program Gender Analysis - What to Ask</td>
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<td>AusAID - Identification and Preparation</td>
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<td>AusAID - Implementation and Monitoring</td>
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<td>AusAID - Evaluation</td>
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<tr>
<td>#Asian Pacific Resource Centre for Women (ARROW) Checklist for Women-centred Design</td>
<td>* needs and review sections</td>
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<tr>
<td>#ARROW - Women-centred and Gender-sensitive Program Management Cycle</td>
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<tr>
<td># ARROW - Checklist to Determine how Gender Sensitive is a Health program</td>
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<td>Pan American Health Organisation (PAHO) - Guidelines for Project/Program Analysis</td>
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<td>Status of Women Canada - Extract from Discussion Paper on Approaches to Consultation</td>
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<td>Ministry for Women's Affairs, New Zealand - Guidelines for Action</td>
<td>* policy development</td>
<td>* consultation section</td>
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Executive Summary
The resource kit is composed of five major parts:
Part One: An introduction to gender analysis
Part Two: Gender and Health
Part Three: Women's Health Policies (National and Victorian)
Part Four: Primary Care Partnerships and Community Health Plans, and
Part Five: Key Issues for PCPs in Developing a Gendered Approach.

Overview
Gender analysis makes women and men in different population groups visible and facilitates awareness of how different groups have different needs.
Gender perspectives need to be more strongly integrated into all policy, planning, service delivery and evaluation, including:
policy
programming and planning
service delivery
consumer participation
quality assurance (including monitoring and evaluation)
at institutional levels, within the individual member agencies and PCPs.

Gender, Biology and Health
Gender refers to ‘women’s and men’s roles and responsibilities that are socially determined’. Gender relations change over time and vary among cultures and particular groups in a society. Sex refers to the biological and physiological differences between women and men's bodies.

Sex differences in symptoms, progression and response to treatment have been identified in a range of conditions and diseases. These sex differences are often poorly understood due to limitations in clinical trials and a lack of consideration of sex and gender influences.

Gender has tended to be neglected in research on social inequalities and within the social determinants of health perspective.

A Gender Analysis Framework
Gender analysis is a specific form of social analysis. A gender analysis explores and highlights the relationships of women and men in a particular community or society, and the inequalities in these relationships. Gender analysis looks at:
1. Gender division of labour and responsibilities, in relation to: production or employment practices, reproduction, household and community services, community management and politics
2. Access and Control of Resources and Benefits
3. Analysis of factors and trends influencing the gender division of labour and access to resources
4. Program Cycle analysis: considering the above factors in all stages of planning, implementation and evaluation of programs and projects.

Gendered data for planning
Quantitative data that is broken down into comparative data on women and men (‘sex disaggregated data’) is a fundamental requirement for effective planning. Aggregating women and men into one unit such as ‘people’ or ‘households’ will make any gender differences invisible. Qualitative data obtained through participation and consultation with women and men on their perceptions, priorities and needs is crucial.

Gender analysis and diversity
Gender roles and relations vary among different groups in Australian society, and change over time. Gender relations are dynamic and interact with other social identities and inequalities. Men
and women as population groups are diverse in regard to age, class, race, culture, poverty and socioeconomic status, sexual orientation, ability and isolation. Gender interacts with other social identities and inequalities including social class, race, ethnicity etc. Every person exists in a framework of multiple identities.

**Gendered Policy and Programming**

Gendered approaches are embedded in policies, programs and plans. In contrast to gender aware policies, gender-blind policies make a number of assumptions, recognise no distinction between the sexes and are often implicitly male-biased. ‘Mainstreaming’ refers to the integration of gender concerns into the analyses, formulation and monitoring of policies, programs and projects, with the objective of ensuring that these reduce inequalities between women and men. Organisations and institutions are also gendered.

**Gender Influences on Health**

Gender differences (related to differing gender roles and responsibilities, access to and control over resources and social expectations) can influence both women and men's:

- exposure to risk factors
- access to and understanding of information about disease management, prevention and control
- subjective experience of illness and its social significance
- attitudes towards maintenance of one's own health and that of other family members.

Gender factors can be protective or risk enhancing in relation to health and must be considered to develop effective health promotion. The understandings of women and men themselves are critical for informing health promotion and service planning.

**Gender Relations in Australia**

Despite formal equality between women and men, there are still significant differences in the status, roles, responsibilities and access to and control over resources between women and men in Australia. Gender roles, responsibilities and social expectations continue to play an important role in shaping life choices and circumstances.

**Gender and Health Policy in Australia**

The women's health movement in the 1960s and 1970s led to the development of stand-alone women's health centres and the development of the National Women's Health Policy in 1989. The Victorian Women's Health Program came into existence in 1987. Women's Health Services have a dual strategy - provision of direct services plus influencing other service providers - to improve the responsiveness of the health system to women's needs.

**Primary Care Partnerships (PCPs)**

The Primary Care Partnership (PCP) strategy was introduced by the Victorian Government in 2000. PCPs prepare Community Health Plans which cover service planning, partnerships and service coordination.

The specific needs of particular population groups are identified in order to address those with particular needs. However, gender has tended to be considered in a partial way by Department of Human Service and by Western Region PCPs.

**Strengthening PCP Gender Planning Capacity**

Four conceptual understandings are the foundations for PCP capacity building:

- Gender is a cross cutting issue. Gender needs to be considered in all analyses of population groups and health and illness issues.
- Gender neutral terms and categories (people, clients, consumers, carers, communities) can make invisible differences among groups of women and groups of men. Categories used should be examined to identify who is included, and who is not.
- Sex disaggregated quantitative data must be consistently collected and analysed to see if there are any patterns of variance in key indicators between women and men among particular groups. Qualitative information on the perspectives and priorities of diverse groups of women and men is
required to map service provision, identify areas of need, determine priorities and monitor and evaluate services from a gender perspective.

There is no blueprint for incorporating gender perspectives and analyses into primary care planning, policy and programming. A combination of strategies and entry points is required. High level commitment and planning by PCP and agency staff, allocation of resources (including specialist expertise and staff development) is required.

**Actions Identified for Western Region PCPs to plan from a gender perspective:**

<table>
<thead>
<tr>
<th>Health Plan Section Component</th>
<th>How To Strengthen PCP Gender Planning Capacity</th>
<th>PCP ACTIONS/PRACTICES</th>
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</thead>
<tbody>
<tr>
<td>Partnerships Section: Consumer and Carer Strategy</td>
<td>Ensure that participation of consumers and carers includes diverse groups of women and men</td>
<td>Community consultation practices are resourced and tailored to the diversity of the community and involve women and men. Checklist survey/audit tools amended to collect sex disaggregated data and identify diversity of those participating as consumers and carer representatives in various mechanisms</td>
</tr>
<tr>
<td>Service Planning Section: Integrated Service Plan (ISP)</td>
<td>Sex disaggregated data consistently collected and analysed. Qualitative information from diverse groups of women and men inform identification of needs, gaps and priorities. Cross Alliance ISP Matrix revised to direct attention to gender across the four life stages.</td>
<td>Sex disaggregated data consistently used for PCP planning. PCP program for collection of qualitative information from diverse groups of women and men to inform identification of needs, gaps and priorities. Cross Alliance ISP Matrix revised (for sex disaggregated data) and in use. Workforce development in areas of gender planning, gender and health.</td>
</tr>
<tr>
<td>Service Planning Section: Health Promotion</td>
<td>Gender perspectives incorporated into health promotion strategy and projects.</td>
<td>Gender aspects identified for health promotion (HP) issues. Action research and peer education models used for health promotion projects. Sex disaggregated data kept for all HP projects and activities. Workforce development: health promotion and gender.</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>Ensure gender is explicitly included in population profiles, health conditions/issues, in data collection and analysis, priority setting, monitoring and evaluation.</td>
<td>Establish gender leadership group to facilitate sharing of lessons learned and best practice re. gender sensitive methodologies and experience across the Western Region. Workforce development in gender sensitive approaches to evaluation.</td>
</tr>
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</table>
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Glossary of Key Terms

**Gender**: the socially constructed roles and relationships between women and men. Unlike biological differences that are the same throughout the human race, gender categories, behaviour and roles are learnt, it differs among cultures and social groups and changes over time.

**Gender analysis**: is a specific form of social analysis, which explores the relationships of women and men in a society or community. This is achieved by looking at the allocation of roles and responsibilities, along with access to and control over resources between men and women. A gender analysis should be applied at each stage of the project planning, implementation and evaluation cycle.

**Gender analysis framework**: a method of research and planning promoting gender issues.

**Gender division of labour**: Women and men have multiple work roles and responsibilities, both in the paid workforce and in unpaid work in the family, household and community. Some tasks or occupations have been historically and culturally defined as ‘women's work’ or ‘men's work’. There may be different patterns for women and men in relation to four key areas: productive work: paid employment or farming, reproductive work: pregnancy, childbirth, child rearing, household and community services, activities which must be carried out daily to meet family basic needs, community management and political activities.

**Gender redistributive (or gender transformative) policies**: transform existing distributions of power and resources to create a more balanced relationship between women and men. The policies may focus on strategic gender interest and target both women and men or women or men separately.

**Gender-blind policies**: recognise no distinction between the sexes, the policies may make a number of assumptions and are often implicitly male-biased.

**Gender equality**: that men and women enjoy the same status. Gender equality means that women and men have equal conditions for realising their full human rights and potential to contribute to national, political, social and cultural development and to benefit from the results.

**Gender equity**: is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field.

**Gender Planning**: refers to both short and long term goals as to how projects and programs may bring about greater equality between women and men.

**Gender relations**: refers to the relative position of men and women in the division of resources and responsibilities, benefits and rights, power and privilege. The use of gender relations as an analytical category shifts the focus from viewing women in isolation. The term acknowledges that the category within women and men’s experience emerges from a historical patriarchal positioning of women as secondary to men.

**Mainstreaming**: the integration of gender concerns into the analyses, formulation and monitoring of policies, programs and projects, with the objective of ensuring that these reduce inequalities between women and men.

**Practical gender needs**: relate to inadequacies in living or employment conditions of women or men that can be improved without challenging structural and gendered inequities.
**Sex:** refers to biological differences: genetic, physiological and biological between women and men. These are the same throughout the human race and do not change over time.

**Sex disaggregated data:** is statistical information that compares the situation of women and men by giving numbers of males and females in a given population. Without sex disaggregation of data, it is not possible to see if there are any patterns of variance in key indicators between women and men.

**Strategic gender interests:** are concerned with gender divisions of labour, power and control in society. Addressing strategic gender interests involve challenging the existing unequal relationships between women and men and promoting greater equality between women and men.

**Bibliography**


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PART ONE: Introduction to Gender Analysis

Overview
Part one sets the scene and introduces key concepts and perspectives for gender analysis. It provides a gender analysis framework and covers information, data and research approaches for gender analysis. Gender analysis can be applied to projects and programs, policy and organisations. The section ends with an overview of selected gender analysis tools included in the resource set.

This section provides the framework for the more detailed consideration of gender and health issues which will be examined in Part Two and a gendered perspective on primary care partnerships and community health planning in the Western Region of Melbourne in Part Four.

Gender and Gender Analysis
The term ‘gender’ refers to socially constructed roles and relationships between women and men. These roles and relationships are learned, change over time and vary within and between countries and cultures.

Gender is one of the principal sources of power and inequality in most societies. Gender operates at an individual level through gendered identities, in relationships between women, men, boys and girls. In addition, gender influences and is influenced by social institutions including families, the market and the state. Government policy making and resource allocation is gendered in its impacts, even if not explicitly recognised in its development.

Gender analysis is the term for a specific form of social analysis focusing on gender.

Gender Analysis
Gender analysis ‘explores and highlights the relationships of women and men in society, and the inequalities in these relationships, by asking: Who does what? Who has what? Who decides? How? Who gains? Who loses? When we pose these questions, we also ask: Which men? Which women? Gender analysis breaks down the divide between the private sphere (involving personal relationships) and the public sphere (which deals with relationships in the wider society). It also looks at how power relations within the household interrelate with those at the international, state, market and community level’ (March, Smyth and Mukhopadhyay, 1999: 18).

Gender analysis can be applied to policy and legislation, projects, programs, sectoral and national development plans.

Governments, international organisations and non-governmental organisations use gender analysis as process that assists in better targeting, planning and implementation of interventions. Gender analysis can help develop relevant and effective policies and services that are focused on the needs of diverse women and men.
Key Concepts: Sex and Gender

**Sex** refers to the biological differences between women and men. Sex differences are concerned with men and women's bodies. There are multiple sex difference criteria - chromosomes, gonads, external genitalia, internal structures and hormone profile. Women bear and breastfeed children whilst men produce sperm. Sexual differences are the same throughout the human race.

The term **gender** 'refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of our biological differences' (WHO, 1998: 5-6). The experience of how men and women are socially constructed can vary considerably from culture to culture.

While 'sex is a fact of human biology; gender is not. The experience of being male or female differs dramatically from culture to culture. The concept of gender is used by sociologists to describe all the socially given attributes, roles, activities and responsibilities connected to being a male or a female in a given society. Our gender identity determines how we are perceived and how we are expected to think and act as women and men, because of the way society is expected to think' (March, Smyth, Murhopadhyay, 1999: 18).

The following quote illustrates some of the different social expectations of women and men that influence behaviour, relationships, workforce participation and division of family responsibilities, from the perspective of a young woman the Western Region of Melbourne:

### Being a girl in the West

'We have our advantages and disadvantages. The advantages are that we don't really have to do much because we aren't really expected to. The bad thing is that we have to worry about everything like our periods and not getting pregnant, making sure we have safe sex because most males don't really care if sex is safe or not. We also have to get married and when we have kids give up our careers and males still get to work…

Some girls are way too 'girly' and don't get out there because they don't want to break a nail. Then you get girls, like me, who just don't give a crap about what other people think and are willing to give anything a try. Most guys feel threatened… because I think we come on a bit strongly… Most women are expected to cook, clean and look after the kids. I would much rather be the one going out and getting a job and bring in good pay, pocket some and pay my own bills' (anonymous author cited in Women's Health West, 2002: 145).

### Women, Men and Gender Relations

What is considered ‘masculine’ and what is considered ‘feminine’, desired personal characteristics, appearance, behaviour and appropriate work and leisure activities for women and girls, and for men and boys can be quite different within a particular culture or society.

Gender socialisation starts at an early age, as indicated by the following account:
Luke and Kezia

Luke and Kezia were twins, 10 days old. We were to take them to the doctor for their first 10 day check. I dressed one in pink and the other in blue.

After the first few people we met I became aware of a clear difference in the way people related to each twin. Kezia was prodded in the chest, her head touched, patted even, or she was chucked under the chin, ‘Who's a bit little chap then’, ‘You can see he's like his Dad’ were the comments largely addressed to me.

Luke, yes you're right, he was dressed in pink, was rarely touched but he was spoken to, ‘Aren't you a beautiful little one then?’ There was eye contact made. Voices were softened. It sounded as if he was about half her weight although they were both the same’ (Watts (1995), cited in Luck, Bamford and Williamson, 2000: 41).

Gender relations

refers to the relative position of women and men in the division of resources, responsibilities, benefits and rights, power and privilege. As an analytical category, gender relations emphasises the importance of viewing women and men in terms of the interdependencies and relationships, rather than viewing women or men in isolation (International Women’s Tribunal Center, 1997).

Gender analysis directs attention to social institutions and structures that reinforce and perpetuate gender relations. Gender-based divisions of labour (in both the paid workforce and in unpaid family and community work) and differing responsibilities among women and men are a key focus of attention:

A society where women and men are equal …

[With the exception of childbearing], ‘only in a society where men and women constitute unequal genders is there any reason why gender should be an important organising principle of the social division of labour…For nothing in the fact that women bear children implies that they exclusively should care for them through their childhood; still less does it imply that women should feed and care for adults, nurse the sick, undertake certain agricultural tasks or work in an electronics factory. A society where women and men were equal would be one where the arbitrary fact of sexual difference did not mark out the possibilities and limitations of economic activity for the individual’ (Mackintosh, quoted in Canadian Council for International Co-operation, 1991: 16).

Gender roles and relations are rarely equally balanced. Women and men often undertake different tasks both in the home and in the paid workforce, and in community and political spheres. Women and men generally do not have equal access to and control over resources including money, credit, employment, information, education, power and influence, leisure time.

Work that has traditionally been undertaken by women has often not been valued in the same way that men's work is. For example, unpaid work in the home or community is often not counted in national accounting systems and not included in national economic statistics such as Gross National Product. This absence is despite the necessity of such this unpaid work, which enables others to undertake what is considered ‘productive work’. Likewise occupations or industries that are seen as ‘women's jobs' often offer lower pay and are less highly regarded than ‘men's jobs'.

Historically, attention on gender tended to focus on 'gender as difference' - differences between women as a single group and men as a single group. This has gradually been replaced with a focus on ‘gender as diversity’, reflecting that the social relations of gender are complex, and that there are considerable variations and differences among women as a group and men as a group.

Early writing on gender in Australia tended to be in terms of ‘roles', often referring only to ‘male' and ‘female' roles. However it has increasingly been recognised that sex role theory can underestimate the diversity of gender patterns, and overlooks power relations and the economic dimensions of gender. Likewise, ‘socialisation' theories tend to miss the active process through
which children grow and develop, and the energy with which people embrace or reject conventional gender models. Increasingly writers on femininity and gender issues now talk about femininity and masculinity being expressed in various forms, recognising that in each society there are diverse ways in which women and men choose to construct their gender identity, with reference to particular groups and institutions. Don Sabo points out that ‘gender identity and behaviour are not simply imposed on individuals by socialisation… individuals actively construct their gender identity and behaviour. Gender identity is actively worked out, revamped and maintained by individuals who are immersed in socially and historically constructed webs of power relations’ (Sabo, 1999: 4).

**International and Human Rights Perspectives**

In the 20th century there was considerable progress in recognising that both women and men are entitled to enjoy the same human rights and fundamental freedoms. The Universal Declaration of Human Rights, the major human rights conventions on civil and political rights, and on economic, social and political rights, the Convention on the Elimination of Discrimination Against Women (CEDAW) all include equality between women and men as an international standard that is fundamental to human rights.

Governments around the world (including Australia) have signed these conventions and made commitments to the goal of gender equality and women's empowerment. The International Conference on Population and Development in Cairo in 1994 recognised the importance of gender equality in sexual and reproductive health. Women’s rights and the obstacles to gender equality were identified across 12 critical areas (including health) in the Platform for Action adopted at the Fourth World Conference on Women held in Beijing in 1995.

The following is an extract from the Platform for Action concerning gender equality and women's health:

**Women's Health and Gender Equality**

‘Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and wellbeing and their ability to participate in all areas of public and private life.

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical wellbeing and is determined by the social, political and economic context of their lives, as well as biology. Health and wellbeing elude the majority of women. A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups.

In national and international forums, women have emphasised that to attain optimal health throughout the life cycle, equality, including the sharing of family responsibilities, development and peace are necessary conditions’ (United Nations, (1995: Chapter IV, Part 89).

Despite increased awareness of gender inequality and considerable progress in recent decades, there is a considerable body of work in both developing and developed countries that demonstrate that gender inequality and gender discrimination remain pervasive in many dimensions of women’s lives - world wide (World Bank, 2001).

**Indicators of Gender Equality in Australia**

In Australia women enjoy the same rights in law as men. Barriers to women's equal participation in many areas of life have been significantly addressed in the last forty years. This makes it easy to overlook that in a number of domains women and men are not yet equal, as revealed by differences in employment patterns and income, unpaid work and family responsibilities, and participation in decision-making and leadership positions.
Gender analysis focuses on gender relations and inequalities in a number of domains (as outlined below in a gender analysis framework). The boxes on the following pages present a snapshot of gender equality indicators in Australia:

**The gendered nature of the Australian workforce**
In March 1999, 50 per cent of Australian women were in paid work, constituting 40 per cent of the Australian workforce.
As casual employment has increased from 13 per cent in 1982 to 26 per cent in 1996, and part time employment increased from 15 per cent to 25 per cent over the same period, women have been consistently over-represented among casual workers. Women make up 72.4 per cent of all part time workers and 63 per cent of all casual workers. 32 per cent of all working women are employed as casuals.
There is endemic gender segmentation of the workforce with women working in a restricted range of industries and occupations.
Women workers are mainly concentrated in two industries: retail trade and health and community services. Women make up a majority of workers in two other industries: education, and accommodation, cafes and restaurants, and constitute a significant sector in manufacturing (26 per cent).
Even within these industries, after 30 years of equal pay in principle, women are further concentrated in a narrow range of **occupational categories at lower levels of status and pay**. In 1999, comparing the **earnings** of all employees, women earned 66.3 cents to men's $1; if only full-time workers are considered, women earned 80.5 cents to men's $1.
Women make up only 8 per cent of private sector boards, 10 per cent of non-executive directors and 1 per cent of executive directors (Women's Rights Action Network Australia, 1999).
Gendered responsibilities and multiple roles
Women undertake 70 per cent of the unpaid work in Australian households and are more likely than men to reduce or leave paid employment to fulfil these responsibilities. The amount of time women spend on housework and childcare varies substantially during their lifecycle, peaking in the childbearing and early child rearing years. Men, on the other hand, do more or less the same amount of domestic tasks throughout their adult lives. Family caregiving, the home based care of ill, frail, elderly or disabled family members, is a responsibility that falls disproportionately on women. The overwhelming majority of unpaid carers (nearly 80 per cent) are women. Women's Health Australia found that trying to meet the on-going demands of multiple responsibilities can take a toll on the physical, mental and emotional health of women carers (Lee, 2001: 146-152).

Violence against women
23 per cent of women who have ever been married or in a defacto relationship have experienced violence by a partner at some time. Only 19 per cent of women who were physically assaulted and 15 per cent of those who were sexually assaulted reported the incidence to the police. The Women's Safety Survey found that, of women who had been physically assaulted in the previous 12 months, 58 per cent spoke to a friend or neighbour about the assault, 53 per cent spoke to a family member, 12 per cent spoke to a counsellor, 4.5 per cent spoke to a crisis centre. A high proportion of women accessing non-domestic violence services state abuse or violence as the reason: 40 per cent of adults accessing Supported Accommodation Assistance Program services gave violence or abuse as the reason (Australian Bureau of Statistics, 1996).

Gender overview of Australian politics 2001
Commonwealth Parliament per cent women
House of Representatives 23.0
Senate 28.9
State/Territory Parliaments
Victoria 25.8
NSW 20.0
Queensland 19.1
Western Australia 22.0
South Australia 27.5
Tasmania 11.8
Australian Capital Territory 16.0
Northern Territory 22.4
Local Government 25.3
(Sawer, 2001).
Gender Equality and Gender Equity

The terms gender equity and gender equality are used in different settings with differing understandings about both terms. The definitions and understandings used in this paper originate from those outlined below by Status of Women Canada:

Gender equity is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantage that prevent women and men from otherwise operating on a level playing field. Equity leads to equality.

Gender equality means that women and men enjoy the same status. Gender equality means that women and men have equal conditions for realising their full human potential to contribute to national, political, social and cultural development, and to benefit from the results.

Originally, it was believed that equality could be achieved by giving women and men the same opportunities on the assumption that this would bring sameness of results. However, same treatment was found not necessarily to yield equal results. Today, the concept of equality acknowledges that different treatments of women and men may sometimes be required to achieve sameness of results, because of different life conditions or to compensate for past discrimination (Status of Women Canada, 1997: 9).

The achievement of gender equality implies changes for both women and men. Internationally it has been recognised that it is important to build alliances and work with men to address inequalities in women's status.

The story of the fox and the crane:

Equal treatment does not mean the same treatment

The Fox invited the Crane to dinner. He served the food on a large flat dish. The Crane with her long, narrow beak could not eat. The Crane invited the Fox to dinner. She served the food in a deep vase, and so the Fox with his short, wide face could not eat. Both friends had an equal opportunity for nourishment, but each time one of them could not take advantage of the opportunity (UNDP, 2001, Resource 29: 109).

Gender analysis to date has tended to focus on women because women are disadvantaged in relation to social and economic resources and decision-making. Efforts to identify and redress imbalances have focused on women's situations and women's views. Gender analysis can also be used to focus on men. Gender relations and the wider social context needs to be brought into view whether the focus is primarily upon women, men or both women and men.

Social ideologies and interventions may impact differently on women and men, and services or programs may be targeted specifically to women or men. In working for equality of outcomes among women and men, it is not necessarily the case that the same services or approaches will be appropriate for both women and men.
Relationship between Gender and Other Social Identities
At times, gender analysis is (mis)understood to be simplistic, viewing all men and all women as the same. It is important to recognise that women and men as groups are not homogeneous. It is necessary to use gender analysis in a way that makes visible not only women and men, but also the diversity that exists among groups of men and groups of women. Gender interacts with other social identities including social class, race and ethnicity. Each person exists in a framework of multiple identities. Dorothy Broom points out that ‘a person is not black at one moment and male the next: he is always a black male (among many other things).….Gender is an aspect of each person's individual experience and social life’ (Broom, 1999: 54).

Gender relations must be seen as a part of other power relations and imbalances in society. The assumption that all women always have a single interest is false. Women and men are diverse in many regards including age, class, race, culture, sexual orientation, ability and geographical location.

Gender, race, class and age are ‘socially constructed classifications rather than static or immutable properties of individuals. Such classifications are shaped by, and in turn shape, not only individual actions and interactions but also institutional arrangements and processes… In addition to being individuals' socially constructed sociopolitical locations, the categories are also designations of group power relations, foundations for social organisation and features of social policy’ (Dressel, Minkler and Yen, 1997: 583).

In specific reference to health issues, we can identify that differences in health attitudes, health behaviour, health care needs, access to curative and preventative health care services, and treatment by health care providers have been found between older and younger women, women of minority and majority groups, low income and high income women, women in the paid workforce and homemakers, lesbian and heterosexual women, and women suffering from specific physical or mental health problems (Gijsbers Van Wijk, Van Vliet and Kolk, 1996: 709).

Gender cross cuts all population groups

Gender cross cuts all population groups
‘Gender….cross cuts all population groups in ways that affect its meaning and significance. That is, gender is multiple (more than two). For health and social services, this is particularly important since we must consider people who may be vulnerable because of geography, ethnicity, race, class, religion, sexuality, age or ability. But all these categories intersect with gender. When the categories are oversimplified and we concentrate on only one at a time, many important issues will become invisible. For example, some non-English speaking women may have disabilities; there are gay men in prison; the very meaning of ‘old’ is different for Kooris because of their shorter average life spans. Effective strategies require an appreciation of the diverse factors shaping the health of real people (as opposed to statistical categories)' (Broom, 2001: 6).

Gender and Social Change
Social, cultural and general relations are not fixed and immutable. As social constructs, gender roles vary from group to group within a society and change over time. In even the most homogeneous society, it is recognised that gender relations and culture are constantly changing. Differing interpretations of gender roles and responsibilities may exist within people from within the same social, cultural, ethnic, class background at the one time.

A number of gender related social changes have been identified in Western societies over the last 30 years in particular, including changes in patterns of employment, education, family and household structures, and the relationship between home and work. The changes are complex and subject to diverse explanations concerning the relative importance given to different factors, including, for example, economic changes, changes in attitudes, changes in power.
Time use studies have often found that while men may take on more domestic work when their partner is in paid employment, it does not necessarily equalise the amount of work carried out by men and women. It remains to be seen whether there is a process of ‘lagged adaption’ as changes in gendered division of household work ‘catch up’ with changes in men's and women's paid employment.

Research in the 1970s and 1980s tended to find that previously married people tended to have the worst health, while married people (particularly men) had better health than single people. However given changes in marriage patterns and divorce, it may be that these findings no longer hold (Annandale and Hunt, 2000: 15).

In a diverse society such as ours, friction can be caused by changing expectations across generations, between the sexes and within different groups (WHAV, 2001: 2). Analyses need to be grounded in the perceptions and perspectives of diverse groups of women and men, not only ‘experts’. Gender analysis provides a framework to seek the perspectives and information on gender roles, relations, responsibilities and access/control issues amongst different groups of women and men.

A Gender Analysis Framework

A ‘gender analysis framework’ is generally understood as a ‘method of research and planning for assessing and promoting gender issues in institutions’ (March, Smyth, Mukhopadhyay, 1999: 11). There are a number of different frameworks (see March et al for an overview), which have common features such as the recognition of reproductive activities and productive work. However gender analysis frameworks also differ in their scope and emphases. The choice of the most appropriate framework will depend on the task at hand, the context and the resources available (March et al, 1999: 22).

The following framework is based on the work of Caroline Moser and developed by Juliet Hunt (Hunt, 2001: 25-28). It contains key terms and concepts for gender analysis, and is a four step process:

1. **Gender division of labour and responsibilities: who does what?**

   Women and men often have different economic and social roles and responsibilities, within the household, in employment and in community affairs. Men and women often have multiple roles, all of which must be taken into account.

   **Gender roles and responsibilities** of women and men need to be considered in relation to:
   - Production - employment (paid work) in the formal sector of the economy (and where applicable, activities in the informal sector of the economy)
   - Reproduction - contraception, pregnancy, childbirth, breastfeeding, child rearing
   - Essential household and community services - including care of the sick and elderly, household tasks, such as food preparation, shelter, cleaning, laundry
   - Community management and politics - including cultural and religious ceremonies, political participation.

   Data about the work women and men actually do can be presented in an activity profile to identify similarities and differences.

   An analysis of the gender division of roles and responsibilities should be undertaken for each of the socio-economic and/or ethnic groups affected by a program or project.

2. **Access and Control of Resources and Benefits: who has what?**

   An access and control profile collects information on:
   - what access women and men have to productive resources (land and natural resources, labour, capital/credit, information, education and training)
   - what control they have over these resources
who benefits from the use of these resources.

Where a project or a service introduces new resources (information, training, assets, other resources), these resources also need to be considered in relation to which groups of women and which groups of men will have access to and/or control over decision-making and use of these resources.

3. Analysis of Factors and Trends: what factors influence the gender division of labour and access to resources?

Demographic, economic, political, social and cultural factors influence the gendered division of labour, which has to be viewed as a dynamic and changing over time.

Critical questions are:
what key factors - past, present and future - influence and change gender relations, divisions of work, and access to and control over resources?
what constraints and opportunities do these factors present for promoting gender equality and the empowerment of women?

4. Program Cycle Analysis: analysing and applying all of the above information to all stages of the program cycle.

Data collection, participation and consultation with communities should be undertaken not only prior to a project or program at the design stage, but also during monitoring, management and evaluation.

Participation and consultation with women and men on their perceptions, priorities and needs is crucial, rather than ‘deskbased’ integration of how women or men should be integrated into programs and projects, without seeking their views or involvement (Hunt, 2001).
Good Practice Tips for Gender Analysis

Gender analysis
is a process to be adapted, depending on the context and purpose
takes account of other variables which intersect/interact with gender (age, class, ethnicity/race)
involve stakeholders and the views and experiences of the women and men concerned
must take account of changes that happen over time
analyses both the social relations between women and men at a micro level and the structural features of society that reinforce gender inequality both needs to be analysed.

Beware of:
global generalisations and ‘universal relationships’
assumptions and stereotypes
generalities: be specific about which women and which men and in which contexts.
Data and Information Requirements

All methods of data collection whether quantitative or qualitative, participatory or non-participatory can be gender sensitive or not depending on how they are designed and applied.

Central to gender analysis is the collection, analysis and application of sex disaggregated data, statistical information which compares the situation of women and men. Sex disaggregated statistics give straightforward numbers of males and females in a given population. If we were comparing men and women’s workforce participation we would need to unpack the existing data.

While there have been many improvements in the collection and availability of sex-disaggregated data, it is still not the case that sex disaggregated data is routinely collected or available. Without sex disaggregation of statistical data, it is not possible to see if there are any patterns of variance in key indicators between women and men, for example, in waged employment in a particular industry or sector, or the year 12 retention rates.

Gender statistics provide factual information about the status of women, for example a change in their status over time (UNDP). They do not have to be disaggregated by sex, for example: ‘25 per cent of married women report experiencing domestic violence at least once in their lives’; or, in Victoria the percentage of female local councillors increased from 6.9 per cent in 1980 to 20 per cent in 1994.

Qualitative data and information is highly valued in gender analysis. Statistical data may not be able to present an adequate picture of what the real life situation may be for particular groups. For these reasons, seeking the involvement of women and men in defining the issues and presenting their perspectives is considered vital in undertaking a thorough gender analysis.

Qualitative data can be valuable for its explanatory power, and can help explain why women and men behave in particular ways or make particular choices. Qualitative analysis looks at how and why, the dynamics, motivations and interactions of people’s experiences. Qualitative data may indicate problems with the provisions of services and with quality issues that are not illustrated by quantitative data.

Qualitative and participatory research is likely to be particularly useful and important for gaining an understanding of women’s and men’s own perceptions of health and ill health, the factors causing this, attitudes towards treatment and care and how to improve the situation.

Qualitative research including interviews, focus groups and other methods provides access to the voices and perspectives of women and men and is often crucial in attempting to understand gender relations. Qualitative research can be particularly accessible to disempowered and disadvantaged people because it (ideally) enables them to identify the agenda and issues from their own perspective.

Accuracy of quantitative data can be a limitation in some areas. Data available may be subject to various problems including infrequent collection, sex bias, poor enumeration and imprecise use of key terms.

Ideally, gender analysis involves both quantitative and qualitative data and information, which enables us to analyse the relationship between a particular issue and the broader context.

Linking the micro and the macro

‘The integration of qualitative and quantitative methods is critical to effective macro-micro linkages. It is essential to overcome the limitations of small project approaches which cannot inform policy, and of policy creation based on research that is devoid of local context and realities. Understanding the current situation leads to appropriate preventative and health promotion strategies’ (Sims and Butler, 2000).
Inclusive Research
As outlined above, qualitative and participatory research with women and men is a basic step in gender analysis. This should take account of gender and other social identities in an inclusive approach.

Dressel, Minkler and Yen have stated that inclusive research aims to bring those at the margins of social discourse to the centre:
’researchers must seek to understand social realities through the eyes of variously positioned groups rather than imposing the frameworks of dominant groups onto the others. …Truly inclusive research recognises that group memberships cuts across categories such as race, class and gender and explores the interconnections of these rather than reducing an individual or group's reality to a single factor’ (Dressel et al, 1977: 580).

Traditional approaches to addressing the issue of inclusion have been criticised for perpetuating the problems inherent in research by, and typically on, members of dominant groups. The ‘add and stir’ approach has been described as an approach where researchers simply add previously overlooked samples or groups to their data collection or analysis, without appreciating that the questions which frame their research may not be responsive to the realities of these groups (Dressel et al, 1997: 580).

To illustrate this point, studies on the feminisation of poverty in later life in the United States have tended to take an add-and-stir approach which led to race blind theoretical formulations. ‘What are meant to be general statements about gender and poverty are made and then, as an afterthought or elaboration, specialised statements about black (or Hispanic or Native American) women are made… The point here is subtle but critical. In the… add- and-stir approach … it is implied that similar outcomes in women’s lives are produced by the one and only factor of patriachy. Acknowledged, but not accounted for, are the worse (and sometimes different) conditions faced by racial-ethnic women….who experiences are forced into the model rather than being utilised to refine or critique the model itself’ (Dressel et al, 1997: 582).

The ‘add-and-stir’ approach is often based on the assumption that race, gender, class and age are factors that differentiate individuals, and focuses on between group comparisons. A number of shortcomings have been identified in such an approach. These include that it:
overlooks power relations, power dynamics and material inequalities, and
diverts attention away from social structural analyses and social and political structures, including social policy.

The alternative to the add and stir approach is to increase inclusivity by attempting to bring to the centre of discourse those groups that are traditionally kept at the margins and to avoid imposing the frameworks of dominant groups on to others. The following example is drawn from research in the United States:

Poverty, racism and sexism
‘When Dressel and Barnhill move the lives of African American grandmothers raising their grandchildren under harsh economic conditions to the centre of focus, they reveal that age is not a master or primary status for their sample. That is, issues that have oppressed these women all their lives - poverty, racism, and sexism - have greater salience than age-based issues for their wellbeing and welfare of their families. As a consequence, age-focused service interventions are less useful to them than are financial assistance, legal aid and improved educational services for their grandchildren’ (Dressel, Minkler and Yen 1997: 582).

Gender Planning Concepts
Gender analysis was initially developed as a tool used in the planning and implementation of projects. Gender planning took the analysis of gender issues a step further, by focusing on long term goals, and how projects and programs may bring about greater gender equality between women and men (Hunt, 2000: 15). Caroline Moser developed the concept of gender planning. She
characterised gender planning as distinct from traditional planning, which was often viewed as a technical task, in several ways: ‘First, [gender planning] is both a political process and technical in nature. Second, it assumes conflict in the planning process. Third, it involves transformatory processes. Fourth, it characterises planning as ‘debate” (Moser 1993, quoted in March et al, 1999: 56).

The concepts of practical gender needs and strategic gender interests were developed by Caroline Moser (based on work by Maxine Molyneux) as a tool for planners. Practical gender needs usually include inadequacies in living conditions such as employment, housing and health care. If these are met, the lives of women (or men) would be improved without challenging the existing gender division of labour or challenging women's subordinate position in society. In contrast, strategic gender interests relate to gender divisions of labour, power and control. If these are responded to, the existing relationship of unequal power between women and men can be addressed.

Depending on the context, women's strategic gender interests may include legal rights, domestic violence, equal wages, and women's control over their own bodies. Men may also have strategic interests: they may aim to transform their own roles (to be able to take a greater role in childcare or to resist conscription into an army) or, they may resist women's demands for more control over their own lives. In real life, it may be that practical needs can be met in a way that assists women (and men) to challenge unequal gender power relations (March et al, 1999: 20).

Gendered organisations and ‘mainstreaming’ gender
The United Nations Third World Conference on Women held in 1985 adopted the Nairobi Forward Looking Strategies for the Advancement of Women, which included a call for ‘mainstreaming’. Since then, the concept of gender mainstreaming has become increasingly popular, as part of a recognition that significant and far reaching changes are involved in moving from limited women's components or small scale interventions to addressing gender in all economic and social structures, sectors and all levels of decision-making.

The United Nations Economic and Social Council (ECOSOC) in 1997 defined the concept of gender mainstreaming as follows:
Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels.
It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political spheres, so that women and men benefit equally, and inequality is not perpetuated.
The ultimate goal of mainstreaming is to achieve gender equality (ILO, 2000).

Mainstreaming can include gender-specific interventions as well as policies and programs that are directed to both women and men.

In specific reference to organisations, how an organisation operates internally and how it implements its mandate externally must both be considered in relation to gender equality issues. The following box summarises key questions for examining how an organisation measures up on gender issues:

Gender equality and institutions
‘From a gender equality perspective, there are at least two challenges regarding institutions:
How can an organisation promote more equitable relations between women and men through the implementation of its mandate?
How can women and men participate equally in the institution (in its structure, its decision-making processes, and in the jobs it offers?” (Woroniu and Schalkwyk, 1998: 1).
Ideally the process of mainstreaming transforms the practice and operations of an organisation. This is contrasted with an integrationist approach, where an organisation might present itself as ‘mainstreaming gender’ without critiquing or making changes in its internal and external operations. Some of the basic principles of mainstreaming gender in an organisation are: Responsibility for implementing the mainstreaming strategy is system-wide, and rests at the highest level of the organisation. This involves adequate accountability mechanisms for monitoring progress. Gender analysis is applied consistently across all areas of activity, rather than making assumptions that issues or problems are gender-neutral. Gender differences and disparities are identified. Additional resources (financial and human resources) and political will are required for translating the concept of mainstreaming into reality. Efforts are made to broaden women’s equitable participation at all levels of decision-making. Mainstreaming does not replace the need for targeted, women-specific policies and programmes, and positive legislation; nor does it do away with the need for gender units or focal points (Hannan-Andersson, quoted in ILO, 1999).

Organisational cultures must be taken into account in diagnosing and planning for change and building organisational capacity to mainstream gender. Some of the elements to be considered in organisational capacity for gender mainstreaming include: appropriate knowledge and skills; strategic management; effective networks and linkages; an enabling policy and institutional environment; and a supportive economic, social and political environment (UNDP, 2001).

### Resources for Gender Audits of Organisations

‘Gender auditing’ tools have been developed to undertake gender analysis of organisations. The following are included in the resources section of this kit:

- ‘A checklist for gender integration in programming and management’, developed by InterAction
- Gender route developed by NOVIB.
- Organisational change and equality between women and men, developed by Woroniuk and Schalwyk 1998).

### Gender Analysis of Programs and Projects

As outlined in the gender analysis framework above, gender analysis should be systematically applied to all stages of the program and project cycle, from identification and design to implementation, monitoring and evaluation.

Clarity about for example, the target group, identification of gender differences in the division of labour and responsibilities, and access to and control over resources among the project or program participants are essential elements of good program/project design.

The following box highlights some of the information that is required at the program/project design stage:
Project design questions

‘Who (women/ men/ both) is the target (direct and indirect) of the proposed project? Who will benefit and who will lose? Which women? Which men?
Have women and men been consulted on ‘the problem’ the intervention is to solve? How have they been involved in the development of ‘the solution’?
Does the intervention challenge the existing division of tasks, responsibilities and resources among men and women?
Which needs of women and men will the intervention address: practical, strategic or both?’ (UNDP, 2001: 38).

Other elements of program/project design and implementation to be considered include:

- Program/project objectives: do they refer explicitly to women and men?
- Program/project consultation and participation strategies: do they involve women and men, and identify constraints to women’s and men’s participation and strategies to overcome those constraints?
- Monitoring: are arrangements in place to monitor gender impacts through collection of sex disaggregated data (e.g., impacts on gender division of labour and workloads, on access to resources, on changes in women’s status, etc)? Have gender-sensitive project targets and indicators been developed?
- Resources: are project resources adequate to deliver services and opportunities to women and men?
- Staffing and management: is responsibility for gender issues included in the responsibilities of program/project staff, and have strategies to strengthen their capacities been identified and resourced? (AusAID, 1998)

Program/Project evaluation is a further stage of the program/project cycle where gender analysis is critical to ensure that lessons learned are able to be incorporated into future activities in similar projects or programs. Some of the issues to be considered include:

- How have women and men participated in and benefitted from project activities? This includes collection and analysis of sex disaggregated data on men’s and women’s participation, and information provided by women and men involved in the project in consultations on the gender impact of the project.
- How have women and men been advantaged or disadvantaged by the project? This should be considered in relation to each group targeted or affected by the project, with reference to gender divisions of labour, access to and control of resources.
- Has organisational capacity to implement gender-sensitive programs/projects been strengthened, and what constrained or facilitated this? (AusAID, 1998).
Resources for Gender Analysis of Programs and Projects

The following are included in the Resources section of the Kit:

- ‘Gender analysis: what to ask’ developed by the United Nations Development Program (UNDP), in the UNDP Learning and Information Pack
- Identification and preparation, in AusAID's Gender and Development Guide
- Implementation and monitoring, in AusAID's Gender and Development Guide
- Evaluation, in AusAID's Gender and Development Guide
- Checklist for Women-centred Programme Design developed by ARROW, from the ARROW Resource Kit
- Women-centred and Gender-sensitive Programme Management Cycle developed by ARROW, from the ARROW Resource Kit
- Checklist to Determine How Gender-Sensitive is a Health programme, developed by ARROW, from the ARROW Resource Kit
- Guidelines for Project/Program Analysis developed by Pan American Health Organisation, from the Workshop on Gender, Health and Development.

Gender Analysis of Policy

Examining policy from a gender perspective has led to a recognition that apparently gender-neutral policies have gendered impacts.

Kabeer and Subrahmanian developed the following gender classification of policies:

- **Gender-blind policies**, which recognise no distinction between the sexes, make a number of assumptions, and are often implicitly male-biased;
- **Gender aware policies**, which recognise distinctions between men and women and include these issues in policy development.
- **Gender neutral policies**, which work within the existing gender division of resources and responsibilities. Although in common usage, the term gender neutral is often used in the same way as gender blind.
- **Gender specific policies**, which respond to the practical needs of women or men, within the existing gender division of resources and responsibilities;
- **Gender redistributive (or gender transformative) policies**, which transform existing distributions of power and resources to create a more balanced relationship between women and men, touching on strategic gender interests. They may target women and men together, or women or men together separately’ (1996: 11-13).

A number of countries, including Canada, Sweden, New Zealand, Finland, have adopted gender analysis as an integral part of governmental policy development. In Australia, the Women's Policy Development Office, Government of Western Australia has produced ‘What's the difference: a guide to using gender difference to improve public sector performance’ (1999).

Canadian Government Experience in Gender Analysis

In 1995 the Canadian Government adopted a policy requiring federal departments and agencies to conduct gender-based analysis of future policies and legislation. Status of Women Canada (SWC) prepared a working document to assist in the implementation of the government-wide policy. This document notes that policy decisions are to a large extent about values - the values of those involved in policy development and analysis, the values of the system in which they work and the values of society.

The key features and reasons for undertaking gender-based analysis is outlined by Status of Women Canada (SWC) as follows:

- ‘Gender based analysis is a process that assesses the differential impact of proposed and or existing policies, programs and legislation on women and men. It makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men and of their different social realities, life expectations and economic
circumstances. It is a tool for understanding social processes, and for responding with informed and equitable options' (SWC, 1998: 10).

Eight steps are identified:
Identifying, defining and refining the issue
Defining desired/anticipated outcomes
Defining the information and consultation inputs
Conducting research
Developing and analysing options
Making recommendations/decision-seeking
Communicating policy
Assessing the quality of analysis.
The steps can both be followed sequentially and revisited with the emergence of new information or perspectives.

Good practice tips
‘Gender-based analysis should be a common thread woven from beginning to end throughout the entire policy process, and not merely an additional heading/section in briefing notes.

It is always good practice to keep asking the gender question throughout the process. This requires examining sex-disaggregated quantitative and qualitative data; questioning basic assumptions, and developing an understanding of the interrelationships among each of the major economic and social factors, and how these relate to gender’ (Status of Women Canada, 1997).

Resources for Gender Analysis of Policy
The Resources section of the Kit includes:
An extract from the New Zealand Ministry for Women's Affairs Guidelines for Action

Tools and Resources for Gender Analysis

Embedded in gender analysis frameworks, including the framework outlined above, are key conceptual tools including gender division of labour, access to and control over resources, practical gender needs and strategic gender interests (Canadian Council for International Cooperation, 1991: 24).

The term ‘tool’ is also used to refer to observation and other research techniques utilised by users of gender frameworks (March, Smyth and Mukhopadhyay, 1999: 11). These are often matrices or tables that facilitate the collection and analysis of data in a particular area central to the framework. For example, in step 3 of the gender framework outlined in this paper, factors which influence the differences in the gender division of labour and access to and control over resources may be represented in a table with three columns: influencing factors, constraints and opportunities (March, Smyth and Mukhopadhyay, 1999: 35). As with gender frameworks, the usefulness of particular tools varies, depending on the purpose, the task, context and resources available.

The term tool is also used in a third way, to refer to resources that are designed to be used routinely and systematically in organisational work practices. Many organisations that are concerned to institutionalise gender analysis in their work have developed resources or ‘tools’ for their use. Training resources and courses, checklists and guiding questions are the main types of tools/resources developed. Some of these are available on the web, and in various publications. They can provide useful resources and starting points for other organisations working in similar areas.

Guiding questions are often useful in providing a memory aid to check that women's and men's needs and concerns have been addressed in planning. Guiding questions provide a starting point
to formulate additional questions, specific to the particular context and activity. In themselves, they do not provide strategies or assess the likely effectiveness of particular projects or strategies (AusAID, 1998: 8).

A number of gender analysis tools have been included in the resource kit that accompanies this discussion paper. They have been selected as good examples of practical tools that have been developed and used by a range of organisations to improve attention to gender issues and promote gender analysis in their own work. The resources may be useful for developing tailored tools for specific purposes in organisational auditing, planning, program/project cycle work and service provision and quality improvement processes by primary care partnerships and individual agencies.

The tools have been developed for a variety of purposes, with suggested uses outlined in the table below. All can contribute to a process of quality improvement.

<table>
<thead>
<tr>
<th>Source and Name of Tool</th>
<th>Organisational ‘Audit’</th>
<th>Participation and Consultation</th>
<th>Project and Program Planning Cycle</th>
<th>Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>InterAction - Checklist for Gender Integration in Programming and Management</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Juliet Hunt - Understanding Gender Equality in Organisations: A Tool for Assessment and Action</td>
<td>*</td>
<td>* participation and consultation strategies section</td>
<td>* program, projects, activities and procedures</td>
<td>Building capacity section</td>
</tr>
<tr>
<td>NOVIB - Organisational Gender Diagnosing</td>
<td>*</td>
<td></td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>SIDA - Organizational Change and Equality between Women and Men</td>
<td>*</td>
<td></td>
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<td>*</td>
</tr>
<tr>
<td>Sue Dyson/Women’s Health in the South East (WHSE) - Counting Heads</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Sue Dyson/WHSE - Diversity Snapshot</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>United Nations Development Program Gender Analysis - What to Ask</td>
<td></td>
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<tr>
<td>AusAID - Identification and Preparation</td>
<td>*</td>
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<td>*</td>
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<tr>
<td>AusAID - Implementation and Monitoring</td>
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<tr>
<td>AusAID - Evaluation</td>
<td>*</td>
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</tr>
<tr>
<td>Asian Pacific Resource Centre for Women (ARROW) Checklist for Women-centred Design</td>
<td>* needs and review sections</td>
<td>*</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>ARROW - Women-centred and Gender-sensitive Programme Management Cycle</td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>
End Note

While tools developed by other organisations can be very useful and enable others to start working on gender in their own organisational context, it is important to be aware of the limitations of gender frameworks and tools - they do not in themselves make it easy to ‘do gender’. As March, Smyth and Mukhopadhyay point out: ‘Practioners must be careful to employ gender frameworks in a serious, systematic way. Adequate resources, including time, skills and suitable preparation, are all essential. Using the gender frameworks should go hand in hand with a coherent and gender-sensitive use of other relevant techniques, such as data collection. As Naila Kabeer says, ‘No set of methods are in themselves sensitive to differences and inequalities between men and women; each method is only as good as its practitioner’ (cited in March, Smyth and Mukhopadhyay, 1999: 14).

‘Checklist management’ - the ticking off issues without serious commitment to their substance - has been demonstrated to be ineffective unless there is existing commitment and ownership by senior staff. Commitment and ownership by all staff is also to be encouraged. Training and workforce development in gender analysis and gender issues in relation to key organisational areas can also be important in developing organisational capacity to use gender analysis frameworks and tools in appropriate ways. Organisational learnings and reflection can also be part of a capacity building process that includes developing tailored gender tools that meet the specific needs and interests of organisations and partnerships.

In itself, the process of gender analysis does not ensure that policy development, planning, programs and projects will facilitate transformation in gender relations or improved outcomes for women and men. Changes are also influenced by other factors including the use of appropriate and effective strategies for participation and consultation with women and men, the quality of the information collected and how creatively the information is applied to planning and program design, implementation and evaluation (Hunt, 2001: 22).

It is important to remember that gender frameworks and tools are not intended to be purely technocratic tools deprived of their political dimension. The application of gender perspectives requires the commitment of both individuals and organisations to promote gender equality, to use gender analysis systematically and thoughtfully rather than as a tokenistic tool (March, Smyth and Mukhopadhyay, 1999: 5).
A Gender Agenda: Planning for an Inclusive and Diverse Community

References


International Women's Tribune Centre. (1997), The Tribune, # 56, April.


A Gender Agenda: Planning for a Diverse and Inclusive Community

PART TWO: Gender and Health

Overview
The following discussion builds on the gender analysis framework, concepts and gender perspective's on organisations, planning, programming and policy outlined in Part One. Part Two focuses specifically on gender in relation to health. This then forms the basis to examine gender in relation to primary care partnerships and community health planning in the Western metropolitan region of Melbourne in Part Four.

The paper supports the view that gender relations and inequality in society influences: the health of women and men access to health services and the responsiveness of those services to women and men the structure of the health system and the allocation of resources through planning and priority setting, service provision and evaluation and review (Jahan, Ahmad, Hunt, Klugman, Schalkwyk and Siberschmidt, 1998: 11).

From this perspective it suggests that the health sector can reinforce or redress gender inequalities and be gender sensitive or gender blind in planning, service delivery, research and evaluation. As Dorothy Broom points out, ‘ignoring the effects of gender on health does not eliminate those effects; it simply makes them invisible, and hence impossible to incorporate explicitly into training, services, interventions and broader understanding of the people's health’ (Broom, 1999: 5-6).

There is much to explore in relation to women and men's experiences of health, wellbeing, illness, risk factors, appropriate health interventions and treatments. This section utilises information from Australia and other western developed countries, including the USA and the United Kingdom. It aims to raise issues and look at health and health services in a gendered way, to point towards areas that need to be taken into account in service planning and provision.

Biomedical and Social Understandings of Health
What we understand by health and illness informs how we explain and address both issues. Two main approaches to understanding health and illness include: the biomedical and the social determinants of health approaches. Both approaches coexist within our health sector and influence health policy, planning and the allocation of resources.

The biomedical approach focuses on the disease process within the individual patient. The approach attempts to understand ill health through a detailed scientific examination of disease causing agents and biological responses, and responds to illness by developing drugs and vaccines to treat, cure and prevent diseases. The biomedical model has gained a dominant position in Western medicine and in formal approaches to health and health care. Within this approach, most illness is seen as either inevitable or caused by inappropriate personal behaviour brought on by poor lifestyle choices (Hanson, 1999: 9).

The social determinants of health approach is broader than the previous approach, and incorporates the World Health Organisation's definition of health as: 'A state of complete social, psychological and physical wellbeing and not merely the absence of disease.' Implicit in this definition is the idea that health is not a purely physical phenomena and is influenced by socio cultural, economic and psychological factors. According to this approach, individual and community health status is a social product linked to the impact of structural factors defined by social and organisational systems and mediated through social relationships (Hanson, 1999: 9). In other words, this approach argues that health and well being is intrinsically influenced by social factors such as employment, housing and income.

According to the social model of health, societal relations determine patterns of health and illness. Social analyses of health have focused on economic relations, and found broad correlations
between socio economic situation, life chances and health. In addition to class or socio economic status, other dynamics of social organisation including gender and ethnicity are seen as influencing patterns of health and illness.

As Nancy Breen points out, 'causes of death and disease prevalence ratios vary over time by social class, gender, race and even age, indicates that social discrimination enters into the process of health in important ways. This remains true even if the explicit pathways have not been articulated and the relative importance of the various factors have not been measured' (Breen, 1999: 5).

It is noteworthy that both the biomedical and social determinants of health approaches have neglected gender considerations until relatively recently. Both biomedical research and research studies into social inequality have often failed to focus adequately on gender.

**Sex, Gender and Health**

One of the central difficulties in understanding gender influences on health and illness in our society relates to the contribution and interaction between biological/physiological factors and social and cultural (gender) factors. At one end of a continuum are primarily sex based explanations of differences between women and men, while at the other end are social and cultural explanations for differences between women and men. It is now acknowledged that sex-based biological factors are more complex than had been thought. Biomedical research has found evidence of biological differences between the sexes in virtually every organ and system of the body. Sex differences have been identified in cardiovascular disease, cancer, autoimmune diseases, neurology and mental health, HIV/AIDS, responses to pharmaceuticals, tobacco, alcohol and illicit drugs, obesity and musculoskeletal health (Society for Women's Health Research, 2001).

In practice it is often difficult to distinguish the relative contributions and interplay of biological (anatomical, genetic, hormonal) and social factors in relation to both well being and disease among women and men. Sex and gender often interact, as indicated by the following example of women's vulnerability to heterosexual HIV/AIDS transmission.
Interactions between biological and gender factors: HIV/AIDS infection through heterosexual transmission

Women are more vulnerable than men to HIV infection through heterosexual relations

Biologically:
- women have larger mucosal surface; micro lesions which can occur during intercourse may be entry points for the virus; very young women are even more vulnerable; coerced sex increases risks of micro lesions
- more HIV virus in contained in sperm than in vaginal secretions
- as with STIs, women are at least four times more vulnerable to infection; the presence of untreated STIs increases susceptibility to infection

Socially, due to unequal power relations:
- women may be unable to refuse sex (because of economic dependency or violence)
- women may not be able to negotiate use of condoms
- multiple partners may be considered acceptable for men (World Health Organisation, 2000b: 1)

Gender Blindness in Medical Research

Until recently, biomedical research often restricted participation in clinical trials to men. Medical research focused on women mainly in relation to reproductive and sexual health. Women's health was often seen as synonymous with and reducible to illnesses or conditions related to women's reproductive health (WHO, 1998a, 2000a: 26). In other areas, women were largely excluded from clinical studies of disease, diagnostic procedures, management, therapy and prevention. A concern to protect women (particularly pregnant women) from participation in clinical trials, difficulties in taking the menstrual cycle into account, recruitment and retention problems, due perhaps to women's primary care taking roles and responsibilities, and higher costs were among the factors that appeared to exclude women.

Implicit were the assumptions that findings that were relevant to men were relevant to women and that health throughout the lifespan follows the same course for women as it does for men. As Dorothy Broom has pointed out, 'the male domination of medicine, the focus on males in research, and the privileging of the male body as normal' has left the legacy that 'we know relatively little about how non-reproductive disorders may manifest themselves differently in women and men, how risk factors may vary, or how the sexes may differ in their response to therapeutic interventions' (Broom, 1999: 44).

Reducing women's health to women's reproductive health has had a number of negative consequences for the state of scientific knowledge, including:
- an inadequate understanding of and research on gender differences in health and illness
- a paucity of information pertaining to basic physiology and pharmacokinetics in women (WHO, 2000a: 26). A number of differences between women and men in responses to pharmaceuticals have been found. Here are some examples:
Sex Differences in Response to Pharmaceuticals

Women and men respond differently to some pharmaceuticals:

A much higher percentage of women than men develop the life threatening ventricular arrhythmia torsades de pointes after taking a variety of drugs such as antihistamines, antibiotics, anti-malaria drugs, cholesterol lowering drugs and anti-arrhythmia drugs.

A liver enzyme, CPY3A4, is responsible for metabolising more than 50 per cent of pharmaceutical drugs. This enzyme is more active in women than men, which can lead to sex differences in effectiveness and/or adverse reactions.

Certain types of painkillers, called kappa opiates, are more effective in providing post-operative pain relief in women than in men receiving treatment. (Society for Women's Health Research, 2001)

Looking at the US experience it was only in 1990 that the National Institute of Health (NIH) in the United States issued guidelines mandating the inclusion of women in clinical trials. In 1993 the US Congress passed legislation requiring the inclusion of women and minorities in federally funded clinical trials, except where specific criteria for the exclusion of those groups could be satisfied (WHO, 2000a: 27).

In 1994 the Institute of Medicine in the United States undertook a survey of clinical studies to investigate the perception that women's health interests received less attention than the health interests of men. The study found ‘there are many unanswered questions about gender based differences in response to treatment… In general, investigators have not done one or more of the following: reported the results of gender analyses, performed gender analyses of study results, or recruited adequate numbers of women to support the kind of subgroup analysis that would be needed to resolve these questions’ (quoted in Taylor, 1994: 148).

One of the principles included the following point. ‘The scientific community and the institutions that support it must ensure that scientific advances in medicine and public health fairly benefit all people, regardless of gender, race, ethnicity or age. Therefore, the national research agenda must ensure that medical research promotes the health and wellbeing of both women and men’ (Taylor, 1994: 148).

Biomedical research has often also failed to study the complex interaction between biological and cultural factors. This is true for both men and women, as the gender blindness of much research has meant that sex and gender influences on women's health have not been explicitly studied.

Overcoming the neglect of research on women's health will no doubt take some time. In Australia, the Australian Longitudinal Study on Women's Health (ALSWH) - Women's Health Australia (WHA) - aims to clarify cause and effect relationships between women's health and a range of biological, psychological, social and lifestyle factors. It is an important project initiative to be implemented for at least 20 years (Lee, 2001).

Gender Differences in Diagnosis and Treatment

Gender differences in diagnosis and treatment of various conditions and illnesses have been identified. Some explanations relate to the absence of knowledge about disease processes and risk factors in women due to their absence in clinical trials. For example, diagnostic tools and therapies developed for men may be inappropriate for women, as indicated by the following example:
Diagnosis of Schizophrenia in Women and Men

'Androcentric bias, where men's experiences are taken as the norm and/or their symptoms and patterns of illness inform models of explanation will lead to error. For example, men who develop schizophrenia often have an earlier onset of symptoms than women. Hambrecht et al (1992) applied the criterion from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders that stipulated that schizophrenia could only be diagnosed if symptoms were present before 45 years of age, to data obtained from the WHO Determinants of Outcome of Severe Mental Disorders. Application of this criterion resulted in the exclusion of 5 per cent of men but more than double the percentage of women (12 per cent)' (Astbury, 1999: 17).

The absence of women in clinical trials may lead to a male pattern of symptoms being the standard for diagnosis. For example, women's symptoms of CVD may be different to men's. Chest pain is the predominant initial and subsequent symptom of CVD in women, whereas in men heart attack and sudden death are often the first symptoms.

Gender stereotypes and differences in the ways that women and men present their symptoms to doctors may influence clinical decision-making. To illustrate this point, delays in diagnosis of CVD in women may be attributed to women detecting cardiac symptoms and seeking medical help earlier when symptoms may not be pronounced, or due to women or their doctors looking to other explanations of the symptoms such as menopause or emotional causes. One study found that the patient's presentation style alters the physician's diagnosis approach, with physicians suspecting a cardiac cause four times more often in a female patient with a 'businesslike' presentation (Gijsbers Van Wijk, Van Vliet and Kolk, 1996: 712).

Women, Men and Cardiovascular Disease

Cardiovascular disease (CVD) includes heart disease, heart attack and stroke. While heart disease has been recognised as a major problem for men, there has been until relatively recently less awareness among both doctors and women that heart disease is a major killer of women.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>15,024</td>
<td>12,801</td>
</tr>
<tr>
<td>Stroke</td>
<td>4,812</td>
<td>7,170</td>
</tr>
<tr>
<td>Other cardiovascular diseases</td>
<td>2,061</td>
<td>2,358</td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td>1,171</td>
<td>916</td>
</tr>
<tr>
<td>Heart failure</td>
<td>988</td>
<td>1,567</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>410</td>
<td>730</td>
</tr>
<tr>
<td>Rheumatic fever and rheumatic heart disease</td>
<td>87</td>
<td>171</td>
</tr>
<tr>
<td>All cardiovascular disease</td>
<td>24,746</td>
<td>26,051</td>
</tr>
<tr>
<td>All causes of death</td>
<td>67,073</td>
<td>60,129</td>
</tr>
</tbody>
</table>

Many risk factors for CVD are different in women and men. Women's symptoms of CVD may not be recognised because they may be very different to men's. Women may not receive the same levels of preventative or symptom-associated treatment for CVD as men. Increased smoking among young women is considered alarming for future trends, as smoking doubles the risk of heart attack and stroke. Smoking in combination with the use of oral contraceptives multiples the risk 10 times. (Australian Institute of Health and Welfare National Mortality, 2001: 4)
Along with differences in diagnoses, differences in the treatment of CVD in women and men have been identified. American studies undertaken on ischaemic heart disease among men and women found it was treated less quickly and less aggressively in women than in men. There is evidence that women with a myocardial infarction (MI) have a higher risk than men of death during MI, of operative death during bypass surgery, and of death, cardiac distress and re-infarction in the post-MI year (Gijsbers Van Wijk et al, 1996). It has been identified that there is a significant race and gender gap in such treatments as cardiac bypass surgery and angioplasty remains even when such medical variables as types of angina, age, symptoms, and previous myocardial infarction are controlled for (Dressel, Minkler and Yen, 1997: 594).

**Gendered Exposures to Risk Factors**

Women and men may be differentially exposed to the risk of contracting a range of diseases by virtue of the gender division of labour. Research studies have largely focused on men in paid work and workplaces. More recently, the health stresses of domestic and caring work, largely undertaken by women in the home have been examined. While a gender analysis framework would consider the interaction of multiple roles and responsibilities, this approach has not been usual in looking at gendered exposures to risk factors in the health area.

Much of the consideration of gendered exposure to risk factors has been in relation to men's paid work in particular occupations or industries. Men have traditionally taken on the ‘most dangerous’ jobs. Mining, construction, waterside work and farming have been male dominated occupations with comparatively high occupational health and safety hazards as reflected in death and injury statistics. Men's rates of industrial accidents and diseases have historically been higher than female rates and deaths from occupational causes more common among men than among women.

However, women suffer many chronic, often undiagnosed and untreated occupational health problems in the supposedly safe ‘women's’ jobs in the workplace. These jobs include working on conveyor belts, in electronic plants, garment and textile factories, hospitals and piece work at home. The jobs involve speed, repetitive motions and restricted positions which tend to produce disease patterns such as musculoskeletal disorders, cumulative trauma disorders which are rarely recognised or compensated in equal proportions to male disability (Sims and Butler, 2000).

To take another example, the nursing profession has traditionally been a ‘female’ profession. Nurses have high rates of pre-term and low birthweight babies, and the factors contributing to these outcomes are identified as standing, lifting, moving heavy weights and the strain of night shifts (Hanson, 1999: 23).

Research on psychosocial influences on health have focused on ‘the control factor’ and looked at this in relation to paid work. It has been identified that people who have high demands at work and very little discretion in dealing with those demands and deciding how to do their work, have the highest rate of disease. Stress in the workplace increases the risk of disease, and job insecurity and unemployment is also bad for worker's health (Swan, 1998). The gendered segmentation of the labour market and women’s concentration in casual and lower level jobs, with lower levels of autonomy, pay and other rewards raises concerns that women may be particularly exposed to work related stress. This stress may negatively impact on their physical and emotional health, including their mental health (Broom, 1999: 44).
Depression

In Australia one in four women and one in six men will experience depression at some stage in their life.

Depression is the most prevalent mental health problem among women, and likely to be accompanied by other psychological disorders which are more common in women such as anxiety disorders.

Environmental and social factors especially negative, irregular, disruptive life events have been found to trigger depression. Social theories of depression emphasise the importance of severe events and life difficulties characterised by loss, humiliation, entrapment and a sense of lack of control and inferior rank.

Social disadvantage and poverty have been identified as leading to greater mental health risks. Reduced autonomy and decision-making, increased exposure to dangerous environments and violence and discrimination have been identified as risk factors.

Risk factors linked to gendered experiences, particularly sexual abuse and violence in childhood and adulthood have been identified.

(Astbury, 1999; World Health Organisation, 2000a)

Changes in the labour market and work are leading to new forms of the work environment. While call centres are similar to old style factories in that large numbers of workers are in one location, other trends are emerging. Homeworkers in garment production and teleworking in various occupations are blurring distinctions between the home and work environments (Annandale and Hunt, 2000: 7). Unemployment and associated stresses have been identified as important areas to investigate further in terms of health impacts on women and men.

In addition to risks to health from paid work, women and men may be differentially exposed to risk factors from the gender divisions of labour in relation to reproductive roles and responsibilities, and essential household and community services. The concept of control in relation to unpaid work and family responsibilities and its relationship to gender and health appears to have been relatively neglected to date.

Smoking is a well-known hazard for a range of serious diseases, and smoking behaviour varies between women and men:

Smoking and Gender Issues

‘Smoking has different social meanings and symbolic power among different sectors of the population, and some of those differences are gendered’ (Broom, 1995: 44)

Smoking habits of women and men have varied significantly over time, and there is some debate about what future trends may be.

Smoking rates in Australia: percentage of adult smokers

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1945</td>
<td>72</td>
<td>26</td>
</tr>
<tr>
<td>1964</td>
<td>58</td>
<td>28</td>
</tr>
<tr>
<td>1976</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>1986</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>1995</td>
<td>27</td>
<td>23</td>
</tr>
</tbody>
</table>

While smoking was less prevalent in 1995 than in 1977, the greatest proportional decline was among people aged 45 and over and the least among young people aged 18-24. Surveys of teenage smoking indicate that young women are now smoking in equal if not greater numbers than young men. The 1998 National Household Drug Survey found that 24 per cent of males and 26 per cent of females aged 14-19 were current smokers.

(QUIT, 1998)
More men than women smoke, and in the past this difference was much more pronounced. This is reflected in more men than women dying from lung cancer. Smoking contributes to greater male morbidity and premature mortality from cardiovascular diseases. It has been suggested that perhaps half of the sex difference in longevity may be attributable to smoking (Broom, 1999: 44).

Gender analyses of health must take account of changes and trends in gender differences in behaviour and gendered exposures, with reference to the range of behaviours of particular groups of women and men, rather than a simple analysis of women as a whole and men as a whole. The following table highlights some differences in smoking prevalence rates among women and men, across generations and among differing cultural backgrounds based on a recent study in Sydney.

### Gender, Ethnicity and Generational Changes in Smoking

High rates of smoking have been reported in some adult ethnic groups in Australia. Both male and female secondary school students from non-English speaking backgrounds (NESB) have been found to have lower rates of current and daily smoking than those from English speaking backgrounds (ESB).

NESB students are more likely to report having never smoked (70 per cent) than those from ESB students (57 per cent).

Although NESB students report higher paternal smoking rates (35 per cent for NESB fathers compared to 29 per cent for ESB fathers), smoking rates among mothers of NESB students are lower (18 per cent NESB compared with 28 per cent ESB).

A research study investigating the factors influencing smoking behaviour in NESB students in three Sydney secondary schools found that there was a distinct gender difference in smoking prevalence which related to gender roles within the Arabic and the Vietnamese cultures.

Males were more likely to smoke and their smoking behaviour was more likely to be accepted by the community. Among the Arabic community, it is not common for women to smoke, at least until marriage.

Other factors influencing smoking included family rules and norms, some culturally determined behaviours (the offering of cigarettes, particularly at social occasions, was common and viewed as a courteous gesture), and access to and availability of cigarettes (Rissel, McLellan, Bauman and Tang, 2000: 223-225).

### Experience of Injury and Illness

Women and men may perceive particular illnesses or injuries in different ways, based on their own gender identities and expectations, roles and responsibilities and/or the influence of social stigma and societal responses. The social consequences of ill health for particular groups of women and men may influence health outcomes in significant ways. The following example gives an indication of the different meanings and health impacts of domestic violence compared to the experience of violence outside the home.

### The Personal Meaning and Social Consequences of Violence

‘A particular injury, such as a concussion or laceration, may be physically the same, regardless of how one was injured. But the personal meaning and social consequences may be very different depending on whether the injury was sustained in a car accident, a mugging by a stranger, a pub fight with a drinking companion, or an attack by one's intimate partner. The first three sources of injury are likely to be singular or rare events, to be publicly acknowledged, and to receive immediate assistance. By contrast, 'wife bashing' is apt to be repeated and escalating, shrouded in shame and secrecy, and often concealed from health care workers. Indeed the source of injury is frequently undetected, even when injuries are so severe that the victim presents at an emergency service…the psychological impact of being attacked by a loved and trusted partner is particularly devastating and personally debilitating' (Broom, 1999: 45-46).
Men and women's responses to serious and chronic illness may be shaped by their gendered identity and life experiences. Qualitative studies have found that men's sense of 'self' is challenged by serious and chronic illness. In order to 'cope' with their situations, men typically seek to re-establish characteristics, which are associated with traditional notions of masculinity. Gordon in a study of testicular cancer found that men's verbalisation of the process as one of 'fighting cancer' allows a reaffirmation of masculinity, as does attempting to re-involve themselves in activities that are seen to be male, such as their paid work (1995). Gordon noted that men generally did not handle the emotionality of their experience well. In addition, the strategies men often use to cope with their illness, can also have ramifications for their partners. Men typically adopted a task-orientated approach to coping, while women altered their emotions and mobilised family support. Gordon found that men's responses may in turn contribute to further ill health, notably psychological illness and distress for men themselves (Popay and Groves, 2000: 83-84).

A further examination of the experience of chronic illness among both women and men found that men typically focused on action as a key element of identity, and had individualistic responses, compared to women's connections with their family relationships and talking about issues with others (Popay and Groves, 2000).

**Gendered Health Services**

Reorienting and reorganising the health, medical and scientific professions to address sex and gender issues in their work requires attention. It may entail an examination of our own assumptions, experiences and understanding of gender. ‘We are all the product of a socialisation process that influences our perceptions, values, attitudes and practices about the roles of women and men, and this is reflected in service delivery’ (WHAV, 2001: 2).

Assumptions and attitudes about gender among planners and service providers may need to be examined and named in order to provide services that respond appropriately to the needs of women and men. Gendered assumptions relating to health and experience of illness may be quite varied. For example, a qualitative study undertaken by Bendelow (1993) on women and men’s experiences and perceptions of the causes of pain found that women and men both believed that women were better able to cope with pain because of the experience of childbirth and different socialisation. In contrast, men and boys were expected to be stoic and discouraged from emotional expression of pain. It was believed that men would take longer to admit to pain than women and that when men did report their pain, they would be more likely than women to be taken seriously by health workers. In a related study, the same researcher found that health workers interviewed believed that women were more likely than men to suffer from pain with psychogenic rather than physical origins (cited in Popay and Groves, 2000: 81).

Gender sensitive services take sex and gender into account in the delivery of services. This includes recognition that women and men may have different needs, experiences and issues in the health service system. Gender responsive practice addresses gender related barriers and responds to individual life experiences and specific needs.

The principles of gender sensitive health care are:

- self determination of health care,
- acknowledgement of the diversity of women and men,
- adherence to a holistic approach (Gijsbers van Wijk, van Vliet and Kolk, 1996: 718).
A Gender Agenda: Planning for an Inclusive and Diverse Community

Gender Sensitive Health Care
‘Health care that is truly gender sensitive acknowledges gender differences in the nature, experience, presentation, risk factors, aetiology, and consequences of health problems, in the needs and expectations of men and women with regard to health care services, and in their responses to and the implications of treatment. Moreover, these gender differences are not regarded as intrinsically biological, but as resulting from socialisation processes and the social position and social roles men and women occupy’ (Gijsbers Van Wijk et al, 1996: 717-718).

Women responsive practice is ‘a component of gender responsive practice … developed with a consciousness of the specific needs of women in the context of their cultural and social settings and a desire to achieve equity in outcomes. It takes into account the different factors which advantage or disadvantage women and develops programs and services which will address these disadvantages, reach women in appropriate ways, understand their needs and preferences and result in positive health outcomes’ (Women's Health Association of Victoria, 2001: 3-4).

The language used to discuss issues in policy, procedures and related areas communicates norms and expectations. Language and practices used by service providers needs to be gender inclusive to ensure that women and men are able to receive health care that meets their particular needs.

Resources
Additional resources in the Resource Set include:
Dyson, S. (2001) ‘Diversity Snapshot Worksheet’ and
Asian-Pacific Resource Centre for Women (ARROW). (1996), ‘Checklist to Determine how Gender-Sensitive is a Health Program’.

Men and gender
Recent attention on the impact of gender on health in Australia has largely focused on women. Gender is often overlooked as an aspect of men's social identity. This has often been part of the assumption that male characteristics and attributes are the norm, with women being a variation on the norm. As Greig, Kimmel and Lang point out ‘the processes that confer privilege on one group and not another are often invisible to those upon whom that luxury is conferred. Thus, not having to think about race is one of the luxuries of being of a dominant race, just as not having to think about gender is one of the patriarchal dividends that men gain from their position of the gender order. Men tend not to think about themselves as 'gendered beings', and this is one reason why policy makers and development practitioners, both men and women, often misunderstand or dismiss ‘gender’ as a women's issue’ (Greig, Kimmel and Lang, 2000: 3).

However men's lives are strongly influenced by gender. Cultural norms about masculinity and expectations of men as leaders, husbands, sons, and workers shape demands on men and their behaviour. As outlined in Part One, it is increasingly recognised that there are multiple forms of ‘masculinities’ and diverse ways in which different groups of men choose to construct their gender identities, with reference to particular groups and institutions.

With changes in gender roles, expectations, and relations, particularly across generations, and differences among socio economic and other groups, it is necessary to consider the impact of gender on health and illness among particular groups of men. Emerging areas of research include the impact of gender roles and responsibilities on men's exposures to ill health and premature death, and men's abilities to protect and preserve their health.

A variety of social habits, particularly smoking and drinking, have been linked to ideas about 'normal' masculinity. It is hypothesised that young men in particular may feel pressure to indulge in risk taking behaviours in order to show that they are ‘real men’. In the area of mental health, it has
been noted that there are a narrow range of emotions men may feel free to express. Examples of these emotions include anger, rage and frustration.

Much of the interest in the influence of ‘masculinity’ or ‘masculinities’ has been in relation to ‘risk taking’ behaviour. In some cases, the risk taking is not explicitly linked to gender roles and expectations. ‘Making men more conscious of gender as it affects their lives as well as those of women is a first step towards challenging gender inequalities’ (Greig, Kimmel and Lang, 2000: 4). Experience in many countries shows that it is necessary to raise these gender issues sensitively for examination and discussion among groups of women and men, in families and at community and societal levels if harmful aspects of masculinities and gender relations are to be addressed, and positive impacts encouraged.

Health differences and gender relations

At a superficial level, gender issues in health are often narrowly understood in terms of sex differences in sexual and reproductive health and particular diseases or conditions which are experienced only by men or only by women. For example, women's health issues may be thought of as endometriosis and breast cancer, while prostrate cancer and impotence may be seen as men's health issues (Broom, 1995a: 8).

In popular and professional circles much of the discussion about gender and health in Australia has been tied up in discussions about ‘sex differences’, usually in terms of whether women’s or men's health status is worse. The discussion is usually conducted with reference to mortality and morbidity statistics, and can be summed up as ‘men die but women get sick’.

A concern with ‘gender as difference’ directs attention to the incidence of various diseases among women and men such as those outlined in the box below.

### Life Expectancy of Women and Men in Victoria

In 1996, Victorian men had a life expectancy at birth of 76.1 years and women 81.7 years. Life expectancy of Victorians is slightly higher than the Australian average and approaches the highest life expectancy figures recorded internationally of Sweden and Japan. The life expectancy at birth of men is 5.6 years less than that of women. A similar difference in life expectancy between men and women is found in all industrialised countries. Between 1979 and 1996, life expectancy at birth has steadily increased at a rate of 0.30 years annually in men and 0.21 years annually in women. In 1996, premature mortality was responsible for 180,462 years of life lost in men and 149,419 years lost in women. (Department of Human Services Victoria, 1999)

It is important to note that sex differences in mortality have varied historically and vary around the world. There is evidence of men surviving 20 per cent to 40 per cent longer than women in prehistoric times. From the nineteenth century onwards women started to outlive men in the industrialising countries of Europe and North America (Popay and Groves, 2000: 68). Despite the greater longevity of women in developed countries, in many areas of the world women still have much higher death rates than men.

A focus on gender differences in terms of lifespan, diseases or disabilities often does not go further to consider why there may be different patterns of disease and death among women and men. It is also important to recognise that ‘gender patterns of mortality and morbidity may not be set in stone and may change again in response to both social pressures from above and agency from below’ (Carpenter, 2000: 54).
Gender relations and health

‘The health of women and men is a product of many elements, not just differences in reproductive organs. The sexes differ in the lives they typically live, and these differences can influence health. That is, gender is a significant complex element in the social production of health and illness’ (Broom, 1999: 41).

‘The emphasis on gender differences has been highly useful but perhaps it has also deflected research on some of the similarities between women's and men's health risks or… the relational character of gendered health synergies that can positively or negatively influence the health outcomes of both sexes. A relational framework fosters understanding of the interdependencies between women's and men's lives and respective health statuses’ (Sabo, 1999: 8-9).

Gender Relations and Health

Differences in the paid and unpaid work and responsibilities of women and men in our society can influence both women's and men's

- exposure to risk factors
- access to and understanding of information about disease management, prevention and control
- subjective experience of illness and its social significance
- attitudes towards the maintenance of one's own health and that of other family members
- patterns of service use
- perceptions of quality of care. (Women's Health Association of Victoria, 2001: 2)

Diversity in gender relations and health

As outlined in Part One, a gender analysis in health should be carried out for and with particular groups of women and men, rather than making assumptions that current practices support good health either for men or women.

Social relations of gender are increasingly seen as complex (Annandale and Hunt, 2000: 27). These relations affect health outcomes in the following ways:

Similar circumstances may render both men and women vulnerable to ill health or good health
Even when treated the same for the same condition, men and women may have different outcomes
Similar circumstances (eg in the workplace) may produce different effects for women and men, perhaps because of the interaction of other factors or circumstances
Gender identities, expectations and roles can be both health protective as well as health harming, depending on the context
Gender shapes both exposures to risk factors, and experience of illness in various ways.

Understanding how women and men actively reflect on their lives and health and translate this into action or in-action is important for effective health promotion.

Implications for policy approaches

At a policy level, gender analysis can encompass both a women-focused approach and a gendered approach. Each approach may each direct attention to different areas, as outlined by Breen (1999).

Analysis of impact on women:

- Women are more likely to be part of the poorest communities which leads us to consider a policy focus on anti poverty strategies and safety nets
- Women may be epidemiologically more vulnerable, which can result in a policy focus on access to appropriate health services
- Women may have main responsibilities for reproductive, caring, and essential household and community work which can lead to a policy focus on unintended effects of interventions which increase care burdens outside the formal health sector.
Gendered approaches:
- Social and gender inequities in access to services can result in a policy focus on improving access for the disadvantaged gender/groups
- Addressing men and women’s health profiles and behaviours lead to a policy focus on appropriate interventions for reaching men and women
- Redressing male bias in institutions and policy formulation lead to a policy concern with mainstreaming gender at institutional levels (Breen, 1999).

The Social Determinants of Health
There is growing recognition and acceptance of the social determinants of health. Population health data on mortality and a range of studies undertaken in several countries in the last ten years have demonstrated that people who are financially better off live several years longer and have fewer illnesses than poorer people. People’s lifestyles and the conditions in which they live and work have been shown to strongly influence their health and longevity. Significantly ‘most people are kept healthy or made ill where they live, work or play long before they have contact with the health care system’ (Harrison, 1998).

Wilkinson has shown that life expectancy has risen as countries develop economically (as measured by GDP) up to a certain level, but beyond that point further increase in life expectancy is related to the decrease in income inequalities and not to any further increase in GDP. He has related the increase in life expectancy to the change in relative poverty of 12 European countries from 1975 to 1985. Those countries with the greatest decrease in relative poverty show the greatest increase in life expectancy (cited in Luck, Bamford and Williamson, 2000: 67).

The World Health Organisation has taken a lead in promoting the social determinants of health as the basis for policy and action in order to attack the causes of ill health before they can lead to problems.

Ten Interrelated Aspects of the Social Determinants of Health

1. People’s social and economic circumstances strongly affect their health throughout life; health policy must be linked to the social and economic determinants of health.
2. Stress harms health.
3. The effects of early development last a long-time; a good start in life means supporting mothers and young children.
4. Social exclusion creates misery and costs lives.
5. Stress in the workplace increases the risk of disease.
7. Friendship, good social relations and strong supportive networks improve health at home, at work and in the community.
8. Individuals turn to alcohol, drugs and tobacco and suffer from their use, but use is influenced by the wider social setting.
9. Healthy food is a political issue.
10. Healthy transport means reducing driving and encouraging more walking and cycling, backed up by better public transport.
(Wilkinson and Marmot, 1998: 9)

Gendering the Social Determinants of Health
A gender perspective is usually absent from analyses of social determinants of health. Gender relations, gendered institutions and gender inequalities need to be explicitly inserted into analyses of social relations, social systems and institutions. Tackling the root causes of inequalities expressed in health requires an analysis of the impact of policies on the health and circumstances of the most vulnerable sections of society. A gender analysis must be central to such processes.
The WHO has explicitly 'conceptualised gender as a powerful structural determinant of mental health that interacts with other structural determinants including age, family structure, education, occupation, income and social support and with a variety of behavioural determinants of mental health. Understood as a social construct, gender must be included as a determinant of health because of its explanatory power in relation to differences in health outcomes between women and men' (WHO, 2000a: 4).

The following box on sex differences in the relationship between socio economic status and drug deaths and suicide indicate that gender should be considered as an important social determinant of health:

**Drug Deaths and Suicide**

There is a clear socio economic gradient in suicide among young men aged 15 to 24 - rates decline with rising socio economic status - and this gradient increased between 1985-87 and 1995-97. With drug dependence deaths, however, the gradient apparent in the mid 1980's had almost disappeared a decade later (ie little difference between socio-economic groups.

Among young women, the gradients for both suicide and drug deaths are reversed over this period - deaths in the mid 1990s are higher in the higher socioeconomic group. For all causes of death, the socioeconomic gradient increased for young males between 1986-87 and 1995-97 but declined for young females (Eckersley, 2001: 12).

Using the social determinants of health framework, including the importance of control and autonomy and the impact of stress on health, is instructive when considering the situation of particular groups of women who may experience high demand and low control in both their employment and in their personal relationships. Women working in casual positions in low paid insecure positions, plus juggling responsibilities for children, home and possibly other caring roles could be expected to experience negative impacts on their health.

**Researching Gender Inequalities in Health**

The social determinants of health perspective focuses attention on socio economic status and gradients in exposure to material, psycho social and behavioural risks. Much of the research has centred on men in their paid work (Carpenter, 2000: 49).

Only recently has research investigated the quality of both paid work and domestic work and health status among both women and men. Until the late 1980s there was little comparative research. Research on the health impact of work began with comparisons between women in paid work and full time 'housewives'. Research later began to build a range of additional work and family related factors into their analyses.

By the 1990's researchers were beginning to stress the need to develop measures of work related experience which fully capture the complexity of the workplace and working life, and the quality and meaning of men and women's experiences. ‘The more specific that gender comparative research seeks to be, the more it is constrained, not only by theoretical and methodological limitations, but by the fact that at the beginning of the 21st century being male or female remains such a key organising feature of all aspects of our lives, systematically structuring opportunities and experiences’ (Annandale and Hunt, 2000; Lee, 2001).

Over time, a number of theoretical and methodological approaches to research on gender inequalities in health have been developed, the table below details key aspects of these.

<table>
<thead>
<tr>
<th>Framework</th>
<th>Theoretical approach</th>
<th>Methodological approach</th>
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<tr>
<td>Traditional</td>
<td>• Only implicit&lt;br&gt;• ‘Gender’ equals difference between women and men&lt;br&gt;• Distinction between sex/gender&lt;br&gt;• Focus on women's exclusion</td>
<td>• Social roles and statuses as properties of individuals which affect health&lt;br&gt;• Women-only samples&lt;br&gt;• Static</td>
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from/inclusion in social roles and circumstances | Work and health as predominant focus
---|---
**Transitional** | Growing recognition of
- Cross-cutting patterns of gender inequality
- Similarities across men and women, and differences within women and within men increasingly emphasised
- Increasingly gender inclusive approach emphasising diverse axes of inequality
- Stress upon the meanings that people attach to roles and statuses
**Emerging/new** | Explicit attention to the gender order seen as essential
- Questioning of the hard division between sex and gender
- Gender comparative
- Incorporation of the gender order in analysis
- Combination of quantitative and qualitative methods
- Emphasis on social changes over time in the gender order (in both degree and form) at individual and structural level

(Annandale and Hunt 2000: 29)

Annandale and Hunt emphasise that it is important to
- build an explicit consideration of differences within groups of men and groups of women into the research process
- be aware of new forms of gender related equality and inequality that emerge between women and men, and between subgroups of women and subgroups of men, and
- highlight the complex ways in which the social relations of gender may impact upon men's and women's health (2000: 31).

**Social Capital and Gender Relations**
The concept of social capital is central to the social determinants of health. Putnam has written widely on social capital and defines it as ‘those features of social organisation, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit’ (cited in Harrison, 1998: 5). Social relationships, social support, formal and informal social networks, shared norms, trust, and community and civic engagement are seen as important indicators of social capital.

Social capital is seen as a public good that is protective of health and also as vulnerable to large scale or rapid social and economic changes. Using data from 39 states in the United States, Kawachi, Kennedy and Lochner (1997) found that income inequality was strongly correlated with low per capita group membership and lack of social trust.

Belle (1990) has identified that social networks do not only function, as sources of social support but can also be ‘conduits’ of stress. Poverty imposes considerable stress on individuals and families and may remove many potential sources of social support, where relatives and friends are in similar positions and vulnerable to an increased number of stressful life events (cited in WHO, 2000a: 59).

Putnam's conceptualisation of social capital has been criticised as gender blind, in that he considers only the possible negative effects of increasing numbers of women participating in the labour market on community groups and social interaction, and the effects of divorce and single parenthood on the family. A gender focus has lead to increased attention to gender differences in building and sustaining social capital in communities. It has been suggested that it is necessary to take into account gendered roles of women and men with respect to social capital (Luck, Bamford and Williamson 2000: 68).

Researchers have suggested that men's access to social capital is qualitatively different, and often less robust, to that of women. In the United Kingdom, Kelly, Wood, Campbell, Penn and Gillies carried out research into the differences in women and men's social networks in a local area. They
found that ‘social capital is not a homogenous resource that is equally created, sustained and accessed by all members of a particular community. People are embedded in local networks in different degrees and in different ways’ (Kelly et al, 1999: 3).

This study found that while there were considerable variations (based on marital status, health status and family responsibilities) among women and men as groups, there were gender differences in the types of networks men and women were part of. Three types of community networks were identified:

- informal networks of family, friends and neighbours
- voluntary networks relating to sports, hobbies and leisure activities
- networks relating to the wider community eg neighbourhood watch, local political parties.

Gender differences were also found in the type of support that men and women created and drew upon in their day to day lives, as well as differences in the type of support that men and women gave and received from these networks. The findings suggest that the different ways in which men and women create, sustain and access social networks at different levels need to be taken into account in community development, health promotion and community strengthening initiatives.

### Interlocking Oppressions and Intersectionality

The social determinants of health research has found that relative poverty, as well as absolute poverty, leads to worse health and increased risks of premature death. Migrants, ethnic minorities and refugees are particularly vulnerable to social exclusion, and their children are likely to be at special risk. Racism, discrimination and hostility can harm health. Communities may marginalise and reject women and men who are ill, disabled or emotionally vulnerable. It is important to consider what this means for particular groups of women ie: migrants, women with disabilities, Koori women and others. The impact of violence against women on women's health is a particular issue must also be taken into account.

As articulated at the World Conference on Racism in 2001, ‘an intersectional approach to discrimination’ acknowledges that:

> ‘Every person, man or woman exists in a framework of multiple identities. Factors such as age, class, race, ethnicity, religion, sexual orientation, gender, disability, citizenship, national identity and geo/political context are all determinants in one's experience of life. This means that a woman's experience of discrimination may also be affected by, for example, her race or religion. Women experience racism as migrants, as refugee women, as indigenous women, or as women from backgrounds other than English speaking, when they are single heads of households, living with disabilities, girl children, lesbian women, young mothers or older women. Each of these facets of identity can compound the experience of racism. The intersection of race, ethnicity, religion and gender obstructs women of minority communities in the enjoyment and exercise of their fundamental human rights’ (Sisely, 2001: 5).

The concepts of ‘interlocking oppressions’ and ‘intersectionality’ are linked. ‘The notion of interlocking oppressions refers to the macro level connections linking systems of oppression such as race, class and gender…the notion of intersectionality describes micro level processes - namely, how each individual and group occupies a social position with interlocking structure of oppression described by the metaphor of intersectionality. Together they shape oppression’ (Collins quoted in Dressel et al, 1997: 583).

### Health Promotion

The World Health Organisation has defined health promotion as ‘fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health - not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services and the physical environment’ (WHO, 1998b: 16).
The Ottawa Charter articulated a strong social justice framework for health promotion. The Ottawa Charter states that ‘health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs and to change or cope with the environment’ (Ottawa Charter, 1986: 1).

**Health promotion with women and men**

‘Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things, which determine their health. This must apply equally to women and men’ (Ottawa Charter, 1986: 2).

However, how health promotion has been conceptualised varies considerably in terms of its targets and its transformatory potential. Three broad approaches to health promotion have been identified: the medical approach: reducing the prevalence or risk of disease the lifestyle approach: promoting a healthy lifestyle (behaviour risk factor model) the socio-environmental approach: addressing social and structural barriers to health.

Critical health promotion theorists distinguish between individually focused health promotion, which places responsibility for maintaining good health on the individual, and collectively focused health promotion, which is directed towards cultural change (Pease, 1999).

**Gendered Health Promotion**

Health promotion should start from an awareness of the different issues and experiences of men and women in relation to particular health issues (National Ageing Research Institute, 2001). Strategies for promoting better health would be more effective if they were to target men's and women's particular experiences, access to and control over resources, and build on how women's and men's gender roles can act to protect or to prevent good health for themselves and for others. Finding non-threatening ways to raise and reflect on gender roles, relations and stereotypes is particularly important, if health promotion is to be effective.

The concepts of ‘practical gender needs’ and ‘strategic gender interests’ should inform the design and delivery of health promotion programs to meet practical needs. Methodologies and processes should aim to address disadvantage and discrimination and empower those involved in programs.

It may be possible to minimise the health burdens arising from gender roles and inequalities, but the focus on health interventions to minimise this burden will not resolve the fundamental causes of the differential exposure to such risks. In such cases, fundamental changes must be made which involve going beyond ‘risk factors’ to discussing and addressing underlying causes. Attention to gender and other social identities needs to be explicitly mainstreamed into health promotion.
**Mental Health Promotion**

Programs addressing depression and promoting mental health should facilitate increased social equity and gender equality, to promote changes in gendered experiences and life situations that have been identified as risk factors for depression.

Research has identified the following factors that are protective against depression:
- sufficient autonomy to exercise some sense of control over one's life in response to severe events
- access to adequate material resources (to provide for choice in response to severe life events)
- presence of emotional and social support.

Programs that aim to reduce depression need to address structural factors as well as individual factors and have a strong gender focus. A focus on reduction of individual lifestyle risk factors may neglect the very factors that brought that lifestyle into being.

(WHO, 2000a)

Health education messages can reinforce gender stereotypes, for example the ‘healthy eating to prevent heart disease’ where women were cast in the roles of cooks and responsible for men's health, rather than promoting behaviour change in men (Broom, 1995b: 10). Effective anti-smoking messages may need to be tailored to different population groups, and take account of gender differences.

**Health Promotion Issues: Smoking**

Social and particularly gender influences have been important in influencing both smoking uptake and decisions to stop smoking among women and men in Australia.

Men's greater responsiveness to public health campaigns has been attributed to the fact that more information was available concerning the health damaging effects of smoking for men. Men may have been more responsive to the anti-smoking messages since they were more likely to have known someone of their own sex who had been adversely affected by smoking.

Cigarette advertising has been a based on themes of success and sex appeal for both women and men. Women have been extensively targeted in tobacco marketing specifically in women’s magazines prior to the ban on advertising. Smoking has been portrayed as both a passport and a symbol of the success and independence of the modern woman.

Health promotion work with particular groups should be informed by an understanding of gender differences in the social meaning and the symbolic power of smoking, plus the reasons and the contexts in which diverse groups of women and men smoke. Factors and trends (demographic, economic, social and cultural factors) that impact on particular generations or groups in society are important to consider in developing appropriate campaigns. Single-issue individualistic approaches to smoking cessation may well be less effective than intersectoral programs that improve the daily lives of women smokers caring for children in low income families. (WHW, 2002).

Health education messages can also be used as vehicles to raise awareness of non-stereotyped roles and portray sharing of roles and responsibilities to promote gender equality. Interventions will be more effective when the messages developed reflect the lives and experiences of the target group.

**Health Promotion and Intersectionality**

Health promotion has historically been aimed at influencing high risk behaviour in individuals, it has been largely irrelevant to population health, except perhaps on a political and symbolic level.
Harrison (1996) noted that less than 1 per cent of the total UK spending on health has been directed to health promotion (1998: 4-5).

According to Harrison, health investment and health promotion are integrative concepts, where health objectives are integrated into housing, nutrition, transport and income policies and programs. This integrated approach contrasts with programs that address additive activities, for example smoking or drinking. ‘It is changing these social systems to integrate health objectives that is the goal of health development and promotion. Maintaining health damaging social systems then purchasing marginal health promotion programs ’ in addition’ to ameliorate their effects simply misses the point. The implication is that beyond minor infrastructure costs, a great deal of health investment and health promotion might be achieved without any financial resources at all’ (Harrison, 1998: 6).

The evidence about the impact of social inequalities and lack of control on health and well being has clear implications for health promotion. As well as addressing structural changes related to economic, living and working conditions, health education efforts targeting less privileged groups need to take into account the gender realities experienced by those women and men. Health education campaigns may need to be more localised, based on community development principles including the process where members of the target group take control over the aims, activities and messages of the campaigns.

As set out in the Ottawa Charter for Health Promotion, ‘ health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing’ (Ottawa Charter, 1986: 1). This is consistent with a gender perspective that gender inequality in society influences the health of women and men, and promoting gender equality in health requires action to be taken not only in the health sector, but in other sectors to promote gender equality and the rights of all members of the society (Jahan et al, 1998: 9).

A gender perspective and the social model of health both encourage us to go beyond the confines of the health sector and the interventions it can deliver alone, to work towards policy initiatives that are multisectoral in their approach.

Rationales for a Gendered Approach to Health
The main rationales advanced for a gendered perspective in planning, implementation and evaluation encompass welfare, anti-poverty, equity, economic efficiency, effectiveness, and empowerment.

Gender advocates have often chosen their language and their focus depending on the environment in which they operate. For example, equity arguments may not be sufficiently persuasive in an agency of economists, while economic efficiency arguments alone may not be suitable in a non government organisation where human rights and social justice concerns are priorities. Economic efficiency arguments are often used to justify use of scarce resources, however 'efficiency approaches run the risk of failing to prove their effectiveness under the …five to 10 years typical of most programmes. The social construction of an under-class - in this case - women - takes more than a decade to deconstruct and then to reconstruct’ (ECOSOC, 1994: 11).

A welfare or a poverty approach may be the most feasible entry point for raising gender awareness within a conservative policy arena because of their apparently non-threatening concerns. However, even within a welfare or anti-poverty approach, often strategies used to implement the approach may either leave intact the underlying causes of gender inequality, or fail too create longer-term strategic change.

A gender analysis framework in health enables identification, analysis and action to address inequalities that arise from belonging to one sex or the other or as a result of the unequal power relations between genders. As noted by WHO, ‘these inequalities can create, maintain or exacerbate exposure to risk factors that endanger health. They can also affect the access to and control of resources, including decision-making and education, which protect and promote health, and the responsibilities and rewards in health work. Since these inequalities most often
disadvantage women, a gender analysis has been used so far mainly to explain and address women’s health problems’ (WHO, 1998a: 3).

Gender analysis can also lead to greater conceptual clarity and targeting in health planning, as inequalities in access to health care and outcomes of health care become apparent. The concern with quality in the health sector means that incorporating a gender perspective will require not only quantitative data but qualitative data including the thoughts and experiences of women and men. Gender analysis assists us to ‘see’ women and men in various population groups and facilitates awareness of how different groups have different needs. Gender analysis in health provides concepts and methods whereby these needs can be identified and addressed.
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A Gender Agenda: Planning for an Inclusive and Diverse Community

PART THREE: Women's Health Policies

The Women's Health Movement
The focus on women's health arose in the 1960s and 1970s in Australia, as part of wider social change movements. The initial emphasis was on women's reproductive and sexual health, encouraging women to take control of their health and providing alternative service options for women. Over time the focus on reproductive and sexual health was broadened to include all health issues that affect women. ‘A women's health approach …involves not only providing services around the needs of women but involves the process or manner in which the service is developed, provided and evaluated. That is, it is both a product and a process’ (Department of Human Services, 1997: 16).

Women's activism led to the development of stand-alone women's health centres the development of federal and state government policies and departmental infra-structures in the 1980s.

Key concepts and principles
The origins of the women's health movement have been critical in shaping the two key concepts which underpin the movement - informed choice and control. These concepts identify the need for women to be active participants in decisions made about their care and the best way to respond to their needs.

In order to exercise both control and choice regarding their health and wellbeing, women need comprehensive quality information about health and wellbeing issues and the range of available health care provisions. A key purpose of the women's health movement has been to provide clear and accessible health information to all women. Complementary to the provision of information is the development of women's skills so that they are able to apply the information they receive. Consequently, information and education are critical components of the movement.

Control and choice also need to be reflected in open and inclusive management structures and collaborative decision-making processes designed to break down professional elitism and promote women's input into service planning and delivery. These structures and processes should be responsive to women and their needs and enhance service accountability to consumers. Management structures should also promote the principles of cooperation within and across health and the related sectors.

A second principle is the recognition of the differences as well as similarities between women. The implications of this recognition on practice include using a woman-centred approach, which respects and listens to different women's issues. This principle requires that services are based on an analysis of the needs of women. This includes using research processes such as data collection, evaluation and community needs assessment to identify key themes, which could be responded to in practice or community action.

The third principle is the commitment to community action as a strategy to challenge systems and advocate for change on broad social issues affecting the health of women. Services also will adopt a process of reflective practice so that a women's health framework is used to critically evaluate service development and delivery.

The fourth principle is a commitment to the provision of friendly, accessible, safe spaces for women, which are based in the communities in which women live. Confidentiality is an important issue that impacts on women’s access to services, specifically in rural or within specific cultural communities. It is critical that all efforts are made to reduce the barriers to access which may arise from factors such as cultural or linguistic diversity, class, age, income, disability or sexual preference (Barnett and Radoslovich, 1998: 15-16)
**Victorian Women's Health Services: Principles**

Women's Health Services have a commitment to:

- addressing power imbalances which arise as a result of the effects of gender, physical, intellectual and psychiatric disability, sexuality, social class, race or geographical location
- recognising the importance of women having timely, appropriate, and accessible health information
- an approach which recognises that not all groups in society start from equal positions; therefore, some will require special and additional resources to ensure that their needs are met
- a social model of health
- recognising, validating and promoting women's own experiences of health and health care
- women having greater control over their own health and over their health services;
- promoting the important role Services provided 'for women, by women' play in the health system
- engaging with the health system at a number of levels and using a range of strategies (for example, community education, clinical services, health promotion)
- a woman-centred approach
- a team approach involving positive working relationships between Services within the program, as well as between these Services and mainstream services and programs
- a developmental approach: that is, one which involves people in the process of change, with the aim not only of achieving a desired outcome but of enabling people to gain power, skills and knowledge along the way
- promoting the involvement of women in decision-making within the health system.

(Webster and Wilson, 1993: 21)

**Women's Health Movement and Primary Health Care**

The women's health movement shares a similar philosophical and historical base with the primary health care sector. These include an emphasis on fostering the development of personal skills; community participation; advocacy; collaboration within and across sectors; reorientation of systems and services; accessible affordable and culturally appropriate services; locally based services.

‘Both the primary health care movement and the women’s health movement developed as models designed to reorient the traditional health system more towards approaches that combine a focus on illness prevention and treatment and health promotion. In practice, women's health services have acted as change agents by providing examples of primary health care in action, for example:

- different forms of practice
- the use of collaborative approaches with other parts of the health system or other sectors
- developing partnerships with women
- addressing emerging issues such as domestic violence, child sexual abuse’ (Barnett and Radoslovich, 1998: 16).

**Starting Points in Victoria**

One of the first women's health services in Victoria was the Queen Victoria Hospital in Melbourne. It was established in 1896 by a group of women doctors concerned about the poor health of women and children in slums, the lack of services to meet their needs and the lack of opportunities for women doctors to practice medicine. Each woman in Victoria was asked to donate one shilling toward the cost of the service, which has provided health services for 60 years.

The beginning of contemporary Women's Health Services can be found in the early 1970s when a group of women in Collingwood formed the Women's Health Collective. The Collective operated a Women's Health Service providing medical and support services by women doctors and health workers and funded through voluntary work, donations from clients and fees reclaimed from insurance. In 1974/75 the Federal Government granted partial funding for the Service through the Community Health Program to be administered through the Victorian Hospital and Charities.
Commission. However the funds were never released to the Collective, due to by the Commission, which found varied reasons to withhold the tied Federal Grant. In 1976 the Collective disbanded in partial response to the obstruction identified previously (Victorian Ministerial Women's Health Working Party, 1987: 6).

**Victorian Ministerial Women's Health Working Party: ‘Why Women's Health?’**

In 1985 the Victorian Minister for Health established the Women's Health Working Party to investigate women's health issues and to recommend measures to improve health services for women in Victoria. The Working Party used a variety of consultative methods to seek the views of women in the community. A discussion paper ‘Why Women's Health?’ and questionnaire were distributed, submissions invited, and public meetings held throughout Victoria. Separate meetings were arranged with Aboriginal women, and a meeting and a week long phone-in was organised to obtain the views of women from non-English speaking backgrounds.

The Working Party heard from many women who ‘repeatedly stressed that they found the health care system and providers unresponsive to their needs and that the system and providers frequently devalued women's experience and knowledge’ (Victorian Ministerial Women's Health Working Party, 1987: 2). The Working Party's report found that 'some health policies and patterns of health care directly and indirectly contribute to women's social subordination' and placed 'high priority on the development of new health services administered by and for women. These services have the potential to create new and more sensitive and effective service delivery models' (Victorian Ministerial Women's Health Working Party, 1987: 2-3).

The Working Party identified three principles to underpin the future development of women's health policy and services:

- women should have equal access to all health services
- policy and programs should give recognition to the different health needs of women
- women should be represented and enabled to participate equally in decision-making processes

(Victorian Ministerial Women's Health Working Party, 1987: 3)

**Women's Health – A Strategic Framework**

The overriding and fundamental principle of this report is that the health and wellbeing of women is directly related to the social context in which women live their lives. The experiences of men and women in Australian society are clearly different. Women are more likely to be economically dependent at some stage of their lives. Women are also more likely to be responsible for child-rearing and the care of elderly parents which may prevent them from achieving economic independence.

Women are more likely than men to be poor, as their work is often underpaid or unpaid. Men and women are most often employed in different sort of jobs, have different family responsibilities, are under different pressures and are encouraged to think of their bodies in different ways.

Women are employed in a narrow range of occupations, are concentrated in low paid positions with generally poor working conditions, and have inadequate career structures. This is true for the health industry as it is for other industries.

It is important to recognise that some women are more economically disadvantaged than other women. This is especially true for Aboriginal women. Many women from non-English speaking backgrounds are in low paid jobs.

Women are more likely to be receiving pension or benefits. About 64 per cent of all age pensioners (over 65 years) are women. This is due to the fact that women live longer and, generally, have had less access to superannuation and income over their working lives. The majority, about 92 per cent of single parents who are pensioners or beneficiaries are women.
Despite the long-term rise in women's paid employment, women have also continued to be responsible for domestic labour. For the vast majority of women, working outside the home means they have to work a 'double shift' of paid work and unpaid work, such as housework and child rearing.

The links between low income and poor health status are well documented. In addition, from childhood women and men have been conditioned to behave in stereotyped ways. For women especially, the stereotyping has produced detrimental effects on their health and wellbeing’ (Victorian Ministerial Women’s Health Working Party, 1987: 1).

In 1986 the Working Party forwarded an Interim Report to the Minister for Health. Recommendations were made on new women's health services, women's information and education services, education of health professionals, representation of women, specific health needs, access and the establishment of an office of women's health.

In 1986/87 Victorian State Budget funds were made available to implement a number of key recommendations including the first fully funded Women's Health Centre. The first of Victoria's regional women's health services, the Women's Health Service for the West (now known as Women's Health West) was established in 1987/88. The Women's Health Information Centre opened in early 1988 and a Women's Health Policy and Program Unit with a staff of five was established within the Victorian Health Department.

**National Women’s Health Policy**

The development of a national women's health policy was influenced by the community-based women's health movement and action taken at state government levels to establish women’s health units in the 1980s. In 1987 the Australian Health Ministers Advisory Council established a subcommittee on Women and Health.

The committee noted that ‘women's health concerns extend beyond specific health problems to include the structures that deliver health care and information, and the processes which influence women's interactions with the health system. These structures and processes affect the quality of care women receive, their access to appropriate and acceptable services and their health outcomes’ (1989: 4).

The National Women's Health Policy identified seven priority issues reflecting the concerns of women throughout the life cycle and relating to their varied roles:
- reproductive health and sexuality
- occupational health and safety
- health of ageing women
- health needs of women as carers
- violence against women
- women's emotional and mental health
- the health effects of sex role stereotyping on women (cited in Webster and Wilson, 1993: 17-18).

The policy noted that ‘health concerns extend beyond specific health problems to include the structures that deliver health care and information, and the processes which influence women's interactions with the health system. These structures and processes affect the quality of care women receive, their access to appropriate and acceptable services and their health outcomes.’ (cited in WHW, 1998). The following structural areas were identified as in need of further attention:
- improvements in health services for women
- the provision of health information for women
- research and data collection on women's health
- participation in decision-making, and
- training of health care providers.
The Policy was endorsed by all State Governments, leading to the Commonwealth/State National Women's Health Program, funded over two consecutive four year periods, 1989-1993 and 1993-1997. This funding enabled the Victorian Government to fulfil its commitment to establish a Women's Health Service in each of the regions (see below):

### The National Women's Health Program

In Victoria, the National Women's Health Program has been delivered through:

- 10 Women's Health Services (WHSs),
- Six community health centres providing women's health programs in the Barwon/South West Region, and
- 15 Centres Against Sexual Assault (CASAs)

By 1994, the National Women's Health Program had funded 55 women's health centres throughout Australia.

(WHW, 1998)

In contrast to these policy and funding initiatives of the late 1980s and early 1990s by the mid to late 1990s the government had begun to dismantle these gains. It has been noted that decreasing social expenditure, devolution of responsibility from federal to state/territory levels, and the increasing privatisation of health services had a deleterious effect on women's health policy development and specialist service delivery. The Health Ministers National SubCommittee for Women and Health was abolished in October 1998. In February 2001, a National Women's Health Conference recommended a review and stressed the need for National Policy. [BP1] There is currently uncertainty about the status of the National Women's Health Policy.

Nevertheless, the impact of the National Women's Health Policy has been long-term, as found in a 1997 South Australian study:

'The National Women's Health Policy, since its adoption in 1989, has provided a framework which has guided women's health practice across the nation. The policy is robust and relevant 10 years later. The Policy provided the framework for services funded through the National Women's Health Program. In South Australia, these services have effectively used the framework to direct service provision, as identified in evaluations in 1993 and 1996. The existence of a national policy and its accompanying resource allocation has provided a focus at the national and state levels on women's health which has protected and supported the development of women's health approaches' (Brandt, Gattner and Associates and Purdon Associates, cited in Barnett and Radoslovich, 1998: 24).

### The Victorian Women's Health Program and the Dual Strategy

The Victorian Women's Health Program (VWHP) was established following the 1987 Victorian consultation 'Why Women's Health?' with the support of Federal Government cost-sharing funds stemming from the National Women's Health Policy.

Since its inception the Victorian Women's Health Program has had a dual strategy for effecting change:
- providing services run by women for women
- working with service providers across the whole spectrum of services to improve their responsiveness to women.
An example of the Dual Strategy in Action: the Talking Health Project

In 1999 Women's Health West invited women from four newly arrived communities - Bosnia-Herzegovina, Somalia and both Chaldean and Arabic speaking women from Iraq - to identify the main health issues confronting them. Consultations and discussions with the women from the migrant and refugee communities lead to the production of eight health information audio tapes, which were broadcast on ethnic radio and distributed within the relevant communities.

In the second stage, women from the communities became cultural consultants to the project, developing and presenting training workshops on migrant and refugee women and depression in the context of resettlement. The workshops were conducted for service providers from a range of government and other organisations who come into contact with refugee and migrant women during their resettlement period (Women's Health West, 2001).

The current configuration of funded Women's Health Services came into existence gradually from 1988 to 1992. Each of the statewide and regional women's health services were established independently of one another, with funding amounts based on the particular service and political environment, rather than an explicit formula.

Initially, the statewide services' roles focussed on development and the provision of independent information, while the regional services role was the provision of clinical services. Women's Health Services have faced difficulties in relation to the provision of direct services, which include large regions, high costs in providing clinical services, and difficulties in avoiding the duplication of what is provided elsewhere. Different services addressed these dilemmas in various ways, including:

- offering 'clinics', sessions or programs around specific issues
- assisting marginalised groups of women to access existing health services
- towards working with health service providers improve their delivery of services to women.

Over time, regional women's health services have developed their role to focus on education, health promotion and training. In addition to supplying direct services to vulnerable sub-populations, 'women's services continue to act as demonstration sites and launching pads for enhancing the accessibility and appropriateness of the mainstream, and as colleagues working with generalist services' (Broom, 2001: 2).

Developing links with women's and community networks, agencies and programs within the mainstream of the health system has been crucial to implementing the dual strategy (Beaumont, 2001: 12). Women's Health Services utilise a number of strategies to influence generalist services, as outlined below:

Strategies used by Women's Health Services

1. Exploring and modelling improved ways of delivering services to women.
2. Monitoring women's health issues with a view to identifying trends and concerns and developing an informed base for the Service's work at other levels.
3. Representing women's concerns to government, health services and other bodies to advocate concerns of women.
4. Information and resource development to assist women to access and make better use of health services and resources.
5. Advice and consultation to mainstream services and other organisations regarding service provision to women.
6. Promoting women's participation in decision-making within the health system.
7. Training health professionals.
8. Joint ventures with other services, with a view to encouraging services to allocate resources to address the specific concerns of women and to provide a focus for demonstrating service delivery approaches which are sensitive to women's needs.

(Webster and Wilson, 1983: 29)
The Health Status of Victorian Women: A First Report
The ‘Health Status of Victorian Women: A First Report’ of April 1997 was prepared by the Department of Human Services as the initial step in planning and evaluating future directions in women’s health programs and services. The report provided a snapshot of patterns of health and illness of Victorian women, and was presented as the basis for a five-year statewide women's health plan. At the same time that the Report was released, it was announced that the Annual Women's Budget Statement would no longer be continued.

The draft Two Year Action Plan for Women 1998-2000 was a step in the development of State Government policies and programs. The Action Plan identified four priority areas:

• creating an environment where women and families feel safe
• developing women’s health and family support to promote wellbeing
• ensuring economic security for women through enhanced employment and education opportunities
• promoting women to decision-making and leadership positions.

The Plan identified the following themes for health and wellbeing:

• prevention of violence against women
• age related health issues
• reproductive and sexual health
• women as carers
• emotional and mental health
• emerging health issues.

A focus on health issues for Aboriginal and Torres Strait Islander women, linguistically and culturally diverse women, women in rural and remote areas and women in low socio-economic situations were also identified in the Plan (Office of Women’s Affairs, 1998: 15).

Governmental Changes and Women's Health Policy Uncertainties
The past decade has seen considerable uncertainty over the continuation of the Women's Health Program as a specific, stand-alone program. Proposals for the integration of Women's Health into community health centres and into primary care structures were mooted with during the Kennett Liberal Government.

More recently, the Bracks Labor Party stated that it would continue to fund stand-alone women's health centres and services in Victoria. In the 1999/2000 budget there was a 16 per cent increase to the Women's Health Program budget, with $0.5 million recurrent funding allocated to the expansion of health promotion in women's health programs (Slatter, 2001: 19).

The Bracks Government has articulated core principles that inform the Government's investment in social policy and planning, which include the following:

• the application of a social model of health which recognise that social and environmental circumstances impact on health and wellbeing outcomes;
• a resolve to reduce inequalities in health
• recognition that community building and the empowerment of women are important mechanisms in improving women's health
• an understanding of diversity and how it informs the varied lives and experiences of women (Department of Human Services, 2001: iii).

‘Valuing Victoria’s Women’ Forward Plan
The Office of Women’s Policy Unit launched the Valuing Victoria’s Women Forward Plan 2000-2003 in July 2000. The plan provides a whole of Government approach to four broad areas:

• representation and equity,
• education, work and economic independence,
• health, wellbeing and community strengthening, and
• justice and safety.

The Office of Women’s Policy released a report on initial outcomes in 2001 (OWP, 2001).

**Women's Safety Strategy**

The Victorian Government is committed to developing a Women's Safety Strategy to reduce both the level actual violence against women, and women's fear of violence. The Office of Women's Policy in the Department of Premier and Cabinet is responsible for coordinating the Strategy. The Strategy is being developed through an annual meeting of Ministers, a Women's Safety Coordinating Committee comprised of senior public servants and community involvement through various mechanisms. It is expected that the strategy will be launched in mid 2002.

**Victorian Women's Health and Wellbeing Strategy**

The Government appointed a Ministerial Advisory Committee on Women's Health and Wellbeing (MACWHW) comprising Caroline Hogg (chair) and 21 (women) members. The committee has steered the development of a discussion paper on the Women's Health and Wellbeing Strategy. The discussion paper was released in November 2001, and sought feedback from women and service providers on whether the key action areas and proposed strategies addressed the concerns of women and would lead to improved health and wellbeing for women. Community consultations were undertaken in regional Victoria and Melbourne between November 2001 to February 2002. The discussion paper is to be developed into an operational plan with specific outcomes. It is expected that the plan will be finalised in mid 2002.

**Principles Guiding the Victorian Women's Health and Wellbeing Strategy**

1. Maintain a commitment to reducing health inequalities
2. Develop strategies that support and enhance women's economic independence
3. Implement strategies that focus on prevention and early intervention
4. Strike a balance between communities and diversity
5. Involve women in clinical, program and policy decisions
6. Guard and respect women's rights
7. Keep violence against women on the agenda
8. Ensure a balance between evidence and experience

(Department of Human Services, 2001: 1).

The Discussion Paper takes the social determinants of health as a framework, and notes the following. ‘Although research on inequalities rarely attends to gender …the concentration of women amongst the poor implies that the widening distance between the 'haves' and the 'have-nots' has a heavy impact on women… Given that women's experience of health and wellbeing is inextricably linked with their position in society (women are the primary carers, women have lower rates of income, women suffer more domestic violence), gender has a significant effect on health. A clear indicator of this is the high level of depression and morbidity experienced by women’ (DHS, 2001: 10).

The Policy aims to address the key health concerns of those who have the least access and are the most disadvantaged. Koori women, lesbians, women in prison and those who have been in prison, women with disabilities and working women were identified as key groups for further research. Research papers were prepared to guide consultations with women from these five population groups which were held in July 2001.

The Discussion Paper notes that particular attention must be given to:
• groups whose health is especially poor (such as Kooris)
• people for whom poor health has 'multiplier' effects (such as young people whose problems, if ignored, may persist throughout life)
• those with a cluster or concentration of vulnerabilities (such as young, single mothers who are unemployed)
• people with several health conditions ('comorbidities'), such as those with a mental illness, substance abuse, and self-harming behaviours
• large population groups (such as CALD populations, those with reduced opportunities and people with disabilities).

The discussion paper identifies the following current issues for women in Victoria:
• women's participation and leadership
• violence against women
• emotional and mental health
• access to services
• the impact of women's socioeconomic status on their health and wellbeing
• broader system issues (the structures that deliver health services and information and their operations from a social model of health).

The Victorian Women's Health Program in 2001
The aim of the VWHP is to improve the health and wellbeing of all Victorian women, with an emphasis on those most at risk. This is undertaken through the development and dissemination of health information and health research, the provision of health, community and professional education. The VWHP now includes 11 women's health services: two centrally located statewide services and a woman's health service in each of Victoria's nine DHS regions. The Program also provides funding to a woman's health information service based at the Royal Women's Hospital. All of these services continue to work within the dual strategy of health system change, but at the same time the VWHP recognises the importance of seeing health within its social context and acknowledges that gender is a key factor in determining health outcomes (DHS, 2001: 4).

The Women's Health and Wellbeing Strategy identifies five key action areas, each with strategies proposed that aim to address the needs of women most at risk. The key action areas are:
1. Increase women's participation and leadership
2. Increase access that embraces diversity
3. Enhance women's safety and security
4. Address women's mental and emotional health
5. Extend knowledge on women's health and promote ongoing improvements (Department of Human Services, 2001: 13).
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PART FOUR: Primary Care Partnerships and Community Health Plans

Overview
This section examines the Department of Human Services (DHS) policy and planning requirements for Primary Care Partnerships, with a particular focus on Community Health Plans. The requirements of the Department of Human Services as the policy-setting and funding organisation are the foundation for examining gender issues in the planning processes of the three Primary Care Partnerships (PCPs) in the Western Metropolitan Region of Melbourne.

The three Western Metropolitan Region PCPs are:
- WestBay (covering the municipalities of Hobsons Bay, Maribyrnong and Wyndham)
- Melton/Brimbank
- Moonee Valley/Melbourne

There has been considerable collaboration among the three PCPs as indicated by the establishment of a Cross Alliance Planning Group. Joint activities have been undertaken by consultants on behalf of the Cross Alliance in relation to:
- the Integrated Service Plan (ISP) matrix
- the identification of planning indicators based on service utilisation information, and the
devolution of a consumer and carer charter template and participation strategy.

Community Health Plans (CHPs) are complex documents that have three main components: partnerships, service coordination and service planning. This paper focuses primarily on the service planning component, plus consumer and carer participation which lies within the partnerships component. The service coordination component (encompassing assessment/referral and information management) of Community Health Plans is beyond the scope of the study.

This section is written from the perspective that primary care partnerships and community health plans can reinforce or redress gender inequalities. Without an explicit focus on gender, PCPs may plan in gender-blind ways. Incorporating attention to gender consistently into PCP planning is expected to lead to a better understanding of how gender relations may influence the health and wellbeing of particular population groups in the west, and inform the priorities and strategies developed for improving population health in community health plans.

Primary Care Partnerships

PCP Strategy Aims
In April 2000 the Victorian Government launched the Primary Care Partnership (PCP) Strategy as a major reform in the way services are planned and delivered in the primary care and community support services sector in Victoria. The Government committed $45 million over four years to building a population health and wellbeing approach into primary care planning and service delivery.

The aim of the Primary Care Partnership Strategy is to achieve the overall health and wellbeing of Victorians by:
- improving the experience and outcomes for people who use primary care services
- reducing the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's needs for support (DHS website).
DHS Requirements of PCPs

The Department of Human Services has been responsible for the progressive development and refinements of the frameworks, requirements and parameters for the Primary Care Partnership Strategy. Requirements, guidelines and timeframes have been subject to progressive amendments, revision and changes.

DHS has specified six key deliverables for 2001/02:

- pilot and implement an initial needs identification tool and a care planning tool
- develop service directories in all PCPs
- implement integrated health promotion programs for priority population groups with or at risk of chronic disease and other health and wellbeing issues and demonstrate the impact of these programs
- implement Integrated Disease Management Programs in the four identified PCPs with tangible improvements in the identification, care and management of people with chronic/complex health conditions and identify the impact of these programs on hospital admissions for the clients involved
- increase the participation of General Practitioners in the coordination of care for consumers with chronic or complex conditions
- increase the focus on the reduction of avoidable hospital admissions and emergency demand through joint strategies between primary health and acute health agencies.

DHS has stated that ‘each of these deliverables is underpinned by the continued need for:

- consumers and carers to be engaged in PCPs and inform the changes being made
- sharp and comprehensive analysis of the health and wellbeing needs of each PCPs community highlighting priorities for action. These priorities must clearly inform the actions taken by PCPs.
- evaluation of the process of service reform, the impacts and outcomes for consumers, carers and the community, as well as the development of a quality improvement framework and initiatives’ (Slatter, 2001).

The policy and operational requirements for PCPs are still developing. DHS expectations and requirements plus longer-term issues regarding government funding and resourcing of PCPs, and the relationship of Community Health Plans to Municipal and Mental Health Plans are currently not clear. In the midst of this evolving policy and operational context, it is timely to focus on how gender has been considered in the development and operation of the Primary Care Partnerships.

PCP Members

The Primary Care Partnership Strategy (PCPS) is based on agencies and organisations involved in primary care, cooperating and collaborating, rather than being in competition with each other, as had been the case with the previous State Government approach to the primary care sector. In developing its service system each PCP is expected by DHS to form partnerships with local consumers, carers and communities.

Primary Care Partnerships bring together a range of services including community health services, ethno-specific health services, Aboriginal health services, women's health services, local government, district health services, dental health services, general practitioners, hospitals, and drug and alcohol treatment services.

DHS Expectations of the role of Women's Health Services in PCPs

DHS has stated that ‘the development and implementation of each CHP provides an opportunity for women's health services to contribute their expertise in assisting 'mainstream' services to be more responsive to women's needs. As a result, women's voices should be heard more systematically by providers and governments' (DHS, 2001a: 7).

DHS has also made specific mention of the role and wealth of expertise of women's health services in health promotion. ‘These services will have significant input into the health promotion element of community health plans, for example. Community health and women's health services
may also be nominated to take the lead role in health promotion for their local PCP’ (DHS, 2000c: 10).

DHS staff have identified two additional areas where women's health services have expertise that is seen as particularly relevant to PCPs:

- involvement with consumers in the planning, development, design and evaluation of service delivery.
- engagement on a systemic basis with other providers regarding how they deliver and design services, by networking through partnerships and by providing the evidence base for change.

‘Women's health care services will have increased capacity and leverage to exercise their change agent role and have the opportunity to influence a range of processes such as the development of community health plans that aim to improve the health outcomes of the entire community’ (Slatter, 2000: 21-22).

Women's Health West is an active member of the three PCPs in the Western Region, and has a continued role in sharing its expertise and experience with PCP members to assist with service planning.

Women's Health Services are developing a protocol framework to assist Women's Health Services to negotiate and agree roles, responsibilities, priorities and processes for the most effective management between WHS and PCPs.

Without minimalising the significant roles and impact of ‘change agents’, it is important to be realistic about the influence of one organisation in a partnership, especially a partnership that is developing and responding to a changing framework. Partnerships can take many and varied forms and structures, and change over time with contextual changes. Organisational and personal relationships, power relations, influence and trust can all play a part in how decision-making happens in a partnership composed of a number of organisations with different missions, values and resources.

**Incorporating a gendered perspective into PCP Service Planning**

Given the significant responsibilities of Primary Care Partnerships, particularly the development of Community Health Plans, it is important to ensure that gender is ‘mainstreamed’ or integrated into the analyses, formulation of policies, programs and plans by Primary Care Partnerships and member agencies.

Studies of gender mainstreaming in a variety of contexts demonstrate that while much can be achieved, ‘change agent roles’ can be limited if organisation/partnership-wide and high level commitment is lacking. Gender perspectives need to be incorporated into policies, and reflected in standard practices and procedures, job descriptions, organisational plans and resourcing.

PCPs have primary care service planning and coordination as their focus, while service delivery for the immediate future lies largely with member agencies and other health and community care organisations. PCPs can directly address service planning from a gendered perspective within their responsibilities and through workforce development activities. PCPs can also exercise leadership and influence member agencies through for example, facilitating the development of common understandings and good practices within member organisations.

**Community Health Plans**

Primary Care Partnerships are responsible for working with the Department of Human Services and the community to develop and implement community health plans. The Community Health Plans include three year strategic directions and specific activities outlined on a yearly basis. The three key elements of Community Health Plans are:

1. **Partnerships:** defining how the partnership will work together to implement the Community Health Plan. This includes the members of the partnership, other agencies within the PCP
catchment, plus state-wide organisations. DHS also places emphasis on PCPs relationships with Divisions of General Practice, and consumer and carer participation in PCPs.

2. Service Coordination: addressing how local systems and infrastructure including: information management, needs identification, assessment and referral mechanisms, will enable providers to better coordinate services.

3. Integrated Service Planning: identifying the population health and wellbeing needs of the community and proposing strategies to address these needs within the context of a quality framework. This involves three key areas:
   - identifying community health and wellbeing needs
   - developing strategies to address priority needs
   - evaluating the implementation and outcomes of the strategies.

Community Health Plans are viewed as having four spheres of influence:
   - the primary care partnership itself, including service coordination and planning activities of the partnership as a whole.
   - individual agencies, through influencing the way services are coordinated, targeted and provided.
   - DHS regional offices, which make decisions about the resources and funding for PCPs and services, especially in relation to growth and new initiatives funding. CHPs will also help inform the Department's resource allocation and service funding decisions. DHS has stated the intention that resources are to be better targeted to needs and focused on interventions which can be linked to measurable outcomes.
   - government policy directions, influenced by the PCPs and the broader community.

DHS sees community health plans influencing the primary care system through partnership wide activities such as integrated health promotion, and integrated disease management pilot projects. Progressively, it is expected that these strategies will also inform individual provider service plans. Community Health Plans will be the basis for DHS funding of PCPs in future years (DHS, 2001c: 1). Integrated Service Planning is seen to be part of a cycle of planning, funding, implementation and evaluation.

Where is Gender in the DHS Framework for PCPs?
It is useful to review the processes and approaches taken to CHPs and ISPs in particular, to examine the extent to which gender has been incorporated into both DHS requirements and PCP planning and documents. In addition, to examine how a gendered perspective can add value to current Western Regional PCP CHPs.

The Victorian Government's and the Department of Human Services support the Victorian Women's Health Program and the Victorian Women's Health and Wellbeing Strategy, which is based in a social model of health. However, DHS's use of a gender framework has not been consistent.

DHS has stated that ‘Gender is an important determinant of health and wellbeing, along with socioeconomic status and ethnicity. Women and men often have different life experiences, needs, issues and priorities. This includes, but is not limited to, issues that are unique to women or men, are more common in women or men, have different risk factors for women and men, or are experienced differently by women and men. Women and men will also have different experiences with regards to broader determinants of health, such as social connectedness and socioeconomic status. Data should always be collected and analysed by gender as a minimum base for planning. This should mean not only a breakdown of the population by sex, but also analysis of other indicators by gender’ (DHS, 2001b: 14-15).

However, despite the clear understanding of the importance of sex disaggregated data for gender analysis, the templates for Community Health Plans have not included sex disaggregated data as a basic requirement for CHP planning. Paragraph 3.1.6 states that ‘the identification of needs
should take into consideration the following factors. Depending on local circumstances, PCPs may want to focus on one or more of these factors as a distinct population group:

- gender
- cultural and linguistic diversity
- indigenous status
- economic disadvantage
- rurality where appropriate
- homeless, risk of homelessness or areas of poor housing' (DHS, 2002: 6).

This implies that each factor can be separately focused - yet all population groups are gendered.

Various other documents produced by DHS as policy and operational guides to PCPs likewise lack mention of requirements for sex-disaggregated data. For example, the examples of health promotion interventions give generic evaluation indicators, which for process, reach and impact indicators generally refer only to ‘number of people’ or ‘proportion of people’, as distinct from identifying outcomes for men and/or women.

For effective gender analysis and gender sensitive programming, sex disaggregated data and information is required at all stages from needs identification, service and program design, monitoring, reporting and evaluation. The particular needs and situations of all population groups: culturally and linguistically diverse, socioeconomically disadvantaged, the homeless, remote rural communities, should each be considered in terms of sex disaggregated data and from a framework that incorporates a gender analysis.

**DHS views on Data for Integrated Service Planning**

Interim Guidelines document stated that ‘information for Integrated Service Planning will come from a number of sources, including population and service data, community and stakeholder participation, and other relevant plans. These sources will build on each other. For instance, population data may help to identify specific groups in the community to be consulted, and other plans may have useful data and community consultation’ (DHS, 2001c: 5).

DHS has stated in various community health plan template documents that priority issues based on community and service profiles to improve the health and wellbeing of the PCP catchment population should, where possible, be linked to Burden of Disease data. The issue of which starting point, ie top down or bottom up, is not explicitly addressed by DHS.

DHS has discussed which data indicators should be used for planning. DHS suggested that the following should be taken into account:

- indicators of disease incidence, prevalence, mortality and morbidity, and their associated risk factors
- indicators of wellness, quality of life and health enhancement factors (DHS: 2001b: 14).

**Burden of Disease Data**

Early approaches to the measurement of health of the community focused on the main causes of death, and failed to capture the significant amounts of ill health that results in disability or morbidity. The Global Burden of Disease Study jointly undertaken by the World Bank and the World Health Organisation in 1993 used composite measures (those which combine mortality and morbidity) to measure the health of populations. The unit of measurement - Disability Adjusted Life Year (DALY) is a composite measure of health status, which combines the time lost to premature mortality (Years of Life Lost ‘YLLs’) and the time lived with a disability (Years Lived with a Disability ‘YLDs’).

Use of Burden of Disease (BOD) data for population-based health care planning has since become popular internationally and in Australia. A Victorian Burden of Disease Study was undertaken in 1998, parallel to a national study undertaken by the Australian Institute of Health and Welfare. These studies used the methods developed for the Global Burden of Disease (GBD) Study, with some variations, which include: use of Australian life expectancy at birth data rather than GBD standard; age weighting not used; use of Dutch weights for disabling outcomes of 52 common conditions, supplemented by GBD weights for conditions not considered in the Dutch study.
Victoria is the only State that has calculated BOD for the State, and at local government area (LGA). DHS is developing a core set of data as a common starting point for population-based planning by PCPs. BOD data has been a primary source of data for both DHS and for PCPs, in part due to the difficulties of obtaining useful data from other sources.

The Victorian study found great disparities in the mortality burden between indigenous and non-indigenous people in Victoria. Differences in health status are also found in people living in socioeconomically disadvantaged areas and in rural Victoria. The Victorian study produced sex disaggregated data, including lists of mortality in YLLs by sex, for example:

<table>
<thead>
<tr>
<th>Conditions in Men</th>
<th>YLLs</th>
<th>Conditions in Women</th>
<th>YLLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ischaemic heart disease</td>
<td>37,031</td>
<td>1. Ischaemic heart disease</td>
<td>28,417</td>
</tr>
<tr>
<td>2. Lung cancer</td>
<td>13,986</td>
<td>2. Stroke</td>
<td>13,684</td>
</tr>
<tr>
<td>4. Suicide</td>
<td>8,738</td>
<td>4. Lung cancer</td>
<td>7,240</td>
</tr>
<tr>
<td>5. COPD</td>
<td>7,805</td>
<td>5. Bowel cancer</td>
<td>6,970</td>
</tr>
<tr>
<td>6. Bowel cancer</td>
<td>7,805</td>
<td>6. COPD</td>
<td>5,917</td>
</tr>
<tr>
<td>8. Prostate cancer</td>
<td>5,717</td>
<td>8. Dementia</td>
<td>4,251</td>
</tr>
<tr>
<td>10. Illicit drug use</td>
<td>3,571</td>
<td>10. Suicide</td>
<td>2,651</td>
</tr>
</tbody>
</table>

(DHS, 1999: 21)

**Burden Of Disease Data and Gender Concerns**

BOD data is generally used in health service resource allocation and planning without consideration of the relationships between sex, gender and disease. Measurement involves the use of values, which are not readily apparent in statistics, as in the table above, assumptions and possible biases in the tool and/or the data available.

Gender issues related to burden of disease measurement present three problem areas.

- conceptual issues related to what is being measured;
- biases that arise through the estimation of disease prevalence and incidence;
- biases that rise from the methods for measuring and valuing ill health (Hanson, 1999).

The Burden of Disease approach measures diseases at an individual level, and does not take into account more than one ill health condition at the same time, nor the interdependency of disease. DALY measurements are constructed around diseases, not around patient groups or populations.

The burden measured is ‘the burden of ill health as experienced by the individual... Other burdens, which fall on family, friends and society at large, are not included... In particular, women’s caring roles and predominant responsibility for reproduction will not be captured through this individualistic approach’ (Hanson, 1999: 13).

The measure does not take into account resources other than health services, such as personal support network, employment and income that an individual may access to alleviate disability or disease symptoms.

Some diseases and disability states are inherently more difficult to measure and thus likely to be understated in BOD data. Some conditions may be systematically under-reported and thus underestimated for women, for example fear or stigma may discourage reporting of violence against women either in surveys or routine statistics. Other health conditions may be systematically under reported because women are more likely to be asymptomatic, eg 50-80 per cent of sexually transmitted diseases in women have either no symptoms or symptoms that are not easily recognised.
One set of problems identified by Hanson concerns the definition of ‘burden’. Should burden be limited to disability, be broadened to include handicap, which would take into account the social setting in which ill health occurs, or include a social/cultural measure of burden, which looks beyond the individual to the burden of carers? Moreover, whose values should be used to assign ‘burden’ weights for non-fatal illness? ‘That different groups tend to assess the same health state in different ways is well-recognised… with health professionals, patients, patients' families and the general public providing ratings which differ in systematic ways’ (Hanson, 1999: 26).

Sex differences in the social consequences of ill health are excluded from burden of disease calculations, although they may influence health outcomes in significant ways. Illness may be associated with either stigma or consequences that vary with social context, for example infertility (Hanson, 1999: 13, 17). Mooney has pointed out that ‘Burden is a value laden concept and one man's burden may be greater or lesser if the same nominal burden is born by a woman. There seem no reason to believe that a man and a woman faced with the pain and suffering from the same condition will necessarily weight the burden the same, nor that man and woman will weight for example physical and mental ill health the same’ (Mooney, 2001: 23-24).

BOD data is useful and of assistance in health service planning. However it is of concern that BOD is being used as a resource allocation tool, especially in isolation from other data. Concern has also been expressed about the validity of the BOD data when disaggregated by sub population groups, and its failure to capture the differential health effects of gender, particularly specific health issues for women (Johnstone, Brown and Beaumont, 2001).

The following information on suicide and self-harm shows the importance of adding to the picture obtained from BOD data with information from research and other studies, and explicitly looking at trends and factors for both women and men:

### Suicide and Self-Harm: Supplementing BOD with other Data

According to the Victorian Burden of Disease study, in the Western Metropolitan Region of Melbourne, suicide is the 7th highest (4 per cent) DALY condition for men, compared to the 27th highest for women (1 per cent).

However other research findings suggest a more complex picture:
- adolescent females and males attempt suicide at similar rates but males tend to use more lethal methods
- females predominantly overdose using prescription and over-the-counter drugs; deaths may be officially categorised as accidental deaths rather than suicides
- a local study by Wyndham City Council (2001) showed that over half (57 per cent) of non-fatal drug related overdoses were caused by prescription drugs and over-the-counter drugs. Females comprised 69 per cent of incidents.
- The rate of hospital admissions for deliberate self-harm is much higher for young females than young males.
- Self-harm and suicide also needs to consider the impact on families and women as primary carers.

(Women’s Health West, 2002: 99)

DHS has recognised that the Victorian Burden of Disease study could be questioned on the basis of its ability to measure the disease burden of specific groups, including Culturally and Linguistically Diverse groups. DHS has undertaken to ‘endeavour to ensure that both health and wellbeing factors specific to women are considered adequately in future Victorian Studies’ (2001a: 7).

**Burden of Disease and the Social Determinants of Health**

It is somewhat ironic that while both the Victorian Government and primary care partnerships are working explicitly from within a social model of health, the BOD approach focuses on individual outcomes and health interventions. As Hanson points out, ‘if the allocation of resources is to improve health and health equity, it needs to address the processes that generate ill health and
which influence access to health care resources. Some of these are gendered processes, while others relate to broader structures of inequality and disadvantage’ (Hanson, 1999: 25).

The allocation of resources among disease priorities is a normative process, which requires values and judgements to be explicit, and objectives and timeframes to be clearly defined. Whether one is working from a social model of health or a medical model needs to be specified; if the timeframe for results to be demonstrated is three rather than twenty years, a different focus could well be taken. The cost/benefit approach to health care interventions at an individual level will differ from the cost/benefit approach applied to health promotion for a population.

### Different Approaches to the Allocation of Resources

Evidence based health care might ask what is the most efficient and effective (least cost greatest outcome) intervention that can be undertaken with this group or this patient, that will restore or maintain health?

Evidence based health promotion and health investment should be asking what are the determinants of this population’s health status and what are the most effective and efficient interventions to protect and improve it? (Harrison, 1998: 7).

The prioritisation of different groups in the society can only be undertaken once social objectives have been specified and given explicit weights. There is a need to establish not only which if any groups should receive priority, but the extent and nature of this priority (Mooney, 2001).

### Data used by PCPs for Identification of Health Needs, Priorities and Planning

While three types of data or ‘evidence streams’: population health data, service utilisation data, and community experience data, have been identified to be used in community health planning, the most used data source has been a restricted range of population health data.

**Population data** - ‘above the line’ data - has been the primary source of information for the regional planning ‘indicators’ developed for use by the WestBay Cross Alliance group. All PCPs in the Western Region have drawn primarily on BOD data in their Community Health Plans. An analysis undertaken by WHAV on CHPs suggests that this has been the common practice of other PCPs (Johnstone, 2001).

The data used to date by the three Primary Care Partnerships in the Western Region of Melbourne has had a heavy emphasis on burden of disease data.

**Service utilisation data** - ‘below the line data’ - has been extremely limited and difficult to access or utilise by PCPs in the Western Region. Most organisations providing services in the Western Region have determined their data collection formats in response to reporting requirements for reporting. The data collected by DHS itself is fairly limited, being based on whether agencies have met agreed targets.

**Community experience data** to date has not been used in other than a ‘validating role’ which has limited it’s capacity to identify other health issues and needs.

### Western Region PCP Planning Matrix

The PCP Alliances in the Western Region agreed to test some common planning elements in their approach to preparing, refining and implementing their Integrated Service Plans (ISPs) and other aspects of the community health plans.

A review of primary care services in the City of Melbourne conducted by the Australian Institute for Primary Care in 2000 developed a matrix that has since been trialled and adopted as the ISP Matrix by the three PCPs.
<table>
<thead>
<tr>
<th>Population characteristics</th>
<th>Children (to 12 years) and families</th>
<th>Young (13-24) people</th>
<th>Adults (25-64)</th>
<th>Older people (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic Social Health Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital city issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuum of care</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health and participative activities; Preventative programs Early intervention, support and restorative services Intensive services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A Cross Alliance Planning Workshop in October 2000 considered the matrix as a preliminary model. Workshop participants made a number of recommendations, including the incorporation of gender within the parameters of the life stage groups (West Bay Cross Alliance, 2000). However this has not happened to date, as indicated by the use of the matrix in a recent WestBay PCP Integrated Service Plan Pathways for Achieving Planning Outcomes document (WestBay PCP, 2001b).

There appears to be some differences among the Western Region PCPs in how the matrix is used in practice. Further consideration of the matrix as a planning tool, and development of a broader planning framework and strategy that informs how the tool is used may be useful for all the Western Region PCPs. The City of Melbourne provides an interesting example of how the matrix is currently being used.

**City of Melbourne's Social Planning Framework**
The City of Melbourne has been using the matrix as a planning tool for some time, and has articulated a broad social planning framework within which the matrix is a core tool, along with a number of other tools and processes.

The Social Planning Framework is: ‘an evidence informed approach to social planning, bringing together a number of key elements in a systematic way. Most importantly it makes visible values and assumptions and integrates population based planning principles in order to inform Council actions or allocation of resources’ (City of Melbourne, 2002: 10).

The Framework has five core elements:
1. Taking account: describing and measuring community characteristics and the current service system. A segment of the community, a service component, or projected/forecasted changes to the characteristics of the community can be examined within the matrix format.
2. Identifying opportunities: identifying the 'fit' between the needs of the community, now and into the future, and the utilisation and availability of services and activities.
3. Engaging the community: this encompasses informing the community of the data and policy evidence and listening and responding to community views and aspirations. The City of Melbourne aims to tailor the process and take into account the diversity of perspectives within the community, using a community consultation process tool.
4. Taking action: developing a strategy that takes into account the learning from the three previous steps.
5. Measuring and achieving progress: monitoring the impact, output and outcomes of the agreed activities in step 4.

The City of Melbourne uses the matrix as an ongoing tool for analysing the population health needs and service delivery requirements. In doing so, it acknowledges that ‘meaningful data is not just numbers and statistics but includes people and communities, aspirations, experiences and feelings. It leads to asking more questions, and a deeper understanding of the relationship between different characteristics’ (City of Melbourne, 2002: 18).
The City of Melbourne adapts the matrix for particular purposes as appropriate, for example:
- the cells of the matrix can be populated collectively or by taking one column or one row at a time.
- further division within lifestage groupings can be undertaken.

It is significant to note that in the most recent Social Planning Framework paper, two points raised in this discussion paper have been included in the City of Melbourne approach to the matrix: female/male columns have been included under each lifestage, and the importance of sex disaggregated information noted (City of Melbourne, 2002: 18-20).

**The ISP Matrix and Gender**

The collection, analysis and application of sex disaggregated data and information is central to gender analysis. Without sex disaggregation of statistical data, any differences and similarities among particular groups of women and men will remain invisible and hence unable to be investigated further or addressed in planning processes.

Units of analysis such as families and communities need to be examined to identify who are included in particular categories. Using data on ‘people’ rather than sex disaggregated data on women and men overlooks gender as an important social determinant of health. The aggregatation of data on ‘people’ or ‘families’ prevents consideration of whether there are different numbers of men and women in the various categories, and how the needs and circumstances of particular women and men may differ.

The matrix directs attention to life stages but does not make apparent the need for sex disaggregated data and information, and consideration of gender roles and responsibilities, access to and control over resources and analysis of factors and trends.

**Gender and Life Stages**

A life stage focus may direct attention to particular issues or health conditions that are more common in particular age groups. However it is important to examine gender relations and the particular situation of groups of women and men within each life stage or age group, for example:

- Almost 25 per cent of women are lone parents (compared to 5 per cent men).
- 57 per cent of women aged 65+ are without partners (compared to 25 per cent of men) (ABS, 2000).

Each person exists in a framework of multiple identities. If we concentrate on only one at a time, many important issues will become invisible. For example, a focus on age or life stages may not focus on issues that remain the same across life stages, or the interaction of social identities and social inequalities:

‘When Dressel and Barnhill move the lives of African American grandmothers raising their grandchildren under harsh economic conditions to the centre of focus, they reveal that age is not a master or primary status for their sample. That is, issues that have oppressed these women all their lives - poverty, racism and sexism - have greater salience than age-based issues for their wellbeing and the welfare of their families. As a consequence, age-focused service interventions are less useful to them than are financial assistance, legal aid and improved educational services for their grandchildren’ (Dressel, Minkler and Yen, 1997: 582).

To enable attention to be given to gender in Integrated Service Planning using the Matrix, it is recommended that at a minimum, the matrix be revised to insert two columns under each of the current life stage headings for sex disaggregated data as follows:
As suggested elsewhere, the use of both quantitative and qualitative data is considered vital for gender analysis. Likewise an enquiring approach that seeks to identify assumptions and gaps in information is fundamental to gender analysis.

As PCPs develop their data collection resources, it will be increasingly important to work towards data and information that is not only sex disaggregated but provides information on the intersection of other social identities re: age, ability, socioeconomic status, ethnicity. In the short term qualitative information is likely to be more accessible and useful for PCPs than large-scale statistical information.

**Recommended Actions for Strengthening PCP Gender Planning Capacity: Service Planning Component: Integrated Service Plan (ISP)**

<table>
<thead>
<tr>
<th>How to Strengthen PCPs Gender Planning Capacity</th>
<th>Desirable PCP Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex disaggregated data and information collected and analysed consistently.</td>
<td>Sex disaggregated data and information used consistently in PCP planning.</td>
</tr>
<tr>
<td>Cross Alliance ISP Matrix revised to direct attention to gender across the four life stages.</td>
<td>Cross Alliance ISP Matrix revised for sex disaggregated data and in use.</td>
</tr>
</tbody>
</table>

**Identification of Gaps and Needs: Whose Priorities?**

DHS has noted the value of qualitative research and community consultation in identifying population health needs (DHS, 2001d). ‘Partnerships will also seek direct input from their local communities. Consultation with the community will identify priority issues and needs which may not necessarily be captured in statistical data’ (2000e: 7).

Bradshaw has suggested that there are four different types of need and each is identified using different methods. The four are:

1. **Normative need:** what expert opinion defines as need. (Note: expert opinion changes over time)
2. **Expressed need:** what can be inferred about the health need of a community by observation of the use of services. (Note: long waiting lists may indicate demand is greater than the existing services, but not provide information where no services are provided or where barriers to access or satisfaction with services provided affect use by particular groups)
3. **Comparative need:** derived from examining the services provided in one area to one population as a basis to determine the sort of services needed in another area with a similar population. (Note: the question of whether the level of service provision in the reference area is appropriate or adequate is not addressed)
4. **Felt need:** what people in the community say they want or what they think are the problems that need addressing. (Note: whether people speak for themselves or make inferences about the needs of others must be considered. Information on adequacy or quality of services also varies depending on the expectations as well as the nature of the services provided) (cited in Hawe, Degeling and Hall, 1991: 18-20).

Tapping into each dimension of need is believed to lead to a more comprehensive picture of community problems.
To date, community input into PCP planning has been extremely limited. Short timelines and resource constraints for the development of community health plans have clearly limited what PCPs have been able to consider in relation to community based needs identification and priority setting. However, as Primary Care Partnerships develop, there are opportunities for a greater role for community input into planning processes.

The meanings of health and wellbeing
'The notion of wellbeing does not have a uniform meaning for all sections of society and …policies which aim to bring about the enhancement of human wellbeing must be informed by the definitions of those whose wellbeing is being planned for, rather than by the definitions of those doing the planning ... a second rationale for the importance of participatory methodologies in gender aware planning: enabling the participation of the excluded in the process of policy design is not only critical to ensure policy goals which respond to their priorities but is also a strategic means for overcoming social exclusion' (Kabeer and Subrahamanian, 1996: 25, 27).

Felt Needs and Consultation Mechanisms
There is scope for Western Region PCPs to plan and conduct consultations with diverse groups of women and men and to gather qualitative information to inform community health planning. Participatory methodologies and consultations with diverse women and men are a critical means of carrying out such consultations.

Asking diverse groups of women and men about their health, experiences in accessing services, needs and priorities requires resourcing and adequate time and expertise. There are many different approaches to consultation with differing benefits and shortcomings. The consultation methods chosen needs to be tailored to the purpose and desired outcome, the constituents involved and the available time and resources. Marginalised and isolated groups should be prioritised.

Resources for Consultation and Participation
The Resources section of the Kit includes:

PCPs should identify and seek to remove as many barriers to participation as possible. This could involve some of the following strategies. Using plain language, making available information in languages other than English, simultaneous interpretation or the use of skilled peer facilitators, using alternative formats and media, providing financial support where needed, choosing locations that are accessible and appropriate to the participants (Status of Women Canada, 1997). In addition, setting days and times and locations for consultations that suit the women and men concerned and providing child or respite care may be critical. Effective moderators and different techniques including groups, interviews and home visits, can mean that diverse groups of women and men are able to present their views and perspective’s on their needs and priorities.

Qualitative research and consultations with diverse groups of women and men can add to the quantitative data such as Burden of Disease and service usage data to give a more rounded picture of health and illness among particular populations. These sources of data can be complementary, as indicated by the following study:
Beyond Symptoms - Women's Health Needs Analysis for Melbourne's Western Region

The research used complementary quantitative and qualitative data to analyse the health needs of women in the Western Region.

- Quantitative data collation included population data and regional service data. Key data sources were Australian Bureau of Statistics 1996 Census, Victorian Burden of Disease, Lee, 2001, Women's Health Australia longitudinal study of women's health, the Victorian Department of Human Services data, municipal and service provider data.

Generally, the availability of sex specific data at regional and Local Government Area level is extremely limited. Gaps in data are particularly noted for domestic violence, disability and employment status according to place of birth.

- Qualitative research included 14 group discussions and 37 interviews involving over 130 women, service providers and key stakeholders in the Western Region. The qualitative consultation substantiated the analysis by enabling the spontaneous exchange of women's experiences, feelings and opinions. The qualitative research facilitated a more detailed understanding of the dynamics underlying service usage including barriers and motivators to accessing services, evaluations of service quality, and identification of unmet needs.

(Women's Health West, 2002: Section 2)

Recommended Actions for Strengthening PCP Gender Planning Capacity: Service Planning Component: Integrated Service Plan (ISP)

<table>
<thead>
<tr>
<th>How to Strengthen PCPs Gender Planning Capacity</th>
<th>Desirable PCP Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative information from diverse groups of women and men inform identification of needs, gaps and priorities for Integrated Service Planning</td>
<td>PCP Forward Plans and resources allocated for collection of qualitative information from diverse groups of women and men to inform identification of needs, gaps and priorities in Integrated Service Planning</td>
</tr>
</tbody>
</table>

Development of PCP Planning Priorities

The priorities across the Western Region have been identified by PCP agencies. The process used for planning has been largely top down, not bottom up. There has been limited community involvement: this has been restricted to focus groups presented with priorities that they were asked to validate, rather than starting from a principle of asking the community to identify needs and gaps.

The first step was the identification of common factors throughout the West that are ‘sign posts’ of evidence which point to significant threshold health disadvantage: These evidence signposts were seen as 'litmus' indicators which show either critical exposure to health risk or actual reduced health status in the region. The litmus indicators are drawn from population health characteristics.

The second step involved the connection of the litmus indicators to the continuum of care and four basic life stages sections of the matrix.

Step three was the identification of Cross Alliance ISP indicators based on an assessment of the availability of service utilisation and population health data.

The Cross Alliance indicators include:
- Mental Health
- Younger Persons with disabilities
- Child/Family
• Alcohol and Drugs
• Aged Care
• Carer Support
• Primary Care Early Intervention
• Generic Population Health
• Participative Social Model of Health.

Data that is currently available to inform each of the indicators areas often relies on normative, expressed and comparative need approaches. An examination of available data often raises issues and questions that can not be answered without additional research (WestBay PCP, 2001a). To illustrate this point, an examination of mental health clients by country of birth in relation to total population cannot fully answer the question of whether mental health conditions (eg depression) may be more or less prevalent in certain communities Other factors may impact on the issue, including whether there are barriers to accessing services. In addition multiple risk factors and stresses that may mean that women and men from some communities may be more prone to mental illness than those from other communities.

Current information and data on particular conditions may not do justice to the complexities to assist prevention, treatment and diagnosis, recovery and health promotion from a gendered perspective. Western Region PCPs could do more to examine gender issues in relation to each of the areas of planning interest. Workforce development is also an important mechanism to strengthen PCP capacity to examine gender issues in integrated service planning. Workforce development is also an important strategy to strengthen PCP capacity to include gender issues in their integrated service planning.

**Actions for strengthening PCP gender planning capacity: service planning component - quality improvement**

<table>
<thead>
<tr>
<th>How to Strengthen PCPs Gender Planning Capacity</th>
<th>Desirable PCP Practices</th>
</tr>
</thead>
</table>
| Ensure gender is explicitly included in population profiles, health conditions/issues, and in data collection, analysis, priority setting, monitoring and evaluation. | 1. Establish gender leadership group to facilitate sharing of lessons learned and best practice re: gender sensitive methodologies and experience across the Western Region PCPs and agencies.  
2. Workforce development in gender sensitive approaches to evaluation. |

**PCP identified priorities**

Pressures on PCPs, and DHS, to show benefits from the PCP Strategy may direct focus on areas that are important from an acute care perspective. These may not be the most important in terms of determinants of health status and the improvement of health and wellbeing, particularly for disadvantaged groups over the long term. For example, WestBay PCP has explicitly included in its decision criteria for 2001/02 ‘recognition of proposals with immediate implementation potential and shorter lead times for realising impact’ (WestBay PCP, 2001c).

**Implications for Health Promotion**

An overreliance on BOD data may lead to the danger of compartmentalising social problems. For example it may lead to a focus on treating social reality as if it can be broken down into a series of different compartments, each of which can be analysed and acted upon in isolation from the others. If the highest priorities for primary care planning are derived from the top ranked BOD conditions for the Western Region, there is the danger that specific programs are directed towards particular conditions, rather than recognising the interrelationships among ‘risk factors’ and determinants of health and illness. Likewise, a health promotion focus on one risk factor or condition may fit with national and state health promotion priorities, but not arise from the priorities of particular groups of women and men in a particular region.
Western Region PCPs have identified mental health as a key area of planning interest. As outlined in the resource material on gender issues and depression, the causes of depression are understood to be complex and relate to the interaction of many diverse factors. Social disadvantage and poverty have been identified as leading to greater mental health risks. Reduced autonomy and decision-making, increased exposure to dangerous environments and violence and discrimination are identified as risk factors. Social theories of depression emphasise the importance of severe events and life difficulties characterised by loss, humiliation, entrapment and a sense of lack of control and inferior rank (WHO, 2000: 44). Gendered experiences, particularly violence against women have been identified as risk factors for depression. Multiple risk factors and experiences can greatly increase vulnerability to depression. Depression is also common in people with physical illnesses. The 1997 National Survey of Mental Health and Wellbeing found that nearly half the people who had an affective or depressive disorder also had a related physical problem. For people with physical disorders the prevalence of depression may be as high as 50 per cent.

There has been recognition that there is considerable overlap between the National Health Priority Areas, in terms of factors that combine to increase risk and barriers to better prevention and care. Broader population health initiatives that target these risk factors and barriers will bring benefits across priority areas (Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare, 1999a).

The health promotion projects being undertaken by the three PCPs in the Western Region bring agencies together for collaborative work. It is possible that the ‘capacity building’ and cooperation among partners may also be a significant outcome.

PCPs have funds available for health promotion, and have placed priority on directing resources and energy into health promotion activities. There is scope for PCPs to use their health promotion resources in creative ways, addressing the needs of particular community groups. In addition the PCP can involve women and men from those communities in determining their priorities and health promotion messages and activities. Peer education and action research approaches offer potential to ‘fill in gaps’ about needs and priorities and the barriers to access to information or services experienced by particular groups. These approaches also provide the means to develop effective health promotion programs with the active involvement of women and men from particular groups who may be difficult to otherwise reach.

The concept of community and social capital needs to be examined from a gendered perspective. It has been suggested that there may be both similarities and differences in the ways in which women and men from diverse groups create, sustain and access social networks, and that these need to be taken into account in community development, health promotion and community strengthening initiatives.

**Actions Identified for Strengthening PCP Gender Planning Capacity: Service Planning Component - Health Promotion**
How to Strengthen PCPs Gender Planning Capacity

<table>
<thead>
<tr>
<th>Gender perspectives incorporated into health promotion strategy and projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Target groups and gender issues identified for health promotion projects.</td>
</tr>
<tr>
<td>2. Action research and peer education models inform development of health promotion projects.</td>
</tr>
<tr>
<td>3. Sex disaggregated data and information collected for all HP projects and activities.</td>
</tr>
<tr>
<td>4. Gender perspectives incorporated into evaluations.</td>
</tr>
<tr>
<td>5. Workforce development on health promotion and gender.</td>
</tr>
</tbody>
</table>

Partnerships: Consumer, Carer and Community Participation in PCPs

Definitions and Key Concepts
Consumer participation in health is an area of increasing interest and focus at governmental and organisational policy and operational levels. A number of the reasons advanced for promoting participation include:

- Participation is an ethical and democratic right
- Participation improves service quality, safety and helps gain health service accreditation
- Participation improves health outcomes. Consistent with the social model of health, the very act of participating in health care decisions may improve outcomes, irrespective of the treatment shown.
- Participation makes services more responsive to the needs of consumers (DHS, 2000: 1-2).

The term ‘consumer’ is currently used as a broad category. Consumers are diverse, encompassing a range of people living in Australian society. “Any definition of consumer must incorporate women and men, people from diverse cultural experiences, class positions and social circumstances, sexual orientations, health and illness conditions” (DHS, 2000c: 4). ‘Consumer’ can refer to individuals, carers, groups (health service users or carers), consumer organisations, people who are not currently using services, and the ‘community’. The community can be understood to include specific cultural/ethnic groups, groups of people sharing similar interests or people living in the same geographical area. In the broadest sense, community refers to citizens and taxpayers that ultimately pay for services (Department of Public Health, Flinders University and the South Australian Community Health Research Unit, 2000).

Draper identified the following range of consumer voices:

- **Individual** Individuals who are receiving or have received health care services
  - Carers and/or family members who support individuals who receive health care
  - Groups of consumers, who may share a common experience or chronic illness
  - Consumer organisations including advocacy, self-help and consumer network organisations
  - Potential consumers such as those with unmet needs or from population groups with particular needs or access issues
Members of the community including future users and the wider community that benefits from health care services

Community    Taxpayers and citizens who ultimately pay for services

(Cited in DHS, 2000c: 3)

Participation can operate at different levels and be motivated by differing intentions and expectations on the part of consumers and organisations. Brager and Specht have developed a useful representation of participation as a continuum or ladder:

**The Ladder of Participation**

<table>
<thead>
<tr>
<th>Degree</th>
<th>Participants' actions</th>
<th>Illustrative mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Have control</td>
<td>Organisation asks community to identify the problem and to make all the key decisions on goals and means. Willing to help community at each stage to accomplish goals.</td>
</tr>
<tr>
<td></td>
<td>Have delegated</td>
<td>Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions, which can be embodied in a plan it can accept.</td>
</tr>
<tr>
<td></td>
<td>Plan jointly</td>
<td>Organisation presents tentative plan subject to change and open to change from those affected. Expects to change plan at least slightly and perhaps more subsequently.</td>
</tr>
<tr>
<td></td>
<td>Advise</td>
<td>Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.</td>
</tr>
<tr>
<td>Low</td>
<td>Are consulted</td>
<td>Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so administrative compliance can be expected.</td>
</tr>
<tr>
<td></td>
<td>Receive information</td>
<td>Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.</td>
</tr>
<tr>
<td>Nil</td>
<td>None</td>
<td>Community not involved.</td>
</tr>
</tbody>
</table>

(Cited in DHS, 2000c:3)

Participation approaches can be limited in their appeal to particular groups. It has been suggested that, ‘those who participate are likely to be better educated and better off than your average consumer.’ Bates and Linder-Pelz commented that ‘the trouble with the pluralist choir is that it sings with a middle class accent’. For health services this is a particular problem as those with the worst health status and greatest health care needs are also likely to be those with multiple social disadvantage and least voice in the system… Essentially this means putting much more effort and resources into reaching those whose voices are not usually heard. It also means ‘working smart’ by being culturally appropriate’ (cited in DHS, 2000c: 115).

**Resources for Participation and Consultation**
The resources section of the kit include the following:
- ‘Approaches to Consultation’, extract from a Discussion Paper prepared by the Status of Women Canada.
While it is often recognised that particular efforts and strategies are required to involve consumers from lower socio-economic groups and from culturally and linguistically diverse backgrounds, the Australian literature often appears to overlook the need to address gender representation issues. Consumer participation objectives, processes and strategies can be gender-blind. Attention needs to be given to the participation of both women and men as consumers in participatory processes (Woroniuk and Schalkwyk, 1998a and 1998b).

**Participatory processes do not automatically recognise inequalities and differences between women and men**

Experience shows that participatory processes and ‘attempts to involve poor people’ do not automatically include women. Attention to gender differences and inequality is required if participatory development initiatives are to involve women as well as men. Specific issues include:

**Power imbalances in communities:**

Communities are not harmonious groups with a common set of interests and priorities. There are often strong divisions along the lines of age, religion, class and gender. These power differentials make it difficult for some people to voice opinions that contradict general views. Power differentials may even affect who participates in specific meetings.

**Intra-household and intra-family relations:**

Some women may believe that discussions relating to family matters are not for public forums.

**Different abilities to participate:**

Men may have more experience putting their arguments forward to outsiders in public forums and more confidence in dealing with new people.

**Perceived benefits of participation:**

Women and men may make different calculations about the costs and benefits of their involvement in participatory processes. Given the already high demands on most women’s time, they may not see the extra effort required to participate as worthwhile, especially if the benefits are questionable (Woroniuk and Schalkwyk, 1998a).

**DHS Framework for Consumer Participation**

DHS uses the term consumer to encompass users of a health service, their carers or families or potential users (DHS, 2000a). DHS has also stated that ‘consumer participation is a central requirement for the effective development of Primary Care Partnerships and in the development of Community Health Plans’ (DHS, 2000d: 7). Funding to support consumer participation has been provided by DHS as part of each alliance’s core funding and requires each PCP to report on consumer participation.

Community Health Plan templates identify that PCPs have a responsibility to present a consumer charter of rights and responsibilities. In addition PCPs should identify an outline of the representative processes and structures for consumer, carer and community participation in partnership governance arrangements, integrated service planning and service coordination. ‘As part of the service planning, PCPs will consult with a wide range of individuals and organisations within their catchment area to ensure that the particular needs of their community are understood and addressed. This includes the cultural, ethnic, linguistic and religious diversity of the population.’ (DHS, 2002: 5). Note that gender is not specifically mentioned here, although it should be intrinsic in understanding the particular range of needs and priorities within each of the cultural, ethnic, linguistic and religious groups within PCP catchments.
Pink Paper

Department of Human Services' Approach to Consumer and Carer Participation

DHS's philosophical approach tends towards the upper end of the participation ladder/continuum: ‘Governance is about decision-making processes rather than information gathering or consultation. Consumer participation in governance means that consumers are engaged in decision-making processes at least equally with other stakeholders, and that it can be demonstrated that consumer perspective influences the decisions made … PCPs should consult with their community about how they wish to be engaged in governance and how community representatives should be selected’ (DHS, 2000d: 4).

DHS views charters as DHS specific tools to increase awareness of the rights and responsibilities of consumers. ‘A charter is not an end in itself, but merely another step in the broader strategy of developing customer-focused services’ (DHS, 2000b: 13).

Consumer interest and perspective is also acknowledged by DHS to be central to the process of evaluating services. ‘Consumers and communities have a crucial role in evaluation of services locally and in evaluating the PCP strategy more broadly’ (DHS, 2000d: 5).

PCP Consumer Participation Planning Activities to date

A number of activities have been undertaken by the WestBay PCP Cross Alliance and the individual PCPs to date. Much of this work has related to the development of a template draft charter and a template consumer and community consultation strategy. Each template is expected to be adapted/refined by the PCPs, and by individual agencies in relation to the draft charter. To date, the focus has been on a restricted view of consumer participation in governance structures. To date, attention to consumer, carer and community participation in the two other areas identified by DHS, integrated service planning and service coordination, has been limited.

Consultants have undertaken the following assignments:
- a survey of current practice in consumer and carer engagement with organisations within the Moonee Vally/Melbourne PCP
- development of a draft consumer charter and consumer/carer participation strategy for the WestBay PCP Cross Alliance including two meetings with Cross Alliance agency participants
- for the Moonee Valley/Melbourne PCP, an additional consultation phase with meetings with 12 groups of consumers/carers
- For the WestBay PCP, an audit of current consumer participation strategies used by groups and organisations within the Alliance catchment, and a workshop to determine priorities and a strategies report.

The consultants’ reports show there is a wide range of varied practices and commitment to consumer and carer engagement among agencies within the WestBay CrossAlliance. However the survey provided little if any information on what is the current extent of consumer and carer participation, at what levels, and who is participating in these avenues for participation.

Towards A Gendered Perspective on Carers

There is quite a significant gender division of labour in relation to women taking on unpaid work as carers, and the health and other impacts of caring responsibilities can be significant:
The Gender Division of Roles and Responsibilities: Carers
A carer is defined as someone who looks after another person who has an illness, is frail or elderly, or has a physical, mental or intellectual disability. Caring may be provided for one or more members of the immediate (child, spouse) or extended family (parent, grandparent), or friend or neighbour.
Carers Victoria estimates that 70 per cent of carers are women.
‘Family caregiving is an example of women's work … traditionally regarded as something for which women are better suited than men and something that women should take on willingly without pay or support’ (Hooyman and Gonyea, cited in Women's Health Australia, 2001: 146). The Australian Longitudinal Study on Women's Health found that many women were unable to seek paid employment to combine with the role of caring or were forced to leave satisfying careers. Those unable to work in paid employment reported that finances were strained by the reduced income and by increased family expenses associated with caregiving.
A survey of carer health and wellbeing undertaken by the Carers Association of Australia in 1999 found that carers experience low levels of physical health and energy levels due to the constant pressure of caring, stress, disturbed and lost sleep (DHS, 2001a: 2).
Current government policy of de-institutionalisation favours community integration for people who are frail, have a disability or ageing, with support and respite care often being inadequate to meet peoples needs.

Particular strategies to involve carers in PCP governance, integrated service planning and service coordination must take account of the various barriers carers face in fulfilling their caring and other roles and responsibilities, their existing resources and own interests and needs.

Consumer Participation Perspectives in PCPs
To date, consumer participation in the Cross Alliance process has been narrowly defined. Thomas, Browning and Moran commented, ‘in the present paper and activities, the emphasis is upon community representatives on boards and management committees with the primary care partnerships’ (2001:20). It appears that other aspects or options in relation to consumer and carer participation have not been considered.

It is essential that PCPs are clear about their objectives before strategies or forms of participation are chosen. As in many other areas, multiple complementary strategies often work better than one approach. The various interests and needs of consumers and of organisations/PCP structures need to be put side by side to identify compatibilities and conflicts, options regarding appropriate forms and the resource implications. As in many areas of organisational or community change, clear processes and adequate time for consultation, reflection and further consultation are needed.

The usefulness and appropriateness of having consumer representative(s) on a board or committee involved in governance, especially as the main or sole strategy, may need further consideration:
• Professionals and bureaucrats generally feel comfortable with being part of committees and their processes, whilst many community women and men may not.
• A consumer representative cannot represent all members of all communities. A community or consumer ‘representative’ can undertake to provide a view from a different perspective, and consult with a limited range of people.
• Many consumer organisations and consumer participation research suggest that more than one representative should be appointed to committees or boards. The benefits include a broader range of perspectives and the opportunity for representatives to offer mutual support to each other.
• Multiple approaches and opportunities for consumer participation reinforce and add value to each other. As well as governance aspects, consumer participation in integrated service planning and service coordination, the identification of needs and evaluation of programs and services should also be considered (DHS, 2000c: 70).
Western Region PCP Consumer and Carer Participation Strategy
The Consumer and Carer Participation Strategy template document identified five Key Result Areas:
1. Developing and implementing a Consumer Charter for use within agencies and services within the partnerships
2. The building of skills and resources on the part of consumers to successfully engage with agencies and services
3. The building of skills and resources on the part of agencies and services to successfully engage with consumers
4. The building of commitment on the part of services and consumers to engage with each other
5. The development of representative structures and processes to ensure active working involvement with consumer, carer and community representatives.

Key absences are issues to do with consumer choice and outline complaint mechanisms.

In respect of Key Result area #5, the PCP is to conduct at least one public meeting or forum per year in each municipality to promote consumer participation and seek feedback on the consumer participation strategy. This is much more limited level of participation than that apparently expected by DHS, and could be expected to engage a small and possibly unrepresentative group.

Key Result area #5 also specifies that a Consumer Representative Forum is to be established. It is important that the Cross Alliance and PCPs clarify their objectives in terms of consumer participation and develop appropriate mechanisms for diverse women and men to present their views.

The short proforma consumer and carer participation curriculums were directed towards community members participation in committee procedures and structures for the consumers and carers, and the training for agency staff focused on a narrow range of consumer feedback methods. No mention was made of the involvement of consumers in research, monitoring or evaluation.

Strengthening Gender Perspectives on Consumer, Carer and Community Participation in PCPs
While it is up to PCPs to determine the scope and mechanisms of consumer and carer participation in PCPs, gender perspectives must be considered in planning, monitoring and evaluating experience, as indicated by the following guiding questions:

Gender Perspectives on Consumer, Carer and Community Participation
- Has sex disaggregated data been collected on women's and men's participation as consumers?
- Have women and men been consulted on their needs and concerns?
- Are consumer feedback and participation mechanisms equally accessible to women and men?
- Have constraints that restrict women's and men's participation and the equal distribution of benefits been identified?
- Are there labour/time factors constraining women's or men's participation and the distribution of benefits?
- Have strategies been developed to promote the involvement of women and men from vulnerable, marginalised and disadvantaged groups? (AusAID, 1998).

‘Participation’ may be valued in itself. However if PCPs are looking to consumer and carer participation as a means of improving service quality and making services more responsive to the needs of consumers, it is important to consider how to encourage and facilitate participation from diverse community members. The participation of women and men should be encouraged from
diverse ethnic and language backgrounds, disadvantaged and lower socio-economic groups and with particular health concerns or illnesses (Status of Women Canada, 1997). These equity aspects need to be put on the agenda for further consideration by the CrossAlliance Working Group, within each PCP and at an individual agency level.

It is also recommended that the checklist and survey/audit tools should be re-examined and amended to collect sex disaggregated quantitative and qualitative data, and identify the diversity of those who are currently participating as consumers in various mechanisms.

**Actions Identified for Strengthening PCP Gender Planning Capacity: Partnerships Component - Consumer and Carer Strategy**

<table>
<thead>
<tr>
<th>How to Strengthen PCPs Gender Planning Capacity</th>
<th>Desirable PCP Practices</th>
</tr>
</thead>
</table>
| Ensure that participation of consumers and carers includes diverse groups of women and men | 1. Consumer consultation practices are resourced and tailored to the diversity of the community and involve diverse groups of women and men.  
2. Consumer and carer checklist survey/audit tools are amended to: collect sex disaggregated data and identify diversity of those participating as consumers and carer representatives in various mechanisms. |
References


Dyson, S. (2001), Gender and Diversity: A workbook for an equity approach to practice, Women’s Health in the South East, Frankston, Victoria.


WestBay Primary Care Partnership. (2001a), ‘WestBay Primary Care Partnership Indicators’, WestBay PCP, Melbourne.


Women’s Health Australia. (2001), ‘The Australian Longitudinal Study on Women’s Health’, Commonwealth Department of Aged Care, Canberra, ACT.


A Gender Agenda: Planning for an Inclusive and Diverse Community

Part Five: Key Issues for PCPs in Developing a Gendered Approach

Overview

As relatively new entities, PCPs are aware of the need to develop their capacities in addressing the complexity of the primary care reform process and the evolving task of establishing integrated planning and coordination of primary care services.

Community Health Plans are complex documents that have three main components: partnerships, service coordination and service planning. This paper focuses primarily on the service planning component, plus consumer and carer participation which lies within the partnerships component of community health plans.

We would argue that primary care partnerships need to explicitly address gender issues, in relation to:

• the outcomes they are working for improved population health outcome for women and men
• in PCP structures and processes in relation to service planning, coordination and partnerships.

The participation of diverse groups of women and men can enable their perspectives to inform service planning. In addition, diverse groups of women and men should participate in PCP forums as consumers and carers.

Building PCP gender planning capacity involves:

• the development of sustainable skills
• the development of appropriate organisational structures
• financial and human resources
• commitment.

Gender needs to be included in the key areas of strategic development needed to support the health system efforts in improving population health. They include:

• organisational development
• workforce development
• resource allocation
• leadership and partnerships.

Four Key Foundations for Primary Care Planning

All PCPs in the Western Region are aware of the need to consider gender along with a range of other factors in the development of Community Health Plans. It is timely to further strengthen PCP capacity to ensure that gender considerations are incorporated in service planning and consumer and carer participation in a systematic way.

Four key conceptual understandings are the foundations for PCP capacity building for gender sensitive practices:
1. Gender is a cross cutting issue
Gender must be considered in all analyses of population groups and in relation to health and illness issues and priority areas based on a social model of health. PCPs must continue to look at the particular needs of population groups due to location, social and economic disadvantage, ethnicity, cultural and linguistic diversity, indigenous status, homelessness or risk of homelessness, poor housing areas, age and ability, with an awareness that all these categories intersect with gender.

2. Gender neutral terms and categories should be examined from a gender perspective
Gender neutral terms and categories (people, clients, consumers, carers, families, communities etc) can render invisible the differences among groups of women and groups of men in health status, in paid or unpaid work, responsibilities, access to and control over resources, and different needs or priorities. Categories used should be examined to identify who (which women and which men) are included in particular categories.

3. Sex disaggregated quantitative data and qualitative informations are essential for planning
Sex disaggregated quantitative data must be consistently collected and analysed identify whether there are any patterns of variance in key indicators between women and men among particular groups). Qualitative information on the perspectives and priorities of diverse groups of women and men is required to map service provision, identify areas of need, determine priorities and monitor and evaluate services and programs from a gender perspective.

4. Multiple entry points and strategies are required for gendered planning
There is no blueprint for incorporating gender perspectives and analysis into primary care planning. A combination of strategies and entry points is required. High level commitment and leadership by the PCP and agency senior staff, allocation of resources (including specialist expertise and staff development) and a timeframe beyond the "instant fix" is required if gender perspectives and analyses are to be authentically incorporated into primary health policy, planning and programming.

Actions Identified for Strengthening Gender Planning Capacity

The following matrix identifies areas where Western Region PCPs can take actions to strengthen their capacities to plan from a gender perspective:

<table>
<thead>
<tr>
<th>Community Health Plan Component and Area</th>
<th>How to Strengthen PCPs Gender Planning Capacity</th>
<th>Desirable PCP Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARTNER-SHIPS Consumer and carer strategy</td>
<td>Ensure that participation of consumers and carers includes diverse groups of women and men.</td>
<td>1. Community consultation practices are resourced and tailored to the diversity of the community and involve diverse groups of women and men.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Consumer and carer checklist survey/audit tools amended to: collect sex disaggregated data and identify diversity of those participating as consumers and carer representatives in various mechanisms.</td>
</tr>
</tbody>
</table>

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## Service Planning

**Identification of Issues: DHS framework**
The Victorian Government’s agenda for primary care reform straddles two aims - reducing pressure and demand on acute care services and longer term preventative health promotion. DHS in the CHP template documents has put together both particular population groups, children and younger people, older people, diseases/health conditions, mental health, alcohol and drugs and service provision, emergency hospital demand. DHS has directed PCPs to identify priorities associated with each of the population groups/health issues.
Using a gender perspective, the DHS guidelines and templates could be improved to direct PCP attention to gender issues and the consistent use of sex disaggregated data to assist when planning health services.

**Information and Data**

Adequate and reliable information and data is required when planning from a gender sensitive perspective. If PCPs are to plan in a gender sensitive way, then it is essential that sex disaggregated data is collected and analysed.

At present sex disaggregated Burden of Disease data is used by PCPs, and a PCP population breakdown by sex included among the statistical data. Therefore, burden of disease data must be supplemented by other data and information. Burden of Disease data focuses on individual outcomes in terms of ill health, rather than the processes that generate ill health from a social determinants of health perspective. Quantitative data should be consistently broken down by sex, age, ethnicity, socioeconomic status and other important social determinants of health.

Qualitative data is particularly important for disadvantaged groups because ideally it enables them to identify the agenda and issues from their own perspectives. The perspectives and experiences of diverse groups, both women and men, provide important information on their needs, priorities, the quality of services, and barriers to accessing information.

**Planning Process**

Identification of areas of interest have been undertaken by PCP member agencies, with input from other agencies working in the Western Region. While current planning practices have made good use of the local knowledge of PCP agencies, participation of the local communities - particularly consumer and carers - in the planning process and identification of priorities has been limited to date. There is considerable scope for strengthened community consultation to ensure that the needs and perspectives of diverse groups of women and men inform PCP planning.

The City of Melbourne has developed and is implementing a social planning framework which includes local level neighbourhood consultations. As Western Region PCPs develop planning for primary care within their catchments, there is potential for participatory needs identification to be undertaken in one or two neighbourhoods per year. This offers scope for a planned and resourced approach to obtaining qualitative information and input from diverse groups of women and men at local level. This process would provide a basis to identify needs and to develop health promotion programs where participants are active in determining the project scope and implementation.

Similarly, PCPs may wish to identify particular ethnic or other geographically dispersed communities within their catchments for focused consultations or action research activities. This may be appropriate where available data does not provide sufficient information on a particular community’s needs and priorities and their perceptions of the adequacy of existing services. Where a majority of a particular population group appears to have multiple disadvantages, eg low income, high rates of unemployment or insecure unemployment, high rates of drug use and other areas of social concern, this may be the most strategic approach to identify longer term plans for focused health promotion and service coordination by the PCP. Gender must be a central part of the community consultation processes and community development activities.
**Integrated Service Planning Tool (the Matrix)**
The ISP Matrix being trialed in the Western Region could be revised as set out below to include information on women and men in separate columns in each of the age categories:

<table>
<thead>
<tr>
<th>Boys 0-12 years</th>
<th>Girls 0-12 years</th>
<th>Young men 13-24</th>
<th>Young women 13-24</th>
<th>Adult men 25-64</th>
<th>Adult women 25-64</th>
<th>Older men 65+</th>
<th>Older women 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuum of Care</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Quality Improvement**
Gender analysis can facilitate the identification of needs and improved targeting of services and resources to prioritise needs among population groups in PCP catchments. Gender sensitive processes for the involvement of diverse groups of women and men in community consultations, qualitative information and participation in PCP planning can improve the quality of the service planning and implementation of components of the Community Health Plan.

Evaluation practices must identify which groups of women and men participate in particular programs or access services, and their assessments of the extent to which their needs are being met.

Sex disaggregated data and information provides a foundation for monitoring and evaluating changes as a result of service provision and coordination, and is integral to primary care planning from a gender perspective.

A PCP/Cross Alliance leadership group may be one way to advance sharing of knowledge and approaches and models to develop "best practices" and oversight the development and implementation of gender sensitive planning and service delivery.

**Health Promotion**
A gendered perspective to health promotion requires the use of a development model. Therefore, community based and "integrated" (rather than single issue) approaches to health promotion may offer greater longer term impact in addressing gender and other influences on health and wellbeing.

Health promotion should be monitored and evaluated from a gender perspective and sex disaggregated data kept in relation to all health promotion activities.

**Partnerships**

**Consumer and Carer Participation**
To date, the work undertaken on consumer and carer participation in the Western Region has not focused on gender issues. However is useful to develop strategies to overcome barriers that may prevent diverse groups of women and men from participating in PCP and community consultation processes.

Sex disaggregated data on women's and men's participation should be collected. It is recommended that the checklist and survey/audit tools should be reexamined and amended to collect sex disaggregated quantitative and qualitative data, and identify who is currently participating as consumer representatives in various mechanisms.
It is also suggested that PCP community consultation practices be tailored and resourced to ensure that diverse groups of women and men are consulted and involved in PCP governance and planning processes.

**Workforce development program**
At present, workforce development relates to each component and section of the Community Health Plan. Training for PCP and member agency staff on gender issues and analyses in relation to planning, participatory processes, health promotion, monitoring and evaluation should be considered as a key strategy for increasing PCP capacity. Establishment of a leadership group on gender and health may be fruitful as a way of fostering the sharing of experience and lessons learned on gender sensitive approaches among PCP member agencies.
A Gender Agenda: Planning for an Inclusive and Diverse Community

Tools for Inclusion in Resource Kit

Resource 1
Title: A Checklist for Gender Integration in Programming and Management
Source: InterAction Best Practices for Gender Integration in Organisations and Programs from the InterAction Community, 1996
InterAction (American Council for Voluntary International Action) is an American peak body for US-based relief, development, environment and refugee agencies working overseas.
Description: Two page checklist including critical elements for integrating gender in organisations and programs, plus two page organisational self-assessment form. These contain the main points of the more detailed InterAction Gender Audit, designed as a process for organisational self-assessment and action planning.

Resource 2
Title: Understanding gender equality in organisations: a tool for assessment and action
Juliet Hunt is an Australian consultant with internationally acknowledged expertise in gender and development.
Description: Four page outline of key strategic areas with guiding questions for institutional development to promote gender equality.

Resource 3
Title: Organisational Gender Diagnosing
Source: The Tribune #56, April 1997
The tool was developed by the Dutch non government development organisation, NOVIB, and used with non government organisations internationally. The Tribune is produced by the International Women's Tribune Centre, an international non government organisation based in New York
Description: One page description plus three page checklist which outlines a four step process for organisational gender diagnosing, examining organisational vision, policy objectives, strategies, and activities, internal structure and culture of the organisation.

Resource 4
Title: Organisational Change and Equality Between Women and Men
Source: Sida Equality Prompt Sheet (available on DAC/OECD website) http://www.oecd.org/pdf/M00026000/M00026202.pdf
Sida is the Swedish Government Overseas Development Aid Organisation.
Description: Two page "tip sheet" on issues to consider re gender equality and institutions.
Resource 5
Title: Counting Heads
Source: Sue Dyson, *Gender and Diversity, a Workbook for an Equity Approach to Practice*, Women's Health in the South East, 2001.
The workbook was developed for health workers to work on gender and diversity in policy, planning and program development.
Description: A two page worksheet for an activity to be undertaken over several days or several weeks, to examine diversity and gender relations in a group such as in a work-related meeting or public gathering.

Resource 6
Title: Diversity Snapshot
Source: Sue Dyson, *Gender and Diversity, a Workbook for an Equity Approach to Practice*, Women's Health in the South East, 2001.
The workbook was developed for health workers to work on gender and diversity in policy, planning and program development.
Description: An activity to be undertaken over several days or several weeks to examine who utilises the services of the organisation, and who is missing.

Resource 7
Title: Gender Analysis - What to Ask
Source: Resource 3b, United Nations Development Program (UNDP) Gender Analysis Learning and Information Pack, available on UNDP website.
http://www.undp.org/gender/capacity/gm_info_module.html#GA
UNDP is a major agency of the United Nations that supports development programs in developing countries.
Description: Nine guiding questions applicable for proposed policy, program or projects for project staff and management to ask.

Resource 8
Title: Identification and Preparation
Source: AusAID Guide to Gender and Development (available on AusAID website).
AusAID is the Australian Government's Overseas Aid Agency.
Description: Three pages of guiding questions, designed for use in the identification and preparation stages of development projects.

Resource 9
Title: Implementation and Monitoring
Source: AusAID Guide to Gender and Development (available on AusAID website).
AusAID is the Australian Government's Overseas Aid Agency.
Description: Two pages of guiding questions, designed for use in implementation and monitoring progress of development projects.

Resource 10
Title: Evaluation
Source: AusAID Guide to Gender and Development (available on AusAID website).
AusAID is the Australian Government's Overseas Aid Agency.
Description: Two pages of guiding questions, designed for development projects.
Resource 11
Title: Checklist for Women-centred Programme Design
Source: Asian-Pacific Resource Centre for Women (ARROW) - Resource Kit 1996. ARROW is a regional non-government organisation based in Malaysia concerned with women's health status and development policies and plans.
Description: Two and a half pages of guiding questions for program planners and implementors prior to implementation (covers values, need, rationale context, resources, review, documentation).

Resource 12
Title: Women-centred and Gender-sensitive Programme Management Cycle
Source: Asian-Pacific Resource Centre for Women (ARROW) - Resource Kit 1996. ARROW is a regional non-government organisation based in Malaysia concerned with women's health status and development policies and plans.
Description: One page diagram of participatory planning and decision-making cycle.

Resource 13
Title: Checklist to Determine How Gender-Sensitive is a Health Program
Source: Asian-Pacific Resource Centre for Women (ARROW) - Resource Kit 1996. ARROW is a regional non-government organisation based in Malaysia concerned with women's health status and development policies and plans.
Description: One and a half pages of guiding questions related to gender sensitivity at program or organisational levels. Some questions relate only to reproductive health services, but address gender relations and gender equality as an underlying framework applicable to all health services.

Resource 14
Title: Guidelines for Project/Program Analysis
PAHO is the regional branch of the World Health Organisation.
Description: Two page handout with guidelines for conducting a gender analysis of a health project/program as part of a training workshop. Two pages with four steps to be undertaken in the gender analysis, and questions.

Resource 15
Title: Discussion Paper on Approaches to Consultation
Status of Women Canada is the Canadian Government Ministry for Women.
Description: Section B: vision of consultation (3+ pages) outlines definition, purposes, guiding principles; Section C: Consultation Methods (5+ pages) provides description, advantages and disadvantages of various forms of consultation used by this Canadian government ministry.

Resource 16
Title: Participation and Equality Between Women and Men
Sida is the Swedish Government Overseas Development Aid Organisation.
Description: Two page "tip sheet" on issues to consider re participatory processes and inequalities and differences between women and men.
Resource 17
Title: Guidelines for Action
Description: Four page outline with dot points re data and research, consultation and steps in the policy process, and accountability issues.

Resource 18
Title: Cardiovascular Disease and Gender Issues
Source: Researched and written by Avega Bishop for the Gender Agenda Project Resource Kit
Description: Five page outline covering biological sex differences, cardiovascular (CV) death rates, and gender issues in relation to risk factors and trends, diagnosis and treatment and recovery from CVD illness.

Resource 19
Title: Depression and Gender Issues
Source: Researched and written by Avega Bishop for the Gender Agenda Project Resource Kit
Description: Seven page outline covering a global perspective on gender and depression, definition, Australian situation, causes and risk factors, gender perspectives, depression and particular population groups and mental health promotion issues.

Resource 20
Title: Smoking and Gender Issues
Source: Researched and written by Avega Bishop for the Gender Agenda Project Resource Kit
Description: Six page outline covering biological sex differences related to adverse health effects of tobacco, changing patterns in smoking, smoking and particular population groups, and gender issues in relation to the social meanings of smoking and health promotion.
A Checklist for Gender Integration in Programming and Management

The following checklist includes critical elements for integrating gender in organizations and programs. The list grew out of the 1995 survey of InterAction member agencies' "best practices" and is designed as a tool for planning and monitoring progress.

**Gender Policies and Programming**

- **Gender policy statement**
  - basic assessment of the problem
  - description of values, principles and mission that will guide the organization's policy
  - intent for applying policy throughout different sections of the organization

- **Staff and NGO partner organization participation in development of gender policy**

- **Demonstrated commitment from CEO and senior management to gender policy**

**Gender Integration in Programming**

- **Program planning and project design**
  - collection of gender disaggregated data: time allocation and labor (productive, reproductive and community)
  - gender analysis or gender needs assessment
    - assess the participation of men and women in programs
    - assess impact of project interventions on men and women
    - assess different roles, responsibilities, and needs of men and women, including access to and control over resources and decision-making at household and community levels
  - consultation with local women's organizations

- **Implementation**
  - stated procedures for incorporating gender concerns into projects
  - gender balance of local personnel, enhanced participation of women, gender training, established mechanisms for addressing male opposition to women's activities

- **Monitoring and evaluation**
  - measuring impact and benefits for women and men; women's welfare and participation; women in leadership positions; women's control over resources and decision making; changes in attitudes of men and women at household and community levels; enlistment of male participation, support and consent.
  - monitoring and evaluating teams should have gender balance

- **Centralized department, gender unit or focal point**
  - provides gender training and programmatic support, promotes gender perspective in programs and organization

- **Assigned staff responsibility within different departments, linked to the centralized gender unit or focal point**
Gender Integration Training

- Training for gender awareness, sensitization, planning and analysis
- Follow up training with specific tools and methodologies for institutionalizing the integration of gender concerns throughout the organization

Gender and Recruitment

- Equal opportunity policy
- Gender awareness included in job descriptions and as job recruitment and performance criteria
- Balanced representation of women and men in senior management positions at headquarters and in the field
- Proactive hiring strategies to recruit women into senior management positions
  - advertising through channels likely to reach more women
  - encouragement and provision of training for women to move from mid- to senior level positions

Family Friendly Work Policies

- Flexible working arrangements
  - flextime and flexplace
  - part-time and job sharing working arrangements
  - encouragement of men and women employees to take advantage of flexible work arrangements, including senior managers
- Maternal and paternal leave policies
- Childcare and dependent care leave and support
Understanding gender equality in organisations: A tool for assessment and action

Juliet Hunt, independent consultant

For most bilateral and multilateral development projects, the counterpart agency has already been decided long before implementation commences. Donor non-government organisations (NGOs) also frequently have long-term commitments to counterparts, although the projects and programmes they support with these counterparts may change. Nevertheless, an assessment of counterpart institutional capacity to implement gender-sensitive activities is essential as early as possible in the project cycle, so that an informed judgement can be made of the likelihood of these issues being addressed adequately and appropriately, and so that appropriate strategies for strengthening this capacity can be explored and costed.

International experience shows that donor agencies (both bilateral and NGO) often focus on 'gender training' as the major or only strategy for promoting gender sensitivity and equality within organisations and development programmes. Frequently, training is one-off and is not followed up. Sometimes, it is not linked to agency procedures, tools or specific projects/programmes, and may not be geared to practical skill development. Training outcomes are generally poorly monitored or not monitored at all. Not surprisingly, progress towards the implementation of gender and development policy remains slow. Gender training is most usefully seen as only one of a number of potential strategies for promoting the implementation of gender equality policies.


**Strategic areas for institutional development to promote gender equality**

**Organisational mandate**

- Does the organisational vision, mission statement and/or constitution acknowledge the power inequalities between women and men?
- Does the mandate for promoting gender equality refer to women's and men's experiences, and gender relations (including the power inequalities that exist between men and women)?
- Is there equal representation of women on the board of the organisation?

**Policy on gender and development or gender equality**

- Is there a policy on gender and development, gender equality, or women in development, and how was it developed?
- Was the policy imposed?
- Are there processes to build ownership of, commitment to and understanding of policy and its implications by all important stakeholders? Do staff know about the policy or what is in it?
- What is the content of the policy? Does it focus on women's human rights, gender equality and women's strategic interests? Is there an accurate portrayal of the status of women, gender relations and women's experiences, or does the policy have 'idealised' perceptions of women's roles and workloads?
- Are there systems in place to ensure accountability to policy goals and objectives, in organisational structures, procedures and decision-making processes? Is there an operational or strategic plan to implement the policy with measurable targets and indicators? Are there systems for monitoring progress towards policy implementation, such as consultations on gender equality outcomes, and regular review and audit procedures?

**Commitment to gender equality**

- Does the organisation 'talk the walk' on gender and development policy publicly and privately? Is there a real commitment to reflect on progress in this area and to take steps to improve performance?
- Is there evidence of senior and middle management commitment to policy, and responsibility and accountability for gender equality outcomes?
Organisational structure

- Is there a gender desk, unit or focal point which is responsible for ensuring that gender equality policy is implemented? If not, who is responsible for ensuring that gender issues are adequately addressed, and do they have the capacity and support to do this?
- If there is a gender focal point, where is this unit/desk located within the organisation? Is it strategically located, with clear links to senior management and with field/programme work? Does this unit/desk have authority and are the staff of the gender focal point respected?
- Do staff responsible for implementing gender policy have gender and development expertise? Are they adequately resourced within the organisation, or are they expected to carry out their gender and development responsibilities in their spare time, along with their normal duties?
- How are gender issues mainstreamed: is there acknowledgement that every staff member shares a responsibility to promote gender equality and implement policy? Are gender focal points seen as a valuable source of support and expertise; or is every matter concerning women seen as their responsibility and no one else’s?
- Do organisational policy making, decision making, and communication procedures provide opportunities for all members to participate?

Programmes, projects, activities and procedures

- Who benefits from the programmes, projects and activities carried out? Does reality match rhetoric about who benefits? Does the organisation know the impact of its activities and how this may differ for women and men?
- Is there an understanding of what gender analysis means? Are there appropriate tools for assessing who benefits from programmes, projects and activities (linked to organisational procedures)? (The development of gender analysis tools should build ownership, understanding and commitment to use tools as aids for analysis, rather than as ‘checklists’ or for ‘ticking boxes’.)
- Are there mandatory or voluntary project screening or appraisal of programmes and projects? Are there sex-disaggregated data which show how women and men benefit?
- Is there an understanding of what authentic (versus tokenistic) mainstreaming means? Do women still only feature in ‘women-only’ projects?
- Does the organisation monitor and evaluate the impact of its activities on women and men and on gender relations? (Do organisational procedures facilitate/ensure that this happens?)
- Do activities focus on women’s practical needs or do they support women to define and meet their strategic interests, by challenging traditional perceptions, roles and responsibilities?

Building capacity: A learning organisation

- Does the organisation have systems and processes for sharing lessons and good practice, from within the organisation and externally?
- Is good practice on addressing gender issues recognised or rewarded?
- Are formal and non-formal training opportunities provided for women, such as assertiveness, conflict resolution and leadership training?
- Do staff have the skills to undertake gender analysis of their programmes, projects and activities? Are they resourced, supported and encouraged to gain these skills?
- Is ‘gender training’ practical and linked to agency policy, mandate, procedures and programmes? Is training followed up to ensure that participants apply their skills and learning? Is gender training provided within a human rights perspective?

Personnel management practices

- Are equal employment opportunity and affirmative action principles and policies in place and applied in recruitment and personnel management?
- Do recruitment procedures identify gender equality commitment and gender analysis skills as essential or desirable criteria where appropriate?
- Is the promotion of gender equality and responsibility for gender equality outcomes included in duty statements?
- Do performance appraisal processes include an assessment of gender and development competence and identify strategies for improving staff capacity?
- Does the organisation have a sex-disaggregated employment profile? (See notes on this below.)
- Does the organisation have family-friendly work practices and policies, such as flexible working arrangements, maternal and paternal leave entitlements, and childcare and dependent care leave and support?
- Are sexual harassment policies and procedures in place and applied?
Organisational culture

Each of the above factors will have an impact on organisational culture, which also draws directly from the social and cultural context.

- Does the organisation have strategies for dealing with opposition and resistance to gender equality policy and programmes? Some possible strategies are:
  - harnessing political support and forming alliances within the organisation and country, and externally, to address resistance;
  - ensuring that the mandate for gender equality policy and programmes is clear, that it draws on a commitment to human rights, on women’s and men’s voices and experiences, and on sound and accurate gender analysis;
  - using informal and formal leaders as role models for gender-sensitive practice;
  - engaging in discussion and debate within the organisation on gender issues, to provide people with informal opportunities for learning and exposure to diverse views;
  - reinforcing the implications of policy, ensuring that it is seen as mandatory rather than optional and stressing accountability for implementing policy.

- The empowerment of women within organisations is critical for changing male-dominated cultures.

- Strength, commitment and credibility of gender focal points and senior management is also crucial for changing organisational culture.

Organisational context

- Does the government have a policy on women in development or gender and development, in national or sectoral planning documents? Is there a ‘women’s plan’ that can be referred to, to encourage change within the organisation (such as commitments made at the Beijing Fourth World Conference on Women in 1995)?

- Is there a ‘national women’s machinery’, such as a ministry of women’s affairs, department or office, or national or provincial NGOs or councils that can be referred to, to encourage change?

- What other agencies or organisations are active in the sector or country on gender and development, and what is their approach to gender issues?

A sex-disaggregated employment profile

AustAID’s Guide to gender and development (1998:21) notes the importance of undertaking a sex-disaggregated employment profile in assessing counterpart agency capacity to implement gender-sensitive projects. The following are some issues to consider:

- Numbers of female and male staff according to seniority; occupation/role; management versus field positions (particularly in the project location); educational attainment; and access to training opportunities. It is important to assess whether women are marginalised into particular roles, and why. (For example, secretarial, nutrition or home economics for agricultural agencies; desk-based positions for police departments).

- Are there systems in place to monitor how men and women progress through the organisation, and to reflect on blocks to progress and develop strategies to address these blocks (so that women are encouraged to move into middle and senior levels in the organisation)?

- Approaches to gender issues in other projects and regions, for example recruitment of female staff, training of female staff, gender targeting of beneficiaries, awareness of impact on women.

- Levels of expertise regarding women’s roles in the sector, in terms of gender division of labour, access to and control over resources, approaches to planning for women (welfare-oriented, effectiveness concerns or equality). Locate sources of expertise within the agency.

- Communication strategies, and capacity for and commitment to participatory and consultative approaches to project implementation.

- Receptiveness to, knowledge of understanding of their own government’s and AustAID’s gender and development policy, and to different rationales for working with women (effectiveness, need, equality, sustainability).

Strengthening organisational capacity

These are tips only and are not comprehensive. Strategies need to be developed to suit the organisational and project context. In some cases, the best place to start may be with strategic planning to develop or review policy, or to ensure that there is a debate and shared understanding of policy. In others, strategic planning to implement policy may be a good starting-point.

Personnel management

- Identify female staff who can be involved in planning and implementation of the project, and cost any specific measures needed to support their ongoing participation and involvement in project decision making.

- Set targets and devise strategies for the recruitment of female staff.

- Resource female field staff adequately and monitor the use of these resources.

- Actively monitor barriers to female participation within the agency and develop appropriate
strategies for overcoming these barriers. For example, ensure that adequate and safe transport and housing is available and take into account women’s family responsibilities.

- Monitor the tendency for female staff to be marginalised to administrative or ‘traditional female’ roles.

Training

- Provide project focused and practical gender training for expatriate and local staff, which directly addresses women’s and men’s roles and responsibilities in the sector, their access to resources and their priorities for production and consumption, and project-specific strategies for addressing gender issues.
- Provide bridging training for female staff.
- Ensure that training and responsibilities for female and male staff are equivalent.
- Set targets for female participation in all areas of training, and outline how targets will be met.
- Identify women eligible for management, research and other higher level training.
- Monitor and report on progress in meeting training targets.

In a World Bank funded agricultural extension project in Cameroon (Walker 1990), significant increases were achieved in the recruitment of female staff, in staff training and in the adaptation of extension methods to reach women farmers. Strategies used included:

- equivalent intensive training for all recruits, including rural sociology and farming systems;
- using contact groups in addition to contact farmers, including existing formal and informal women’s groups;
- selecting ‘leader farmers’, half of whom were women, to provide demonstration fields;
- providing credit for both cash and food crops (men’s and women’s crops);
- gender targeting, where groups were initially and temporarily contacted by extension agents of the same gender;
- monitoring of gender impact, which saw the project evolve from neglect of women, to segregated activities, to a hybrid approach of both integrated activities and special women’s focus.

Participation and consultation strategies

- Review communication strategies to ensure that women know of the project and have realistic opportunities for participation.
- Where necessary, organise or support separate groups of men and women as vehicles for communication with the project. If separate groups are not appropriate, monitor women’s participation in mixed groups.
- Identify local formal and informal women’s groups which could act as channels for communication and participation, and monitor membership and access to resources through these groups.
- Ensure that the scheduling of project activities (daily and seasonal), particularly opportunities for participation and consultation, do not clash with women’s highest priority tasks.
- Actively monitor barriers to female participation in the project and develop appropriate strategies for overcoming these barriers.

Negotiation

- Use rationales for gender-sensitive approaches which will appeal to hostile or indifferent staff in counterpart agencies, such as efficiency, effectiveness and sustainability concerns.
- Demonstrate the economic benefits of involving and supporting women, both female staff and in the community. Demonstrate the costs of neglecting women.
- Draw on local government’s statements/rationales for involving and supporting women and men in development planning and implementation.
- Identify in-country advocates for gender-sensitive approaches, and possible networks to support key women in the counterpart agency.

References


Hamerschlag, K. and A. Reerink 1996, Best practices for gender integration in organisations and programs from the InterAction community, InterAction (American Council for Voluntary International Action), Washington, DC.


Macdonald, M., E. Sprenger and L. Dubel 1997, Gender and organizational change: Bridging the gap between policy and practices, Royal Tropical Institute, Amsterdam.


CHANGING ORGANIZATIONS

Changing NGOs

Gender Route is a dynamic process through which 35 "mixed organizations" (NGOs whose work is not aimed exclusively at women, and whose staff is not made up entirely of women) in Asia, Africa and Latin America are integrating a gender perspective into a process of organizational change and development. Through the Gender Route, each organization is initiating unique processes of change regarding vision, policy objectives, strategies, and activities, as well as the internal structure and culture of the organization. The process is being facilitated by NOVIB in The Netherlands, and is a 3-year programme that will be completed in the year 2000 when an evaluation of its impact will be undertaken.

One of the many different tools emerging from the Gender Route process is Organizational Gender Diagnosing, a four-step process outlined below.

Tool: Organizational Gender Diagnosing

Step 1:
Make a Gender Quick Scan of the strengths and weaknesses of your organization by using the Matrix (Chart) on the next page. Answer the different questions on the Checklist (pages 31-32) and score them by each block. In this way, you will see which blocks are stronger and which ones are weaker. We recommend that you do this exercise with different people from the same organization or outside people who know the organization well.

Step 2:
Do a Dynamic Analysis to analyze the functioning of your organization. Ask yourself the following questions: Why is it the way it is? What changes are currently taking place? How can strengths and weaknesses be explained?

Step 3:
Next, do a Diagnosis to identify strategies for change. For a strategy to be successful, a number of requirements need to be met. It needs to be explanatory; it should be based on an understanding of the organization; it should be acceptable to the organization; and it should be realistic.

Step 4:
Finally, create an Activity Plan. On the basis of the dynamic analysis and diagnosis, you can now identify activities that will help you to follow your Gender Route and attain the objective. Write down key activities for each block.

The following pages present Step 1: Gender Quick Scan as an example of how Organizational Gender Diagnosing works. For a copy of the complete framework, contact:

NOVIB, P.O. Box 30919, 2500 GX The Hague, The Netherlands.
Tel: 31-70-342-16-21; Fax: 31-70-361-44-61; E-mail: ellen.sprenger@novib.nl

SOME DEFINITIONS

GENDER: Socially constructed roles assigned to males and females. These roles are learned; change over time and vary widely within and across cultures. Whereas biological sex identity is determined by reference to genetic and anatomical characteristics, socially learned gender is an acquired identity.

GENDER POLICY: An organization's policy that integrates gender issues into the entire spectrum of its activities. The policy also designates responsibility for gender integration through mechanisms such as gender training and gender guidelines.

GENDER RELATIONS: The relative position of men and women in the division of resources and responsibilities, benefits and rights, power and privilege. The use of gender relations as an analytical category shifts the focus away from viewing women in isolation from men.

GENDER SENSITIVITY: An understanding and consideration of the socio-cultural factors underlying discrimination based on sex, whether against women or men.
Presenting the Gender Quick Scan
Step 1 of Organizational Gender Diagnosing*

The Scanning Matrix (Chart) below shows the breakdown of your organization by function (Mission and Mandate, Organizational Structure, Human Resources) and insight into the functions (Technical, Political, Cultural Points of View). By answering the questions on the following checklist, you can begin to see the pair of your organization that are "gender strong" or "gender weak."

Instructions for Scoring the Checklist:
1. Answer the questions on the next two pages by placing a checkmark in the column (Yes, Somewhat, or No).
2. At the end of each block of questions, total your score for that block, and transfer the total across to the Matrix on this page. (Yes = 3, Somewhat = 2, No = 1).
3. Look at ‘How did your organization score’ on page 32 to discover how “gender strong” or “gender weak” your organization is!

* for steps 2, 3 and 4, contact NOVIB (address on previous page)

<table>
<thead>
<tr>
<th>INSIGHTS INTO FUNCTIONS</th>
<th>FUNCTIONS OF ORGANIZATION</th>
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<tbody>
<tr>
<td></td>
<td>Mission/Mandate Goals &amp; Strategies</td>
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<tr>
<td>Technical Point of View:</td>
<td>1 Policies &amp; Actions</td>
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<tr>
<td>Social, Technical &amp; Financial Resources</td>
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<tr>
<td>Political Point of View:</td>
<td>2 Policy Influence</td>
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<tr>
<td>Power &amp; Resource Allocation</td>
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<tr>
<td>Cultural Point of View:</td>
<td>3 Organizational Culture</td>
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<tr>
<td>Values, Standards &amp; Beliefs</td>
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<td></td>
<td>7 Expertise</td>
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The Tribune #56, April 1997 30
<table>
<thead>
<tr>
<th>MISSION/MANDATE</th>
<th>YES</th>
<th>SOMETHAT</th>
<th>NO</th>
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<tbody>
<tr>
<td>Block 1: Policies and Actions</td>
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<tr>
<td>Are gender relations integrated into mission &amp; mandate of the organization?</td>
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<tr>
<td>Does your organization have a clear gender policy?</td>
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<tr>
<td>Does the gender policy have an activity plan? (e.g., one that includes clear allocation of responsibilities and time for monitoring and evaluation)</td>
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<td>Is there enough money to implement the gender policy?</td>
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<td>Is gender taken into account during monitoring, evaluation and strategic planning?</td>
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<tr>
<td>Does your organization empower women?</td>
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<tr>
<td>Block 2: Policy Influence</td>
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<tr>
<td>Is management, incl. the board, involved in gender policy development?</td>
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<tr>
<td>Does management consult with the staff on issues related to gender policy implementation?</td>
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<tr>
<td>Do the staff and management discuss gender issues with outside groups, i.e., consultants, community groups, politicians, donor agencies, etc.?</td>
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<tr>
<td>Are opinions of outside groups and people valued and taken seriously by management?</td>
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<tr>
<td>Block 3: Organizational Culture</td>
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<tr>
<td>Does the staff think that gender fits into the image of your organization?</td>
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<tr>
<td>Does everyone feel that the gender policy belongs to them?</td>
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<tr>
<td>Do women in your organization think the organization is woman friendly?</td>
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<tr>
<td>Do women outside your organization think the organization is woman friendly?</td>
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<tr>
<td>Is your organization gender sensitive, e.g., in terms of language used, jokes and comments made, images and materials displayed, actions taken around sexual harassment?</td>
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<tr>
<td>Does your organization have a reputation of integrity and competence on gender issues amongst women's organizations and (outside) individuals?</td>
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<tr>
<td>ORGANIZATIONAL STRUCTURE</td>
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<tr>
<td>Block 4: Tasks and Responsibilities</td>
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<tr>
<td>In your organization, are tasks and responsibilities concerning gender issues clearly understood?</td>
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<tr>
<td>Are there effective policies and mechanisms in place so that gender learning can take place throughout the organization?</td>
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<tr>
<td>Is there sufficient information to do the job well?</td>
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<tr>
<td>Are staff with specific gender expertise and responsibilities located at influential positions in your organization?</td>
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<tr>
<td>Is the existing gender structure the most appropriate one? (e.g., separate &quot;gender unit&quot; vs. &quot;gender focal points in every department,&quot; etc.)</td>
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<tr>
<td>Block 5: Decision Making</td>
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<tr>
<td>Are decisions on gender policy being made on the basis of monitoring and evaluation exercises?</td>
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<tr>
<td>Are all staff, including gender specialists, participating in decision-making processes?</td>
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<tr>
<td>Are gender decisions made in a timely manner?</td>
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<td>Are conflicts in the workplace dealt with adequately? (e.g., issues of sexual harassment, or dealing with people who are resisting change based on gender policies?)</td>
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</tbody>
</table>

The Tribune #56, April 1997
### Block 6: Cooperation and Learning

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>SOMewhat</th>
<th>NO</th>
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<tbody>
<tr>
<td>Does your organization promote teamwork, involving women, men, and gender focal persons?</td>
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<tr>
<td>Do staff members support each other in problem solving and identification of new challenges in the field of gender?</td>
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<tr>
<td>Does your organization promote exchange, collaboration and other forms of interaction with women's organizations, groups, etc. active in the field of gender?</td>
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<tr>
<td>Are new, innovative ideas and practices welcomed in your organization?</td>
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<tr>
<td>Are new, innovative ideas and practices incorporated into existing practices?</td>
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</table>

### Human Resources
**Block 7: Staff and Expertise**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>SOMewhat</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Is management committed to promoting women to all levels of your organization?</td>
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<tr>
<td>Is this commitment translated into concrete objectives, with a time frame?</td>
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<tr>
<td>Are new staff selected on the basis of gender sensitivity and ability to deal practically with gender issues?</td>
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<tr>
<td>Do men and women receive equal wages for work of equal value?</td>
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<tr>
<td>Are job descriptions clearly defined, with gender taken into consideration?</td>
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<tr>
<td>Are gender issues discussed during performance appraisal interviews?</td>
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<tr>
<td>Is there a gradual increase of gender sensitivity among all staff members? (e.g., as a result of training, change of policies, clearer objectives, etc.)</td>
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</table>

### Block 8: Room for Maneuuvre

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>SOMewhat</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Does your organization support staff who wish to organize around parts of their identity (e.g., sex, ethnicity, religion, age, sexual preference, physical ability)?</td>
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<tr>
<td>Does your organization make allowances for, and have an adequate infrastructure to enable women staff members to carry out their work? (e.g., a safe working environment, adequate toilet facilities, flexible transport arrangements, working hours, maternity leave, etc.)</td>
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<tr>
<td>Is good performance, particularly in gender issues, being rewarded? (e.g., by congratulating individual staff members)</td>
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<tr>
<td>Do staff value different working styles? (e.g., men and women in non-traditional fields of work, more formal or less formal working environments, leadership styles, ways of chairing meetings, etc.)</td>
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<tr>
<td>Are interesting career opportunities offered to both women and men?</td>
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</table>

### Block 9: Attitude

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>SOMewhat</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff enthusiastic about the work they do?</td>
<td></td>
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<tr>
<td>Are staff committed to implementation of a gender policy?</td>
<td></td>
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<tr>
<td>Are staff open to new ideas and innovation?</td>
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<tr>
<td>Are staff willing to change practices?</td>
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<tr>
<td>Is gender taken seriously and discussed openly by men and women?</td>
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<tr>
<td>Is gender stereotyping addressed and countered by individual staff members?</td>
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</table>

### How did your organization score?

140 - 143: **Top Score!** Your organization is "gender strong" in its functional aspects regarding policy, organization, cooperation, decision making, and expertise. Good job and keep up the good work!

100 - 139: **Pretty good!** Your organization has some work still to do regarding gender-sensitizing and re-structuring. Look at which blocks were stronger and which were weaker. This will give you an indication of which areas you need to work on!

45 - 99: **Get to work!** Your organization is "gender weak" and definitely needs to implement a full-fledged Gender Route!
InterAction
Commission on the Advancement of Women
Mildred Robbins Leet Award for the Advancement of Women

Please complete this assessment form and send with a nomination letter summarizing your organization's accomplishments to the address indicated on the back of this form.

Gender Integration in Programming and Management Accomplishment Self-Assessment

<table>
<thead>
<tr>
<th>GENDER POLICY</th>
<th>1995</th>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
<th>1998</th>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a gender perspective in the overall mission and mandate of your organization?</td>
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<tr>
<td>2. Does your organization have a written gender policy that affirms a commitment to gender equity?</td>
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<td>3. Was management involved in gender policy development?</td>
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<td>4. Was the board involved in gender policy development?</td>
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<tr>
<td>5. Did staff and NGO partner organizations participate in the development of the gender policy?</td>
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<td>6. Does your gender policy have an operational plan that includes clear allocation of responsibilities and time for monitoring and evaluation?</td>
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<td>7. Are budget resources allocated for implementation of the gender policy?</td>
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<td>8. Is gender taken into account during strategic planning for organizational activities?</td>
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<table>
<thead>
<tr>
<th>GENDER INTEGRATION IN PROGRAMING</th>
<th>1995</th>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
<th>1998</th>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the integration of gender equity in programs mandated by your organization's CEO?</td>
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<tr>
<td>2. Are gender analysis and needs assessments conducted prior to program planning and project design?</td>
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<td>3. Is gender disaggregated data collected for projects and programs?</td>
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<td>4. Are projects and programs designed in consultation with local women's organizations?</td>
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<tr>
<td>5. Is the gender impact of projects and programs monitored and evaluated?</td>
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<tr>
<td>6. Is there a gender department, unit or focal point in your organization?</td>
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<tr>
<td>7. Is there assigned staff responsibility for gender integration in different departments?</td>
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<tr>
<td>8. Is the assigned staff within different departments linked to the gender department, unit or focal point?</td>
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<tr>
<td>9. Does your organization promote exchange, collaboration and other forms of interaction with women's organizations active in the field of gender?</td>
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</tbody>
</table>
## GENDER INTEGRATION TRAINING

1. Is there training of staff in gender awareness and sensitization?  
   - 1995:  
   - 1998:  

2. Is there training of project and program staff in gender planning and analysis?  
   - 1995:  
   - 1998:  

3. Is there training of senior management and members of boards in institutionalizing the integration of gender into the management of the organization?  
   - 1995:  
   - 1998:  

## STAFFING

1. Is there an equal opportunity policy?  
   - 1995: Yes  
   - 1998: Somewhat  
   - 1999: No  

2. Do women and men receive equal wages for work of equal value?  
   - 1995: No  
   - 1998: No  

3. Is gender awareness included in all job descriptions and job recruitment?  
   - 1995: No  
   - 1998: Somewhat  
   - 1999: No  

4. Is gender awareness included in job performance criteria?  
   - 1995: No  
   - 1998: Somewhat  
   - 1999: No  

5. At headquarters, is there an increase in the representation of women in senior management positions?  
   - 1995: No  
   - 1998: No  

6. In the field, is there an increase in the representation of women in senior management positions?  
   - 1995: No  
   - 1998: No  

7. Is there an increase in the representation of women on your organization’s board?  
   - 1995: No  
   - 1998: No  

8. Are there proactive strategies implemented to recruit or promote women into senior management positions?  
   - 1995: No  
   - 1998: No  

9. Is there respect for diversity in work and management styles in your organization?  
   - 1995: No  
   - 1998: No  

## FAMILY FRIENDLY WORK POLICIES

1. Are there flexible work arrangements in your organization?  
   - 1995: No  
   - 1998: No  

2. Is there a maternity and paternity leave policy?  
   - 1995: No  
   - 1998: No  

3. Is there a child care and dependent care leave policy?  
   - 1995: No  
   - 1998: No  

4. Is there a dependent care flexible spending account program?  
   - 1995: No  
   - 1998: No  

---

Please send the completed self-assessment form with a nomination letter summarizing your organizations accomplishments to:

Suzanne Kindervatter, Director  
Commission on the Advancement of Women  
InterAction  
1717 Massachusetts Avenue, NW, Suite 801  
Washington, DC 20036  
Fax: (202) 667-8236  
e-mail: skindervatter@interaction.org  
Deadline: March 15, 1998
Gender equality and institutions: two challenges

Organisations and institutions are crucial players in development and development cooperation. A gender lens can be applied to NGOs, government bureaucracies, UN organisations, private sector companies, and development cooperation agencies themselves.

From a gender equality perspective, there are at least two challenges regarding institutions:

- How can an organisation promote more equitable relations between women and men through the implementation of its mandate?

Organisations have a profound impact on gender relations and inequalities. Given their mandates and resources, organisations decide (implicitly or overtly) who gets what resources, who benefits from a specific programme and who participates in decisions. For example, there are gender equality implications in the actions of both the Ministry of Finance setting tax policy and a community-based organisation developing a water-users’ committee.

Most organisations pay little attention to the relevance of differences and inequalities between women and men to their area of work. Many people assume that organisations operate in ‘gender neutral’ ways, that their actions will have the same impact on women and men. Yet, it is rarely the case.

Organisations can perpetuate inequality between women and men through implementing policies that widen economic disparities (in the case of a Ministry of Finance) or that fail to support women’s involvement in decision-making processes (in the case of a development cooperation agency). Institutions also have the potential to act in other ways. They can seek to ensure that policies and programmes narrow gender disparities, recognise domestic work, promote more equal decision-making authority and eliminate discrimination on the basis of sex.

- How can women and men participate equally in the institution (in its structure, in its decision-making processes, and in the jobs it offers)?

Analysts have argued that organisations themselves (their structures, ways of working, decision-making, and institutional ‘culture’) can have significant gender overtones. For example, they point out that organisational expectations imply that workers have few or no family responsibilities (that they can be away from home for significant periods of time or that they can work late into the night).

Changing organisations

Planned change, the change agent, leading change, the challenge of change, managing change... The business section of any bookstore is full of texts and studies of organisational change. Yet there are no easy solutions – organisations have proven to be complex. Reaching the goal of equitable relations between women and men will depend on multi-faceted strategies.

Attention has recently begun to focus on how development cooperation organisations can be changed to better promote equality between women and men. The initial focus was on the development of policies, but it was soon realised that the implementation of these policies would require additional supports and even organisational transformation. Key factors that can support the change process include:

- Development of a strategy that is based on the individual characteristics of the specific organisation (mandate, structure, staff...);
- Support from the leadership of the organisation;
- Clearly articulated arguments about why and how a gender equality perspective is relevant to the work of the organisation (even better if backed by strong research);
- Development of strategies to deal with resistance;
- Clear organisational targets and goals (with timelines) to hold the organisation accountable for progress;
- Adequate resources (including staff time);
- An internal catalyst that can mobilise resources and keep the issue on the organisation’s agenda;
- Solid networks with gender equality advocates;
- Identification and mobilisation of allies inside an organisation; and
- An organisational strategy that holds all staff responsible for the gender equality mandate (rather than assigning implementation responsibility to a small, marginal unit).
A gender analysis of an organisation involves looking at several aspects:

- **The institution's mandate and area of work:** It is important that the relationship between the primary area of work/mandate of the organisation and equality between women and men is clearly understood. For example, if the institution is concerned with promoting environmental sustainability, are the linkages between gender inequality and differences and the environment understood and recognised throughout the organisation?

- **Organisational history and culture:** Both the informal and formal rules that guide an organisation can have gender implications. Factors that support increased attention to equality issues include: flexibility, valuing diversity and different professional specialisations (for example, are social analysis skills considered important or just a ‘frill’?), recognition and support for people's family responsibilities.

- **Current personnel:** The skills and attitudes of both management and regular staff are important. Does the leadership of the organisation support the move to greater attention to gender equality issues? Does the current skill profile within the organisation support the consideration of gender equality issues or is there a need for new skills?

- **Organisational routines and procedures:** Internal procedures may offer support or hinder the consideration of gender equality issues. For example, if evaluation and monitoring are weak in general, it will be difficult for the organisation to monitor the impact of its programmes and policies on women and men.

- **External environment and pressures:** Effective organisational change is often promoted through a combination of internal advocates and external pressure organisations. Many organisations have moved to develop new skills or programmes at the prompting of external advocacy groups, donor agencies, or ‘global opinion and consensus’ (such as that established through the Beijing Platform for Action).


Sida Equality Prompt Sheet #15: Organisational change and equality between women and men

Mailing Address: 105 25 Stockholm, Sweden
Visiting Address: Sveavagen 20, Stockholm
www.sida.se
Project 2. Counting Heads

Objective: To gain an overview of the gender dynamics of the environment in which you operate.

Time Needed: Several days or weeks. This is a project based activity and can be set as homework between sessions.

How You Do It:
1. This project can be done with small work groups or as an individual observation exercise. Identify a mixed sex group to observe, this needs to be done in a subtle way so as not to make people feel uncomfortable. It can be done in any setting: in your office, with committees in which you participate, at public meetings or in groups that you run.

2. Use Making Changes Worksheet 1 as a check list as you observe what is happening in the group you have chosen to study. If necessary make brief notes and complete the Worksheet later.

3. When the observation phase of the study is completed, it is time to analyse your observations. Work through and discuss the questions on Counting Heads Worksheet on the next page and keep a record of your findings for future reference.

4. This activity can be repeated a number of times with different groups of people being observed.
Counting Heads: Worksheet

✓ When you go into the group you have identified, do a head count.
  Q How many women are there? ..............................................
  Q How many men? ......................................................
✓ What is the context for the gathering? ..............................................................
✓ Why are people here? ........................................................................
✓ Are women and/or men from culturally or linguistically diverse backgrounds present? Are their numbers representative of their community?
................................................................................................................
✓ Are women and/or men with disabilities present? ............................................
✓ Are issues of relevance to them on the agenda? ....................................................
✓ Are Aboriginal women and/or men involved? Are issues of relevance to them on the agenda?
........................................................................................................................
✓ Are lesbian and gay issues on the agenda? .........................................................
✓ How many young people or older people are involved? ......................................
✓ Are people from a variety of class and socioeconomic groups represented? Is there an awareness of the needs of marginalised groups?
......................................................................................................................
✓ Is childcare provided? .....................................................................................
✓ Is assistance provided to ensure access (eg carers, interpreters etc) ....................
✓ Watch who speaks. Keep a record: draw two columns, one for men, one for women. Each time a person speaks, make a mark in the relevant column. After the meeting you can total the data.

<table>
<thead>
<tr>
<th>Men speak</th>
<th>Women Speak</th>
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<td></td>
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</table>
Diversity Snapshot: Worksheet.

Collect the following information about your service or agency:

**Gender:**
- How many women participate in total? .................................................................
- How many men participate in total? .................................................................

**Cultural and Linguistic Diversity:**
- What percentage are women from non English speaking backgrounds ........................................
- What percentage are men from non English speaking backgrounds ........................................

**Age:**
- What percentage are women aged between 18 and 30 ........................................
- What percentage are men aged between 18 and 30 ........................................
- What percentage are women aged between 31 and 49 ........................................
- What percentage are men aged between 31 and 49 ........................................
- What percentage are women aged between 50 and 69 ........................................
- What percentage are men aged between 50 and 69 ........................................
- What percentage are women aged 70 or over ........................................
- What percentage are men aged 70 or over ........................................

**Disability**
- What percentage are women with a physical or sensory disability .................................
- What percentage are men with a physical or sensory disability .................................
- What percentage are men with a psychiatric disability .................................
- What percentage are women with a psychiatric disability .................................

**Socio-economic Status:**
- What percentage are women on pensions and benefits ........................................

**Sexual Preference**
- Do workers consider the possibility that 'single' people may have same sex partners or significant others?
- Do people disclose their sexual preference to workers to your knowledge?

Review this information. Who is your target group? Who is absent? Who is invisible? Make a note of them here ........................................

Permission to photocopy this page

Is there any reason for these absences?

What kind of messages does our organisation communicate about inclusiveness?

☐ We have information displayed that indicates lesbians/ gay men/ bi-sexual and transgender people are welcome:
  ☐ Yes ☐ No Actions Required

☐ We have ramps, hand rails and other accessories to assist people with physical disabilities:
  ☐ Yes ☐ No Actions Required

☐ The toilets are wheelchair accessible:
  ☐ Yes ☐ No Actions Required

☐ We have signs and pamphlets in a range of languages
  ☐ Yes ☐ No Actions Required

☐ We have information and symbols visible that demonstrates we are Aboriginal Friendly
  ☐ Yes ☐ No Actions Required

☐ All reception and frontline workers have done customer service training and are friendly and welcoming to anyone who enters and provide prompt service.
  ☐ Yes ☐ No Actions Required

☐ The service is in a well lit venue which is readily accessible to public transport
  ☐ Yes ☐ No Actions Required

☐ We use interpreter services:
  ☐ Yes ☐ No Actions Required

☐ We have programs that cater to the needs and interests of specific age groups
  ☐ Yes ☐ No Actions Required

☐ We provide childcare or have information available about affordable childcare
  ☐ Yes ☐ No Actions Required
We provide respite for carers or have information available about affordable respite services

☐ Yes  ☐ No  Actions Required

Workers understand the diverse cultural and religious needs of consumers from diverse backgrounds

☐ Yes  ☐ No  Actions Required

Our Service

These programs cater specifically for women's needs?

These programs cater specifically to men's needs?

These programs reach out to specific groups?

Consumers find out about our service through:

Who is not currently participating?

Reflect on the above data and note down your observations or thoughts. What are you pleased about? What needs to change?
With others in your work group discuss your findings. What are you doing well? What needs to change? What actions are necessary to bring about these changes? List them below.

<table>
<thead>
<tr>
<th>Issue to be addressed</th>
<th>Actions Necessary</th>
<th>Resources/ and supports needed</th>
<th>Who will be responsible</th>
<th>Timelines</th>
</tr>
</thead>
</table>


Now write some objectives to help you to define the changes you want to make and communicate them to other people.
Resource 3b  Gender Analysis – What to Ask.

Both project staff and management should ask at least some of these questions when reviewing project documents, collaborating in project design activities, participating in project review meetings and debriefing project design, evaluation and backstopping missions.

- Who is the target (both direct and indirect) of the proposed policy, program or project, Women, Men, or both? Who will benefit, who will lose? Which Women? Which Men?
- Have women and men been consulted on “the problem” the intervention is to solve? How have they been involved in the development of “the solution”?
- Does the intervention challenge the existing division of tasks, responsibilities and resources among men and women?
- Which needs of women and men will the intervention address: practical, strategic, or both?
- What is the relationship between the proposed intervention and other activities, and with national, regional and international organisations?
- Where do opportunities, or entry points, for change exist? And how can they best be used?
- What specific mechanisms can be proposed to encourage and enable women to participate in the policy initiative or programme, despite their traditionally more domestic location and subordinate position?
- What is the long-term impact in terms of women’s increased ability to take charge of their own lives, and to take collective action to solve problems?
- What is the best way to build on and strengthen the government’s commitment to the advancement of women?
Identification & preparation

- These questions are to be used as a guide only. It is not expected that every question will be relevant to all activities.
- The questions are designed to assist AusAID Activity Managers with their assessment and appraisal of development activities.
- The questions are also designed to assist contractors to incorporate gender perspectives into activity preparation and design.

### Key Guiding Questions

<table>
<thead>
<tr>
<th>Do project objectives explicitly refer to women and men?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are benefits for women and men stated in the project objectives?</td>
</tr>
<tr>
<td>Are women included in the target group?</td>
</tr>
<tr>
<td>Have both women’s and men’s needs in the project sector been considered?</td>
</tr>
<tr>
<td>Have women’s practical gender needs and strategic gender interests been considered? (defined by women themselves)</td>
</tr>
<tr>
<td>Does the project build on women’s and men’s strengths and skills in the sector?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do project documents describe project consultation and participation strategies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have local women and women’s networks been consulted?</td>
</tr>
<tr>
<td>Will women and men be involved in decision making on the project?</td>
</tr>
<tr>
<td>Have constraints to women’s and men’s participation in the project been identified?</td>
</tr>
<tr>
<td>Have strategies been identified to address these constraints?</td>
</tr>
<tr>
<td>Have targets been set for women’s and men’s participation and benefits?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has consideration been given to the current gender division of labour?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has sex disaggregated data been collected on the gender division of labour and responsibilities? (all aspects of women’s and men’s work affected or targeted by project activities)</td>
</tr>
<tr>
<td>Does this data differentiate between socio-economic or ethnic groups affected or targeted by the project?</td>
</tr>
<tr>
<td>Have women’s and men’s productive, reproductive, household/ community service and community management/politics roles all been considered?</td>
</tr>
<tr>
<td>Have girl’s and boy’s tasks and responsibilities also been considered?</td>
</tr>
<tr>
<td>Is women’s participation possible given the existing allocation of time between tasks? (their current workloads)</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Has consideration been given to when and where the project activity will be done? (how will this affect the current division of labour, and how will it constrain or facilitate women's and men's involvement)</td>
</tr>
<tr>
<td>Has consideration been given to the duration of project activities? (how will this constrain or facilitate women's and men's involvement)</td>
</tr>
<tr>
<td>Is the project suited to women's activities? (are project inputs targeting both men's and women's activities)</td>
</tr>
<tr>
<td>Will project activities affect women's or men's access to and control of resources? (eg. loss of land, reduced access to markets)</td>
</tr>
<tr>
<td>Will new technologies benefit both women and men?</td>
</tr>
<tr>
<td>Will women and men be informed about the project and any training opportunities offered?</td>
</tr>
<tr>
<td>Will training be equally available to women and men to ensure absorption of new technology and ideas? (have strategies been identified to ensure this)</td>
</tr>
<tr>
<td>Have constraints and strategies been identified to ensure that poor women and men can access other project resources?</td>
</tr>
<tr>
<td>Are project organisations equally accessible to women and men?         (eg. water user groups, credit and farmer groups)</td>
</tr>
<tr>
<td>Is it necessary to have separate activities or components for women to ensure that their needs and interests are not marginalised? (to ensure that women have equal access to project resources)</td>
</tr>
<tr>
<td>Have the beneficiaries of the project been identified?</td>
</tr>
<tr>
<td>Who will control the benefits from project activities? (such as income earned, food produced or assets created)</td>
</tr>
<tr>
<td>Who will benefit from any income earned?</td>
</tr>
<tr>
<td>Will groups of men or women be disadvantaged by the project? (have remedial measure been taken)</td>
</tr>
<tr>
<td>Has consideration been given to how social, cultural, religious, economic, political and environmental factors will influence women's and men's participation?</td>
</tr>
<tr>
<td>Has consideration been given to how the project might influence these factors, either positively or negatively?</td>
</tr>
<tr>
<td>Are there legal and institutional barriers to women's participation?</td>
</tr>
<tr>
<td>Are there measures which attempt to remove any constraints to women's participation? (eg. travel to the project site is made safer for women, separate dormitory facilities for men and women, separate classes for women)</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Does the Recipient Government counterpart agency have the capacity to implement gender-sensitive projects?</td>
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<tr>
<td>How will the activity affect women’s social status, including their role as decision makers?</td>
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<tr>
<td>Are arrangements in place to monitor gender impacts (the impact of the project on women and men, and on the relationships between them)?</td>
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<tr>
<td>Are project resources adequate to deliver services and opportunities to women and men?</td>
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</table>
Implementation & monitoring

- These questions are to be used as a guide only. It is not expected that every question will be relevant to all activities.
- The questions are designed to assist AusAID Activity Managers with their management and monitoring of development activities.
- The questions are also designed to assist contractors to incorporate gender perspectives into activity implementation and monitoring.

<table>
<thead>
<tr>
<th>Key Guiding Questions</th>
<th>Auxiliary Guiding Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have strategies and targets for promoting equal opportunities and benefits been identified in the project design?</td>
<td>Do strategies and targets address practical gender needs of women as well as strategic interests?</td>
</tr>
<tr>
<td>Are adequate gender-sensitive monitoring mechanisms in place and operational?</td>
<td>Has sex disaggregated data been collected on women's and men's participation on a routine basis?</td>
</tr>
<tr>
<td>Are both men and women participating in the project activities?</td>
<td>Has sex disaggregated data been collected on women's and men's participation?</td>
</tr>
</tbody>
</table>

* * *

- Do performance indicators measure women's and men's access to project resources, services and benefits?
- Are women and men involved in data collection and assessment? (Is this a participatory process)
- Do project staff assigned to monitoring have gender expertise and sensitivity?
- Are project organisations equally accessible to women and men?
- If men and women are not participating equally, are the reasons for this clear, articulated and acceptable?
- Are both men and women benefiting from project activities?
- Has sex disaggregated data been collected on the distribution of benefits and on who has received project resources and services?
- Has consideration been given to whether benefits will be sustainable, and what factors will enhance sustainability?
- If men and women are not benefiting equally, are the reasons for this clear, articulated and acceptable?
<table>
<thead>
<tr>
<th>Have constraints arisen during project implementation to restrict women's and men's participation and the equal distribution of benefits?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Are there labour/time factors constraining women's or men's participation and the distribution of benefits?</td>
</tr>
<tr>
<td>- Is participation and the distribution of benefits constrained by access to and control over productive resources?</td>
</tr>
<tr>
<td>- Is participation and decision making by women and men being limited by social, political, economic and cultural factors? (e.g. participation in farmer, credit or other project groups)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the counterpart agency have the capacity to implement gender-sensitive projects?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Is equal participation and benefits constrained by lack of capacity or commitment in the counterpart agency?</td>
</tr>
<tr>
<td>- If so, have any strategies been identified to address this?</td>
</tr>
<tr>
<td>- Are these strategies able to be resourced?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the project adversely affecting women or men?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Has women's or men's workload increased or decreased as a result of project participation? (consider different socio-economic groups)</td>
</tr>
<tr>
<td>- Has women's or men's access to resources been reduced? (e.g. loss of land)</td>
</tr>
<tr>
<td>- Have any harmful or discriminatory practices against women been reinforced?</td>
</tr>
<tr>
<td>- Have women's and men's skills/knowledge in the project sector been acknowledged and strengthened, or have they been overlooked or undermined?</td>
</tr>
<tr>
<td>- Has women's status in the community suffered?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How is participation by women affecting men's and women's roles and relationships?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Is there a redistribution of access and control of resources between women and men?</td>
</tr>
<tr>
<td>- Are men, counterpart agencies and other key groups accepting of any changes to gender roles or control of resources?</td>
</tr>
<tr>
<td>- Are strategies needed to overcome any adverse reactions? (e.g. women's increased financial independence may negatively affect men's and women's relationships)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are assumptions and information about the characteristics, needs and interests of women and men still valid?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Is there on-going consultation with women and men?</td>
</tr>
<tr>
<td>- Is there on-going collection of data about the needs and interests of women and men?</td>
</tr>
<tr>
<td>- If original design assumptions and information are not valid, is there scope for redesigning elements of the project?</td>
</tr>
<tr>
<td>- Are new strategies, targets, indicators or project resources needed to address any constraints and issues that have arisen during project implementation?</td>
</tr>
<tr>
<td>- Are any changes needed in monitoring strategies?</td>
</tr>
</tbody>
</table>
**Evaluation**

- These questions are to be used as a guide only. It is not expected that every question will be relevant to all activities.
- The questions are designed to assist AusAID Activity Managers with their management and evaluation of development activities.
- The questions are also designed to assist contractors to incorporate gender perspectives into activity evaluation.

### Key Guiding Questions

<table>
<thead>
<tr>
<th>Have the project succeeded in promoting equal opportunities and benefits for men and women?</th>
<th>Have women and men been involved and consulted in collecting data on the gender impact of the project?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do data collection systems explicitly differentiate between the project’s impact on men and women?</td>
<td>Has sex disaggregated data been collected on women's and men's participation?</td>
</tr>
<tr>
<td>Has women's practical needs and strategic interests in the project sector been met?</td>
<td>Have both men and women participated in project activities?</td>
</tr>
<tr>
<td>Have the targets set for women been met?</td>
<td>Have both men and women benefited from project activities?</td>
</tr>
</tbody>
</table>

| Have women and men been disadvantaged or advantaged by the project? | How have economic and social changes produced by the project affected women's and men's roles and relationships? (consider gender division of labour and access and control of resources for each socio-economic group affected or targeted by the project) |

<table>
<thead>
<tr>
<th>Has women's status improved as a result of the project? (e.g., education levels, health status, access to productive resources, employment opportunities, political and legal status)</th>
<th>What practical gender needs and strategic gender interests have been met to advance women's status and decision making power?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are men, counterpart agencies and other social groups accepting any changes to gender roles or control of resources? (have men and women been sensitised to gender issues)</td>
<td>Are strategies needed to overcome any adverse reactions?</td>
</tr>
<tr>
<td>Are positive changes to women's status being sustained and supported after project completion?</td>
<td>Are follow-up activities necessary to promote sustainability?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the counterpart agency have the capacity to implement gender-sensitive projects?</th>
<th>Has this capacity been strengthened during the project?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What has facilitated or constrained this? (lessons learned)</td>
<td>Was adequate gender expertise made available throughout the project?</td>
</tr>
<tr>
<td>Were gender issues adequately addressed in the contract and scope of services?</td>
<td></td>
</tr>
</tbody>
</table>
Has the project been effective in integrating gender into the development activity?

- Were there constraints to integrating women into the development activity, and were these identified during project design and implementation?

- Were strategies and targets identified to ensure that gender issues would be effectively incorporated?

- Were these strategies adequately resourced during project implementation?

- Does the evaluation include recommendations for future activities on how to strengthen women's participation in the project and/or sector? *(Lessons learned)*

- Does the evaluation include recommendations on how to promote equal distribution of benefits in the project and/or sector? *(Lessons learned)*

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**Key documents and tasks**

Ensure that gender perspectives are incorporated into:

- Terms of Reference
- Contract
- Briefing with team members

- Project completion report
- Ex-post evaluation report
- Lessons learned database
Checklist for Women-centred Programme Design

How to Use This Tool

This checklist includes some useful questions for programme planners and implementors to ask themselves prior to programme implementation. It is not designed to be comprehensive and may be added to, modified or sampled, depending on your specific needs. The tool may be used as a discussion resource or as a practical planning tool.

Values, Principles and Philosophy

1. Is there a clear statement reflecting the service model principles, values, and philosophy of both the programme and the sponsor organisation?

2. Do the service model principles include a commitment to responsive and appropriate service delivery to women?

3. Do the service model principles include a commitment to equitable access for women to service planning, resources and information, participation in decision-making and evaluation?

4. Is a statement reflecting the service model principles of the programme clear and accessible to the women for whom the initiative is designed?

5. Are the service model principles in line with the overall goals of the sponsoring organisation? Is the sponsoring organisation committed to women’s participation?

6. Does the statement of principles describe for clients a clear, accessible and supported mechanism for dealing with complaints or grievances arising from their interaction with the programme?

Need

1. Was a needs assessment done amongst women to support the need for this initiative?

2. Who is/are the group/s of women that the programme will most affect?

3. What consultation has been conducted with women from these groups?

4. Do consultation processes take into account the cultural, language, economic, geographic and other diversities of different women within these groups?

5. What consultation has been conducted with other organisations concerned with women’s issues?

6. What are the issues for each level of participation? For example, grassroots women, service providers, other agencies, other stakeholders?

7. In what way is this programme more women-centred than other programmes dealing with similar issues?

Rationale

1. Is there a clear programming rationale for the project (Programme Plan)?

2. Does the Programme Plan include a clear statement of the aim of the project?

3. Does the Programme Plan include clear and manageable objectives for the project?

4. Does the Programme Plan include objectives of the project described in a way that is clear and accessible to all members of the target group?
5. Does the Programme Plan include clear and manageable strategies developed for each of the programme’s objectives?

6. Has a work plan been developed for the management and implementation of these strategies?

**Context**

1. Has the Programme Plan been appraised for a life-cycle (or whole of life) approach and a broad, social health approach so that women's health is contextualised?

2. Is there scope for collaboration with sectors other than health where such cross sectoral co-operation may lead to better health outcomes for women?

3. Does the programme have potential to promote better recognition and response within the general health system to women’s health needs?

4. Is the programme linked to a professional training and development programme for health care professionals so that mainstream services to women are improved?

5. Does the programme seek to involve women actively in their own care and enlarge the options available to them?

6. Does the programme allow for grassroots women to become skilled in order to enable their effective participation in programme delivery?

7. If the activity involves any experimental research about women has it been appraised by an ethics committee?

**Review**

1. Is the programme accountable to women from the community?

2. Has the programme developed indicators (variables which help measure change) based on the programme’s context, principles, objectives and resources?

3. Have women from the community been involved in developing these indicators?

4. Will women from the community be involved in collecting the data that is necessary to prove that the indicators are being met?

5. Will women from the community be involved in assessing:
   - the activities, quality and reach of the services;
   - the ability of the programme to meet its objectives and impact on health co-factors;
   - the extent to which the programme meets its goals and how this has alleviated health needs?

**Resources**

1. Are the resources available to this programme sufficient to support a women's participatory programme model?
Documentation

1. Will experiences of women be documented in a way that is shared, respected, validated and respectful of individual privacy?

2. Is there a planned mechanism for returning information gained from the programme back to the community of women for whom the programme is intended to benefit, for example, through public forums, newsletters, reports in simple language etc?

3. Will other service providers and organisations be able to benefit from documentation of the programme's processes and outcomes as they relate to women?

Source: ARROW Resource Kit Working Group, 1996, ARROW, Kuala Lumpur, Malaysia
Women-centred and Gender-sensitive Programme Management Cycle

How to Use This Tool

This diagram gives an example of the management cycle of a women-centred and gender-sensitive programme including some key aspects. You may want to make transparencies of this tool for group discussions and presentations or modify the components based on your own experience.

Participatory Planning and Decision-Making

Discussion on:
- Are women's needs being met?
- Are women gaining more authority and more control of their life? (empowerment)
- Has there thus been an impact on the roles and identity of women and men (gender roles and identity)?
- Are more women staff and more women clients involved?
- Is there less hierarchy between staff?
- Does the work environment consider gender issues?

Research and Evaluation

- Participatory research - listening to women's voices and experiences
- Qualitative as well as quantitative indicators
- Feedback from women clients
- Assessment of impact of policies and programmes on gender relations and women's position
- Disaggregated data by gender

Training

Includes:
- Broad women's health determinants (e.g., culture, gender)
- Women's rights
- Gender perspectives and gender issues


ARROW - Resource Kit, 1996
10. Does the programme have, as an indicator of effectiveness or success, the extent to which women's relations with men have improved (for example, cessation of violence, more independent and assertive decision-making with the men in her life, more knowledge on legal rights, and so on)?

11. Has the programme identified the gender issues affecting staff and made institutional arrangements to support change (for example, flexible working hours for parents, adequate and fair wage, child care provision, sexual harassment complaint procedures)?

12. Are the occupations and roles of female and male staff without gender stereotyping? If there is gender bias, is this recognised openly (for example, that most of the managers are men and the women are in less influential positions)?

13. Are women represented sufficiently in leadership structures and is there an organisational objective to achieve increased representation?

Checklist to Determine How Gender-Sensitive is a Health Programme

How to Use This Tool

Health programmes vary as to their degree of gender sensitivity. Most programmes are just beginning to be re-oriented. This checklist can be used for both assessing a health programme or the whole organisation. Some questions such as No.4 and No. 5 refer only to programmes offering contraceptive and reproductive health services. These questions, thus, do not require a "YES" to all in order for a programme or organisation to be categorised as gender-sensitive. There may be positive expressions of gender equality in policies and objectives, but these have not yet been operationalised into activities or institutionalised into organisational practices reflecting workplace culture. Programme and organisational change takes a long time.

1. Is it believed by most programme personnel that the social roles of men and women are of equal value (that is, a belief in gender equality)? Is this belief clearly expressed as a programme objective or guideline?

2. Has gender relations and gender inequality been accepted and understood as factors which influence women's health and status, and development in general? Is this expressed in a policy or philosophy statement or as a programme objective?

3. Is there recognition (belief) that men need to take more responsibility in contraception, sexual and reproductive behaviour, child care and domestic work (that is, that a change in gender roles is necessary)? Is this belief expressed as a programme objective and implementation guideline?

4. Is there a programme objective and activities aimed at increasing men's use of contraception?

5. Is health education planned to include discussion and messages on the following gender issues:
   □ the equal value of men and women and the need for joint decision-making and shared responsibilities;

   □ the imbalance of women's responsibility for contraceptive practice (that is, the burden is on women);

   □ the rights of women to good health, quality health services, freedom from violence, joint decisions on childbearing and household expenditure, and so on;

   □ women's legal rights, especially related to health issues?

   □ the actual dynamics of the decision-making of the woman and man in the areas of sexuality, contraception and other reproductive health matters.

6. Are both women and men employed as health service providers?

7. Does an on-going training component exist on gender sensitivity?

8. Do all promotional and educational resources of the programme depict visual images of women and men in non-gender stereotyped roles?

9. Is the programme involved in wider local, national or regional activities aimed at reducing gender inequalities and improving women's status?
COMPONENT 6.1

- Facilitator reads out the questions in the guide and invites clarifying questions.
- Facilitator reminds the groups they will have 60 minutes to complete the exercise. Circulates to ensure they do not spend too much time reading the case, and to ensure they understand the procedure.
- After 30 minutes, announce that they have 30 minutes left; repeat at 15 minutes and 5 minutes.

Text of Handout No. 19:

<table>
<thead>
<tr>
<th>GUIDE TO ANALYZE CASE STUDY</th>
</tr>
</thead>
</table>

I. PROJECT OBJECTIVES
a. What gender roles did the project target in its objectives and to what purpose?
b. What particular health needs of women and men did the project target in its objectives?
c. What development approach predominated in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?
d. In the objectives, did it use a practical gender approach (PGA) or a strategic gender approach (SGA)?

II. IMPLEMENTATION AND IMPACT OF PROJECT

e. What gender roles did the project affect and how?
f. What particular health needs of women and men were affected and how?
g. What development approach actually predominated: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?
h. Did a practical gender approach (PGA) or a strategic gender approach (SGA) predominate in the implementation?
i. What changes occurred during the process of the project’s implementation in terms of access to and control over one or more resources (material/economic, political, information/education, time, internal)? Discuss each target group in turn.
j. Referring to Labonte’s Continuum of Empowerment, give an example of what elements of that continuum could have been incorporated, either in the project design or during its implementation, to respond more equitably and efficiently to the particular health needs of women and men.
Discussion Paper on Approaches to Consultation

B. Our Vision of Consultation

Definition of Consultation

There are many different possible definitions of consultation, many different approaches, and various assumptions which underlie each approach.

This paper addresses official consultation by Status of Women Canada with its constituents, in which the agency formally requests views or participation from groups, either at a meeting or through written input. In addition to this official consultation, there will continue to be informal discussions and exchanges between Status of Women Canada staff and individuals within women's and other organizations. Status of Women Canada staff, in the course of their regular duties, will also sometimes ask individuals or organizations for specific information or input.

For Status of Women Canada, a definition of official consultation includes the following:

a) Consultation takes place before a decision is made, and before Status of Women Canada proceeds to further action on the issue.

b) Consultation is a two-way communication process, in which all parties listen and contribute views, information, and ideas. Status of Women Canada will communicate back to participants about what happened with their views, and constituents may also choose to share their own follow-up to the discussions.

c) Consultation leads to action. It is an opportunity for genuine and respectful listening, in which Status of Women Canada is committed to acting on the views heard. This does not necessarily mean that every suggestion made in a consultation is implemented, but that input will always be taken into account.

d) Consultation is part of the ongoing relationship between Status of Women Canada and its constituents, in which mutual trust and understanding is built up over time, through a continuing process of discussions, decisions, and follow-through.

With whom would Status of Women Canada consult?
Status of Women Canada believes that the key players in advancing women's equality are women's and other equality-seeking organizations and governments at all levels. At the same time, the agency believes that achieving women's equality involves all sectors of society, such as educational institutions, private business, the justice system, the labour movement, the media and religious groups, as well as individual women and men.

Most consultation relationships will be with women's organizations, and other equality-seeking organizations and individuals working actively to advance women's equality. Status of Women Canada will also exchange views with other sectors to advance women's equality in all spheres of Canadian life.

Status of Women Canada recognizes that women are not a homogeneous group, and that they face many different realities as a result of age, race, class, national and ethnic origin, sexual orientation, mental and physical ability, region, language and religion. Equality can only be achieved by acknowledging and respecting this diversity, and consultations by Status of Women Canada will seek a diverse participation of women.

Purpose of Consultation

There are four main purposes for which Status of Women Canada will initiate consultations with its constituents:

a) to seek input on policies, programs, legislation and the future directions of Status of Women Canada, before these are determined;

b) to explore new ideas and emerging issues, to help define issues and questions, or to understand how an issue is affecting women's lives;

c) to develop strategies on questions or issues of mutual concern to Status of Women Canada and constituents;

d) to evaluate programs, policy or functions of Status of Women Canada.

An additional purpose underlying all of these is to work towards a mutually beneficial relationship with the organizations and individuals who share a commitment to women's equality.

Guiding Principles

Each time consultation is undertaken, the approaches will be tailored to the purpose and desired outcomes, the constituents involved, and the available time and resources. However, certain guiding principles will be followed in all Status of Women Canada consultations.

Transparency

1. Objectives of the consultation will be communicated at the outset.
2. Consultations parameters will be clearly identified before consultation begins.
3. The steps in the consultation process, and where the consultation fits in the overall decision-making on the issue(s) involved, will be explained to participants at the outset.

Accountability

4. Status of Women Canada will communicate back to participants about what was heard and how it was used. This may include a summary of the advice received, and an indication of how it will be fed
into the decision-making process. In cases where the final decision can be publicly released, participants will also be informed of the final outcome.
5. Participants will be asked to evaluate each consultation exercise, after its conclusion.

**Mutual Respect**

6. Consultations will be conducted in a climate of mutual respect.
7. The consultation method used will be adapted to the intended participants, the purpose of consultation, and the available resources.
8. Consultation will not always lead to consensus, but should lead to a better understanding of participants' positions.
9. The consultation methods used will respect the differing roles of Status of Women Canada and constituents, and the operating constraints of each.

**Diversity and Accessibility**

10. Diverse groups and individuals will be consulted.
11. Status of Women Canada will remove as many barriers to participation in consultations as possible. This will include using plain language, and may include using alternative formats and media, providing financial support where needed (e.g. transportation, childcare), making information available in languages beyond French and English, simultaneous interpretation, choosing locations that are accessible and appropriate to the participants, and other measures.

**Commitment**

12. Status of Women Canada is committed to consultation with constituents as an integral part of the agency's work.
13. Status of Women Canada will maintain an ongoing relationship with constituents, through regular communication, consultation and feedback.

**Constraints**

*Cost:* Every form of consultation incurs costs (time, money or both) for Status of Women Canada and for the participants. In choosing the appropriate method of consultation, costs will be weighted against the intended purpose and outcome. Status of Women Canada will consider the cost to participants of participating in the consultation process.

*Time:* Status of Women Canada frequently operates within tight timelines in preparing policy advice or making operational decisions. Participants need time to adequately consider the issues, consult with their own membership and networks, and prepare a response. There is often a trade-off between the time available before a decision is made, and the time needed by participants to provide the best input.

*Knowledge and Information:* Unequal access to information, or inaccurate assumptions about the knowledge base of participants can seriously limit the effectiveness of a consultation. In an effort to equalize this access, Status of Women Canada will provide common background information to all participants.

**Annual Consultation Plan**

Status of Women Canada intends to produce and circulate to constituents an annual consultation plan, setting out the major consultations anticipated over the next year. We will attempt to be responsive to emerging and identified needs while balancing the time and resources available for consultation. The annual plan will alert constituents to opportunities to make their views known on
certain issues.
Discussion Paper on Approaches to Consultation

C. Consultation Methods

The number of possible consultation methods and formats is almost infinite, from face-to-face meetings, to written input, to electronic means. For each situation, a different format would tend to be more appropriate, depending on the purpose of the consultation, the participants, the time available, and various other factors.

We have combined the vast range of possible consultation formats into the five basic methods that we think are most applicable for our work. Each of these can be adapted in different ways, to create numerous variations and versions.

The five basic consultation methods are briefly described below, along with the major advantages and disadvantages of each, conditions under which it works best, and when this method should be used. (Note: in this section, the abbreviation SWC refers to Status of Women Canada)

1. Large scale face-to-face consultations

Description:

- Anywhere from about 25 people up to about two hundred people meet face-to-face in one location.
- Often a conference format: can include private deliberations, plenaries and small group discussions, using a combination of presentations, question-and-answer sessions, discussion, report back.
- Many other possible formats, depending on the purpose and participants (e.g. video conferences can be used to link groups of people in different communities across Canada)
- National or regional in scope.

Advantages: 

- moderately large number of groups and individuals can provide input
- provides for interaction/discussion with SWC and among participants, which allows ideas to evolve more quickly

Disadvantages:

- tends to be very expensive
- question of who is invited is often quite sensitive
- who is invited shapes the outcome
- long lead time is required for SWC, and, if
very transparent: everyone sees and hears the input

substantive input is expected, for participants

high risk, in that specific issues or groups can overtake the agenda
discussion can very easily remain at a superficial level

Works best when:

the agenda meets the needs of both SWC and participants, and participants get some immediate benefit from being involved

there is excellent process design and facilitation: the dynamics of such sessions can easily get off-track, or become divisive

there is good background information and preparation, so that the discussion can get to the "real issues"

there is an effective mix of participants: a diversity of opinions and backgrounds, but common objectives

When to use it:

For all types of consultation purposes, however, it tends to be more effective for addressing broad issues and questions, rather than more specialized and technical ones.

When a broad range of input is important.

2. Small group consultations

Description:

Anywhere from 3 to about 25 people meet face-to-face.

Variations can include: one-time session, an ad hoc working group, round table, teleconferences, video conferences, etc. Teleconferences are a possibility for very small groups, but present a number of impediments (e.g. translation), and may be best for working groups or information-sharing.

Tends to be focused on a specific issue, sector or region.

National or regional in scope.

Advantages: Disadvantages:

excellent interaction among participants, and with SWC, enables in-depth discussion of an issue

restricted participation does not permit a broad cross-section of input

can involve specific participants with specific expertise

selection of participants is sometimes sensitive, or difficult, given the limited number of potential invitees

minimal lead time is needed, both for SWC (logistics are relatively simple) and for participants (they are already expert in the area)

may be tendency to involve "the same people as always" or "experts", which tends to exclude new points of view

Works best when:
• there is a clear, specific purpose requiring particular expertise or background
• participants have approximately equal levels of expertise
• participants bring a range of opinions and backgrounds
• there is good background information and preparation, so that the group can get to work quickly
• there is good chairing/facilitation
• combined with another method (e.g. circulating a brief questionnaire to a larger number of groups or conducting a quick telephone survey) to validate the results.

When to use it:

• For all types of consultation purposes
• When broad-based input is less important
• When the issue is urgent, and time is limited
• When the expertise needed is available within a limited group of participants

3. Discussion paper with written input

Description:

• SWC prepares a background paper, which is circulated widely to a large number of groups and individuals.
• Interested participants respond in writing: letters, briefs, or, if SWC provides a questionnaire format, a completed response form.
• In some cases (e.g. evaluation of SWC program or service), it is helpful to ensure confidentiality of responses to encourage frank views from participants.
• This is usually used for input at a national level.

Advantages: Disadvantages:

allows in-depth consideration of an issue by participants • requires considerable lead time, both by SWC (to prepare the document and await responses) and by participants (to prepare responses)

(wide participation is possible) enabling a broad range of views • not interactive, either with SWC or among participants, which does not permit clarification of, or building on, the points raised

participants are largely self-selected, rather than invited by SWC • tends to duplicate effort among participants: many different groups prepare substantially similar input

inexpensive • accessibility can be severely limited by language (e.g. is it in plain writing? available in languages beyond French and English?). The written format excludes cultures not based on the written word

easy to compile responses, if questionnaire format is used • overly complex questions can intimidate the participants, or lead to distorted answers

Works best when:
• the background paper is simple, accessible and brief
• written material respects intended audience (language, content, format, etc.)
• a short questionnaire or key questions to answer are provided and participants have at least two
  months to respond supplemented with other methods

When to use it:

• when there is considerable lead time available
• when limited funds are available
• when wide input or participation is desirable
• when questions are well defined

4. Brief questionnaire

Description:

• SWC prepares a very short update on a specific matter (e.g. 1 or 2 pages), plus a brief
  questionnaire to solicit input on the issue.
• A questionnaire is circulated widely to a large number of groups and individuals. Interested
  participants complete the questionnaire.
• This is usually used for input at a national level.

Advantages:          Disadvantages:

• quick response time
• very focused: does not require as much
  effort by participants
• wide participation possible
• participants self-select instead of being
  invited by SWC
• inexpensive
• can be repeated every 2 or 3 years, to see
  trends in views of groups
• not interactive, which makes it difficult to
  clarify the responses, or build on them
• tends not to solicit in-depth responses
• very dependent on the quality of the
  questionnaire and background information
  which will influence results

Works best when:

• the issue is current or of wide concern the topic is focused and specific
• the background information and accompanying questionnaire are clear and simple

When to use it:

• When the issue is specific
• When the issue can be accurately described briefly, and meaningful input can be received with
  a few questions
• When a broad range of input is needed
• When time is short

5. Internet Discussions
Description:

- SWC sets up a discussion on a specific question or issue.
- SWC outlines background information on the topic and asks some key questions.
- Any interested group or individual with access to the Internet can contribute their thoughts and ideas.
- This is usually used for input at a national level, in the sense that anyone across Canada (and internationally) can have access to it.

Advantages:

- wide participation possible, within the limits of access to the Internet
- participants self-select, rather than being chosen by SWC
- interactive: participants can exchange with each other, and SWC can probe further if a response is unclear or particularly interesting
- rapid response time
- inexpensive, for both SWC and participants
- easy to update and add information; participants can also refer others to information sources on the Internet

Disadvantages:

- participation is limited to those with access to the Internet (equipment, connecting lines, skills to use it, subscription to Internet, etc.) and who are aware of the discussion site
- responses may tend to be more informal and brief, rather than in-depth and more considered
- may include responses from participants not normally part of SWC's constituency (perhaps this is also an advantage?)
- accessibility also limited by language (plain language, availability in French, English and other languages, etc.)
- anonymity of responses limits accountability and transparency of participation
- requires promotion of the site

Works best when:

- the background information and questions are clear and simple
- there is sufficient time for some interaction and evolution of the discussion, for ideas to build (minimum two weeks)
- discussion site has been widely promoted

When to use it:

- when exploring new ideas
- when there is a specific question or issue
- when informal responses are appropriate
- as a supplement to other more tested and more accessible methods
- for working groups or working sessions rather than broad-based consultations
Participatory processes do not automatically recognise inequalities and differences between women and men

Experience shows that participatory processes and ‘attempts to involve poor people’ do not automatically include women. Attention to gender differences and inequalities is required if participatory development initiatives are to involve women as well as men. Specific issues include:

**Power imbalances in communities:** Communities are not harmonious groups with a common set of interests and priorities. There are often strong divisions along the lines of age, religion, class, and gender. These power differentials make it difficult for some people to voice opinions that contradict general views. Power differentials may even affect who participates in specific meetings. Outside officials may only invite ‘community leaders’ (generally men) to participate in consultations.

**Intra-household and intra-family relations:** Some women may find it difficult to speak out in front of their husbands or fathers. They may also believe that discussions relating to family matters (even issues relating to workloads) are not for public forums.

**Different constraints to participation:** Men and women have different responsibilities and workloads, with women often having less time to devote to new activities. Attending specific meetings may raise problems for women if they are set for times of the day when women tend to be occupied. Women’s responsibilities for childcare may also make it difficult for women to participate.

**Different abilities to participate:** Given gender biases in education, women and men often have varying literacy levels. Men may also have more experience putting their arguments forward to outsiders and more confidence dealing with new people.

**Perceived benefits of participation:** Women and men may make different calculations about the costs and benefits of their involvement in participatory processes. Given the already high demands on most women’s time, they may not see the extra effort required to participate as worthwhile, especially if the benefits are questionable.

Gender-sensitive participatory practices challenge development cooperation organisations

Participatory methods are only as good as the people who use them. It is now clear that there is more to participation than a series of exercises. When they are done well, gender-sensitive participatory processes challenge organisations in many ways.

**Skills:** Organisations need to develop the skills to do this type of work. Facilitating gender-sensitive participatory processes requires experience, skills and the ability to deal with conflict, if it arises.

**Time:** Participatory processes can take a long time and may require support over years.

**Flexibility and adaptability:** The selection and sequencing of methods should be based on the specific circumstances. Responding adequately to specific contexts requires flexibility.

**Support:** Participants (women and men) require support as they explore new issues. It is extremely irresponsible for an outside organisation to encourage people to raise issues of gender inequalities and then not support the consequences.

**Follow-up:** Can the organization respond to the issues raised? If development cooperation organisations are serious about participatory processes, they must be prepared to act on the priorities identified and issues that emerge.

Meeting the challenge of equitable participatory development means integrating gender awareness into practice, and not pursuing two approaches with two sets of principles and two series of methods. This much is clear: participation, a loose term to describe a wide variety of practices that aim for more inclusive development, does not automatically include those who were previously left out of such processes. It is only as inclusive as those who are driving the process choose it to be, or as those involved demand it to be...

For those who might be tempted to say, ‘Why should we also be looking at gender? We’re already following a participatory approach!’ we hope they will reconsider.

Participatory Methods Used to Introduce Gender Equality Issues

Beginning in 1992, GTZ assisted the Zambian Ministry of Agriculture, Food and Fisheries to incorporate a participatory approach into their extension service. Extension officers used participatory methods to assess farmers’ priorities, which led them towards a multi-sectoral approach to development. They used seasonal calendars to plan extension activities at times convenient to farmers. They began to involve farmers in monitoring and evaluating the outcome of extension efforts.

However an evaluation revealed that women were not benefiting from the improved participatory approach to extension. The staff began to make concerted efforts to address the problem of women and involve them in the process. As awareness grew, two/three day workshops helped couples to analyse gender relations in their households.

The case study raises several key points:

- Gender is not always the sensitive topic some claim it to be. With the right methods, attitudes and approaches, it is welcomed by local people and staff members.
- Gender is not a foreign, theoretical concept, and it can be addressed by women and men.
- Gender should be inherent in participatory approaches, but is not automatically addressed without specific efforts.


Participatory Methods Illustrate Different Perceptions of Well-Being

The use of gender-sensitive participatory methods in Darco, Ghana, identified differences between women and men in their understanding of poverty. These methods documented people’s own perceptions of intra-household relations and provided a far better understanding of the situation and changes underway than would have been possible through data collection on externally-selected indicators.

Men and women prepared separate social maps of the village and carried out wealth and well-being rankings. Differences in the two discussions were analysed:

- Men’s criteria of wealth centred around assets like a house, car and type of farm. They considered crops grown by men and not women’s crops. Initially they left those with no assets out of the ranking altogether. They then moved on from wealth to a discussion of well-being, using ‘god-fearing’ as the main criterion.
- Women started with indicators like a house, land and cattle but moved to analyse the basis of agricultural production. Again they considered only ‘female’ crops and did not mention cocoa or other crops grown by men. Contrary to common perceptions, women focused on marketed crops not on subsistence food crops.
- Women’s criteria for the ‘poorest’ were related to a state of destitution, and the lack of individual entitlements or health-related deprivation. Men focused on the absence of assets.
- Each group had its own perspective of well being. Women tended to identify factors for women, while men focused on men. Neither group looked at the household as a unit for analysing welfare.
- For both women and men, being wealthy did not always mean being better off. In the men’s analysis none of the rich were ‘god-fearing’ and two houses with no assets had ‘god-fearing’ people. As for the women, the biggest vegetable producers (seen as an indicator of being well off) were not in the richer categories.


Tools and supportive methodologies

**GENDER-SENSITIVE PARTICIPATORY RAPID APPRAISAL (PRA):** PRA methods form the basis of many other participatory ‘tool kits’. One definition of PRA is “a family of approaches, methods and behaviours that enable people to express and analyse the realities of their lives and conditions, to plan themselves what action to take, and to monitor and evaluate the results.” See: PRA: The Power of Participation. IDS Policy Briefing 7, August 1997. (http://www.ids.susx.ac.uk/ids/publications/brief7.html). PRA methods include mapping, seasonal calendars, flow diagrams, and matrices or grids, scored with seeds or other counters to compare things.

Numerous practitioners have warned that PRA methods can be gender blind. Specific efforts are needed to ensure that they take gender differences and inequalities into account. See


Specific methodologies are under development by various organisations. For example, the Food and Agriculture Organisation is promoting the use of SEAGA (Socio-Economic and Gender Analysis). For handbooks, reports of applications and background information, see http://www.fao.org/sd/seaga.

Prepared for Sida by B. Wormuth and J. Schalk, November 1999

Sida Equality Project # 10: Participatory Processes and Equality Between Women and Men

Making Address: 105 25 Stockholm, Sweden
Visiting Address: Sveavegatan 20, Stockholm
www.sida.se
B: Guidelines for Action

Inputs

- When interpreting government policy direction documents, Strategic Result Areas, the Treaty of Waitangi and any other relevant inputs, consider how these can be applied so they further the Government's Outcomes for Women.
- Ensure the objective is not contrary to the Government's Outcomes for Women.

Data and research

- Collect and analyse quantitative data by gender and ethnicity as a minimum base from which to predict outcomes.
- When using sample methods, ensure that the sample is large enough for the data to be disaggregated by gender, ethnicity and the other key policy variables for the question in hand (employment status, income etc.).
- Use qualitative or evaluative research or information gathered by both government and non-government agencies to assist in interpretation of quantitative data, for example, case studies of users of government services.
- Consider how information is gathered and what it was gathered for, in determining its usefulness and credibility. For example, were women included in focus groups, did the organisation gathering the information ask relevant gender questions?

Consultation

- Begin consultation with women at the outset of the policy process to enable accurate scoping of the issue.
- Consider whether groups or individual women should be consulted, the time of day, appropriateness of venue, in particular whether it can be accessed by women with disabilities, how the meeting is to be run, the use of appropriate language, a signer (for those who are deaf or hearing impaired) and the provision of accessible and affordable childcare.
- Consult with different groups of women to reflect the different issues affecting women.
- Allow adequate time for women and especially Maori women to consult amongst themselves as part of the process of forming a view.
- Seek the advice and assistance of the Ministry of Women's
Affairs on key gender-specific issues concerning social and economic policy development.

**Community feedback**

- Ensure that women's views are heard so that any differentials in the gender impacts of the policy initiative are able to be analysed.

**Policy Process**

**Stage One: Define Desired Outcomes**

- Include specific gender equity objectives based on the *Outcomes for Women*.

**Stage Two: Identify Problems and Issues**

- Consider the numbers in the population groups affected and the reasons for the underlying causes of high or low participation or uptake by women.
- Consider in what ways women have different needs, experiences, issues and priorities in relation to the particular policy issue.
- Consider whether there is an opportunity to improve women's status.
- Frame the question or problem to accommodate the information gathered and to ensure the issues for women will be considered in the process.

**Stage Three: Develop Options**

- Consider the impact on and the effectiveness of each option in relation to the *Outcomes for Women* and for women in the population groups affected.
- Build in strategies which reduce, or preferably remove, negative impacts on women.
- Introduce separate initiatives if needed, to reflect the different experiences and needs of women and men.
- If separate initiatives are not necessary, ensure consideration is given to which mainstream initiatives are relevant to the needs of women identified in Stage Two.

**Stage Four: Analyse Options and Make Recommendations**
• Consider how each option would impact on and be influenced and supported by women in the population groups.
• Consider the opportunity costs of implementing each option; will the social and economic benefits to women of implementing the option outweigh the costs to Government?
• Give particular consideration to its impact on Maori women and the Government's obligations under the Treaty of Waitangi.
• Also consider whether the Government has international obligations in relation to women which would be breached by, or could be furthered by, the option.
• Ensure recommendations reflect the information gathered and the analysis carried out in relation to gender.

Stage Five: Implement Decisions

• Ensure the policy objectives relating to women are understood and are carried over into implementation.
• Consider how to ensure the service or programme is appropriate and accessible to different groups of women.
• Consider whether separate implementation strategies are necessary for the policy to be effective for women and men.
• Consider how women will be advised of the new or changed policy or service.

Stage Six: Monitor and Evaluate

• Monitor the performance targets of a service or policy by gender and ethnicity.
• For government agencies, include an evaluation of net social benefits. For example, as well as assessing the cost of a programme aimed at women, it is useful to measure any resultant increase in women's health or employment which has lead to increased earning ability, reduction in benefit dependency and an increase to the Government's tax take.
• For private sector companies, include women in market research, such as in surveys, focus groups, product sampling and programme assessments.
• If the monitoring and evaluation show that the policy or service is not contributing to the Outcomes for Women, modify it so that it does.

Accountability

• Include gender analysis objectives in performance agreements for managers, policy analysts, service and product designers.
• For government agencies, include gender equity objectives in purchase agreements, and Key Result Areas in chief executives'
performance agreements. Such objectives and measures could include:
  - the development of specific programmes targeted at women;
  - percentage targets for uptake by different groups of women;
  - a quality assurance indicator to ensure that the gender impact is taken into account in all policy advice.
- For non-governmental organisations with constitutions, include gender analysis objectives in constitutions to ensure activities meet the needs of women members.
A Gender Agenda: Planning for an Inclusive and Diverse Community

Cardiovascular Disease and Gender Issues: Research Paper

Cardiovascular disease (CVD) refers to all conditions and diseases involving the heart and blood vessels. The major cardiovascular diseases include: coronary heart disease, stroke, heart attacks, rheumatic fevers and rheumatic heart disease.

In Australia CVD kills more people than any other disease. It also creates a heavy burden in terms of disability due to stroke and contributes to increased costs for the health system. It is a key national health priority. Ischaemic heart disease is the top cause of mortality burden in Years of Life Lost (YLLs) for both men (37,031) and women (28,417) in Victoria. Stroke ranks third for men (10,430 YLL) and second for women (13,684 YLL) (DHS, 1999: 21).

While heart disease has been recognised as a major problem for men, awareness among both doctors and women that heart disease is a major killer of women was somewhat delayed. Gender issues in relation to preventative behaviour, diagnosis and recovery following cardiovascular illness require further attention.

Biological sex differences

A number of biological sex differences relating to CVD have been identified (Waldron, 2000; Society for Women's Health Research; Komesaroff 2001):

- the onset of CVD-related health problems tends to occur 10 years later in women than men and is believed to be related to changes in women's hormone profiles after menopause.
- oestrogen appears to have protective effects such as reduced low density lipoprotein (LDL) cholesterol levels and direct protective effects in coronary artery walls,
- testosterone may have harmful effects including reduced high density lipoprotein (HDL) cholesterol levels
- men's greater propensity to accumulate fat in the upper abdomen increases their risk of ischaemic heart disease
- desirable levels for cholesterol have been based primarily on studies in men, newer information shows sex differences and indicate that HDL levels in women must be higher than in men to protect against CVD.
- Type II diabetes is a greater risk factor for CVD in women than in men (thought to be because diabetes interferes with the actions of oestrogens)
- smoking lowers the age of first heart attack and raises the relative risk of heart attack more for women than for men.

Some risk factors are unique to women and they include: use of oral contraceptives and experience of menopause. Smoking in combination with the use of oral contraceptives multiples the risk for women of heart attack and stroke by a factor of 10.

CVD Death Rates

Death rates associated with coronary heart disease peaked in 1968 and have since fallen by over 60 per cent among both men and women. This is significant compared with declines of around 20 per cent in deaths from non-cardiovascular diseases.
The evidence suggests that the decline in death rates for coronary heart disease and stroke have been influenced by changes in some risk factors and in clinical interventions such as lifestyle advice and counselling, drug use, emergency care, medical and surgical treatment, rehabilitation and follow-up care (Australian Institute of Health and Welfare, 2001).

The following table presents the statistics on death due to CVD in Australia:

### NUMBER OF DEATHS DUE TO CVD IN AUSTRALIA, ALL AGES 1998#

<table>
<thead>
<tr>
<th>Disease</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>15024</td>
<td>12801</td>
</tr>
<tr>
<td>Stroke</td>
<td>4812</td>
<td>7170</td>
</tr>
<tr>
<td>Other cardiovascular diseases</td>
<td>2061</td>
<td>2358</td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td>1171</td>
<td>916</td>
</tr>
<tr>
<td>Heart failure</td>
<td>988</td>
<td>1567</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>410</td>
<td>730</td>
</tr>
<tr>
<td>Rheumatic fever and rheumatic heart disease</td>
<td>87</td>
<td>171</td>
</tr>
<tr>
<td><strong>All cardiovascular disease</strong></td>
<td><strong>24,746</strong></td>
<td><strong>26051</strong></td>
</tr>
<tr>
<td><strong>All causes of death</strong></td>
<td><strong>67,073</strong></td>
<td><strong>60129</strong></td>
</tr>
</tbody>
</table>

(AIHW, 2001)

### Risk Factors and Trends

A large part of the death, disability and illness caused by CVD is preventable. Risk factors are: tobacco smoking, being physically inactive, eating a diet high in saturated fats and being overweight. Levels of blood pressure and blood cholesterol higher than recommended also increase the risk of CVD. Any one of the factors increases the risk of CVD on its own; if two or more occur, the risk increases even further. Risk factors are strongly influenced by wider social and economic factors. Women and men in certain population groups have significantly higher mortality from CVD, particularly indigenous Australians and people of lower socioeconomic status. Aboriginal and Torres Strait Islander peoples die from CVD at twice the rate of other Australians.

Changes in CVD rates have been related to changes in lifestyle. However the proportion of Australians undertaking sufficient physical exercise to provide a health benefit has fallen, and the proportion of Australians who are overweight and obese has risen. Blood cholesterol levels have remained relatively constant since the 1980s.

The following table shows the number of Australians with a risk factor for CVD, from 1998 to 1999-2000:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco smoking</td>
<td>2,084,815</td>
<td>1,707,414</td>
</tr>
<tr>
<td>Insufficient physical activity for health</td>
<td>2,696,216</td>
<td>3,071,187</td>
</tr>
<tr>
<td>Overweight</td>
<td>4,121,918</td>
<td>3,329,329</td>
</tr>
<tr>
<td>High blood cholesterol</td>
<td>3,093,623</td>
<td>3,233,119</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>1,882,965</td>
<td>1,763,508</td>
</tr>
<tr>
<td>Diabetes</td>
<td>476,499</td>
<td>433,962</td>
</tr>
</tbody>
</table>

(AIHW, 2001)
Stress has also been established as an important risk factor for heart disease. Some studies have examined the contribution of female hormones to stress responses (Komesaroff, 2001: 15). A study on the effectiveness of two multibehavioural interventions over six months found that stress management, combined with nutrition, and exercise, was effective in decreasing CVD risk factors among older men (McCrone, Brendle and Barton). However it appears that little attention has been given to women and CVD in relation to sources of stress from both paid and unpaid work.

Gender relations and the differing roles, responsibilities and resources, including social support, that women and men may have to exercise lifestyle changes to reduce CV risk have rarely been examined. Smoking, diet and exercise are influenced by gender and other social factors.

In many households women still have the main responsibility for family food preparation. Calvert found that women will not change their family diets if their own diet has to change, but the diet of the whole family tends to change if the husband's diet needs to change (Calvert cited in Johnstone, Brown and Beaumont, 2001: 4). Commercial advertising and some health promotion campaigns have targeted women specifically as being responsible for family diet and health.

Women's participation in sport and physical activity is affected not only by social expectations, but also by gendered roles and responsibilities, particularly in relation to child care, household work and care giving. The clustering of these responsibilities together with greater workforce and community volunteer participation by women may compound difficulties for women in undertaking sufficient physical activity.

A persistent sex difference in exercise begins to emerge in adolescence, with many adult men exposed to the beneficial health effects of exercise. In 1999, 60 per cent of men compared to 54 per cent of women participated at sufficient levels of physical activity for health benefits (AIHW, 2001). However overweight and obesity are more prevalent among men than women (Broom, 1999: 44).

**Gender Differences in Diagnosis and Treatment**

Gender differences in diagnosis and treatment of CVD have been identified. Explanations for the differences have been related to the absence until relatively recently of women in clinical trials, leading to ‘the male model’ of ischaemic heart disease being the standard. A lack of knowledge about CVD processes and risk factors in women has led to underdiagnosis of ischaemic heart disease in women. Another consequence identified is that gender stereotypes can have more influence on clinical decision-making, with doctors attributing women's health problems to emotional rather than physical causes, or to menopause (Gijsbers van Wijk et al, 1996: 712).

Women's symptoms of CVD may be very different to men's. In women, chest pain (angina) is the predominant initial and subsequent symptom of CVD, whereas in men heart attack and sudden death are often the first symptoms. Women are more likely to have subtle symptoms of heart attack such as indigestion, abdominal or mid-back pain, nausea and vomiting. Women may detect cardiac symptoms and seek medical help earlier than men, when their symptoms may not be pronounced. In the United States it has been noted that women delay longer before seeking help for symptoms of acute heart attacks. Few studies have analysed the gender difference in making a decision to seek treatment (Rosenfield, 2000).
Research conducted in the early 1990s in the US, UK and Australia suggests that cardiovascular symptoms are liable to be investigated less thoroughly and treated less aggressively in women than in men. Sometimes the difference may reflect excessive intervention in men, sometimes women may miss out on potentially beneficial therapies (Broom, 1995). American studies found differences in the use of diagnostic and therapeutic procedures among women and men, even when controlling for confounding variables such as age, severity of the disease, risk factors, and when women and men with the same diagnostic outcome are compared (Gijsbers van Wijk, 1996: 712).

The delay in diagnosis and treatment for women can have serious physical and psychosocial consequences including more extensive physical damage, a less favourable outcome and greater disability. There is evidence that women who suffer a heart attack have a higher risk than men of death during the attack, of operative death during bypass surgery, and of death, cardiac distress and re-infarction in the post-heart attack year (Gijsbers van Wijk, et al, 1996).

There may also be differences in the ways that women and men present their symptoms to doctors. One study found that the patient's presentation style alters the physician's diagnosis approach, with doctors suspecting a cardiac cause four times more often in a female patient with a 'businesslike' presentation (Gijsbers van Wijk, et al, 1996: 712).

Women heart attack victims under the age of 50 have higher rates of death during hospitalisation compared to men of the same age. The younger the patient, the greater the risk of death after a heart attack among women relative to men. Some researchers believe that women's high mortality after heart attack is accounted for by preexisting risk factors. However the sex discrepancy is not fully explained by differences in the average ages at which women and men become ill.

**Recovery from Illness**

The prevalence of depression after a heart attack is high, with almost 50 per cent of patients having major or minor depression. A strong relationship has been noted between depression and post heart attack mortality. Individuals who are depressed at time of hospitalisation for a heart attack have a three to four times greater mortality risk within the first four to six months (Zielgelstein, 2001).

Given women's predominance in diagnoses of depression, the relationship between depression and CVD is an important one, if one that has been somewhat ignored in research. Musselman, Evans and Nemeroff (1998) examined all research studies on the link between CVD and depression over a 30 year period to 1997. Most of these studies concerned men. They recommended that 'future studies should focus on women to assess gender-specific psychosocial and physiologic measures. Despite the fact that women are more vulnerable to depression and that CVD is the leading cause of death among adult women in the United States, relatively little research has focused on the etiology and pathogenic mechanisms of major depression among women with CVD' (cited in WHO, 2000: 54).

It has been reported that after heart attack women are more anxious and depressed than men, have more sexual dysfunction and work disability and a poorer adherence to cardiac rehabilitation programs (Gijsbers van Wijk, et al, 1996: 712). Individual personality types, including optimism, high self-efficacy and a sense of personal control have been linked to more rapid physical recovery and return to daily routines, better adherence to lifestyle recommendations and greater life satisfaction in cardiac patients. Psychological factors play an important role in determining cardiac patients adjustment to and recovery from cardiovascular illnesses, and have been noted to be
better predictors of functional and psycho social recovery than medical indices such as illness severity (Kaoukis, 2001). Social supports encourage efforts and lifestyle changes (Kaoukis, 2001), and no doubt also assist in psychosocial adjustments. It appears that little attention has been given to the impact of gender and other social expectations on physical recovery and life satisfaction following CV illness. Given women and men's different roles and responsibilities in paid work and in the home, and as carers for others, it is possible that the impacts of CV illness may be experienced differently by women and men. There may also be gender differences in family and social support, and the significance to women and men of being unable to continue with particular gendered work and responsibilities following CV illness. Given the high rate of depression following CV illness, it is significant that when psychological interventions are added to standard cardiac rehabilitation or care programs, patients' mortality and morbidity rates decrease (Kaoukis, 2001).

Many women may face challenges of reorganising their health behaviours in a social context that does not facilitate optimal recovery. Angus (1996) noted that the nature of women's responsibilities and activities makes it difficult for them to satisfy basic health needs, in terms of family responsibilities and as primary care givers. There may be differences in social support, access to transport and availability of funds or insurance coverage for rehabilitation programs among women and men.

It has also been suggested that cardiac rehabilitation programs may not be responsive to the needs and goals of women. Personnel sensitive to emotional needs, monitoring women closely during exercise, providing opportunities for social interaction with other women, and having classes that are convenient and suit women's schedules have been identified as affecting women's participation in cardiac rehabilitation programs (Makrides, 1999).
References:

Angus (1996)


A Gender Agenda: Planning for an Inclusive and Diverse Community

Depression and Gender Issues: Research Paper

Mental Health

The World Health Organisation defined mental health as: 'the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality' (WHO 2000a: 12).

The determinants of mental health and illness operate at three levels of functioning, which include individual, group and the environment.

Three key social determinants of mental health are
- social connectedness
- freedom from discrimination and violence
- economic participation (VicHealth).

A Global Perspective on Gender and Depression

The Global Burden of Disease Study estimated that depression will become the second most important cause of disease burden in the world by 2020 (WHO, 2000a: 5). Given this prevalence, mental health is a significant global public health issue.

Studies in a range of countries have found that women predominate over men in lifetime rates of major depression. This difference has been documented in clinical and community samples, across racial groups and even after statistically controlling for the effects of other variables which are strongly related to depression such as income level, education and occupation (Astbury, 1999: 10).

What is depression?

Depression is commonly used to describe feelings of ongoing low mood, unhappiness or distress. 'Depression is not one mental illness - the term describes a group of illnesses which all have the characteristic of excessive and long term mood disturbance, often accompanied by feelings of anxiety' (Evans, Burrows and Norman, 2000: 5).

Depression is:
- the most prevalent mental health problem among women
- likely to be accompanied by other psychological disorders which are more common in women such as anxiety disorders. Depression and anxiety are the most common comorbid disorders and a significant gender difference exists in the rate of comorbidity.

Wide variations between countries in rates of depression amongst women and men have been reported. This suggests the importance of cultural factors and social arrangements in the onset of depressive symptoms (Astbury, 1999). Gender relations and possible gender based inequalities must be explicitly considered when analysing cultural factors and social arrangements related to depression.
Depression in Australia

As in other countries more women than men in Australia experience depression. One in four women and one in six men in Australia will experience depression at some stage in their life (VicHealth, 1999).

Prevalence across the Lifespan
Prevalence of depression varies across the lifespan, although different studies identify some variances. Statistics are often not sex disaggregated, which makes it difficult to identify differences in prevalence or patterns, as indicated by the following:

- depression and anxiety symptoms occur in around 4-6 per cent of children and are likely to persist with age if not treated.
- the first onset of depressive disorder often occurs in mid-to-late adolescence and this is the lifestage of peak incidence. 5 per cent of young people suffer from depressive disorders.
- 10-15 per cent of women suffer a major depressive episode shortly after childbirth.
- Depressive disorder may occur for the first time in later life. (Commonwealth Department of Health and Australian Institute of Health and Welfare, 1999a: 4)

Depression and Suicide
Suicide is a leading cause of death in Australia. It was the fourth highest cause of mortality burden in Years of Life Lost (YLL) for men and 10th for women in Victoria in 1966 (Department of Human Services, 1999: 21). Mental disorders, specifically depression, have been identified as the largest single group of risk factors for suicide and suicidal behaviour.

Males and females are equally likely to attempt suicide, but the male suicide rate is almost five times higher than the rate among females. The difference is often related to differences in the methods used by men and women, with men more likely to use firearms or hanging. Female suicide rates are relatively stable across the adult lifespan, while male suicide rates show two peaks, one in younger males and in the oldest age group (Commonwealth Department of Health 1999a: 5). 20 per cent of all adolescent deaths are the result of suicide: 25 per cent of deaths in young men; 17 per cent of deaths in young women. Between 60-90 per cent of young people who attempt suicide are depressed (VicHealth, 1999).

Comorbidity
Depression and anxiety are often experienced together. The 1997 National Survey of Mental Health and Wellbeing found that almost 80 per cent of those with an affective disorder also had an anxiety disorder. More than one in three of those with an affective disorder and one in five of those with a substance use disorder also had an affective disorder.

Depression is also common in people with physical illnesses. The 1997 National Survey of Mental Health and Wellbeing found that nearly half the people who had an affective or depressive disorder also had a related physical problem. For people with physical disorders the prevalence of depression may be as high as 50 per cent.

Diagnosis and Treatment of Depression
Despite women being diagnosed with depression at a higher rate than men, it is not necessarily the case that depression is well recognised in women among doctors, family and friends (Nizette and Creedy, 1998). Depression may go unrecognised by women themselves.
Diagnosis of depression in people who are physically ill can be difficult as indicators of depressed mood may be attributed to a woman’s physical condition or to current medication. Alternatively, there can be over-identification of depression when the symptoms are linked to physical illness (Commonwealth Department of Health, 1999b: 44).

It is believed that only about 20 per cent of people with depressive disorders are correctly diagnosed and only about 20-25 per cent of people with depressive disorders receive treatment (Evans, Burrow and Norman, 2000).

Williams et al (1995) conducted a major study examining gender differences in depression. The study found that women were almost twice as likely as men to be diagnosed with depression and/or anxiety disorders and major and/or longstanding depressive disorders. The study also found that women diagnosed with depression were significantly more likely to be prescribed antidepressant drugs than men with the same diagnosis (cited in NSW Health, 2000: 2).

**Causes and Risk Factors**

The causes of depression are now understood to be complex and relate to the interaction of many diverse factors, including environmental, social, biological and psychological risk and protective factors have been identified. The determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity are still not well understood. Biochemical changes in the brain give rise to the major symptoms of depression, but the precipitants of these are psychosocial (Commonwealth Department of Health, 1999a). Environmental and social factors especially negative, irregular, disruptive life events have been found to trigger depression. Social theories of depression emphasise the importance of severe events and life difficulties characterised by loss, humiliation, entrapment and a sense of lack of control and inferior rank (WHO, 2000a: 44). Social disadvantage and poverty have been identified as leading to greater mental health risks. Reduced autonomy and decision-making, increased exposure to dangerous environments and violence and discrimination have been identified as risk factors. Other interconnecting risk factors for depression are childhood adversity, current marked interpersonal difficulties, a lack of social support and severe events. There is also an increased risk of a depressive episode occurring in the presence of ongoing anxiety (Astbury, 1999).

Multiple risk factors and experiences can greatly increase vulnerability to depression.

**Gender Perspectives**

Earlier attempts to explain the prevalence of depression in women were sought in biologically based sex differences, for example genetic, endocrinological) (WHO 2000a: 31).

Depression is still often viewed as a ‘woman's problem’, however the reasons for the higher incidence of depression are related to social causes rather than biological differences.

WHO has explicitly ‘conceptualised gender as a powerful structural determinant of mental health that interacts with other structural determinants including age, family structure, education, occupation, income and social support and with a variety of behavioural determinants of mental health. Understood as a social construct, gender must be included as a determinant of health because of its explanatory power in
relation to differences in health outcomes between women and men’ (WHO, 2000a: 12).

A substantial body of research has found that both mortality and morbidity rates vary by social class, and highlighted the importance of inequality and low social capital in determining health. As Stein has outlined (1997), ‘perceptions of equity and equality directly affect health… there is a direct effect on health where one stands in the scale of things in society… it is no longer physical causes but social and cognitively mediated processes’ (cited in WHO, 2000a: 32).

Women's generally lower social and economic position in society compared to men's has been linked to negative effects on women's mental health and higher rates of depression. ‘Perceptions of equity and equality - the meaning and symbolism attached to particular events and experiences - does reflect where one stands in the scale of things, and strongly influences women's mental health’ (WHO, 2000b: 45).

Gendered divisions of labour in the economy, the home and community, and gender based expectations about roles, responsibilities and power relations have been identified as likely to contribute to women's greater risks and vulnerability to depression. Socio economic factors including lower rates of pay, part time and casual employment, poverty and unemployment, and caring for a person with a chronic physical or mental disorder have been identified as increasing vulnerability to depression.

In the past 12 years, identification of new risk factors for depression linked to gendered experiences, particularly sexual abuse and violence in childhood and adulthood have influenced research studies. Other risk factors for depression that have been identified are the death of a child, death of a husband or partner and two or more abortions. These losses and abuses are seen as negative in women's own views of themselves and in the loss of valued relationships and social support (WHO, 2000a: 36).

Astbury has pointed out that ‘violence against women… is probably the most prevalent and certainly, the most emblematic gender based cause of depression in women. This is because violence against women encapsulates all three features identified in social theories of depression - humiliation, inferior social ranking and subordination and blocked escape or entrapment’ (Astbury, 1999: 23).

Postnatal depression is best seen as a ‘disruptive life event’ rather than being biologically-based and related to the physicality of childbirth. Risk factors for a depressive disorder following childbirth are predominately psycho social including, for example: marital conflict, the absence of personal support from spouse, friends and family, delivering a preterm baby or one that has physical problems, childhood abuse, a history of anxiety and depression, and stressful life events.

The greater number of women being diagnosed with depression may be related to a complex interplay of gender biases in diagnosis and treatment by GPs and other professionals, the different help seeking behaviours of the sexes, and different ways in which women and men acknowledge and deal with distress.

It has been suggested that women and men respond differently to distress and difficulties due to gender expectations and socialisation. Women may internalise their feelings and difficulties which may lead to feelings of anxiety and depression. Men may turn feelings and difficulties outswards either into excessive drinking or into aggression and the use of violence. Alcohol and aggression may mask depression in men (Busfield, cited in Luck, Bamford and Williamson, 2000: 71).
Differences in diagnosed depression may also be due to different help seeking behaviours. Women are more likely than men to attend health services for physical illness for themselves, their children or those in their care.

**Depression and Particular Population Groups**

Discrimination and disadvantage can cause mental distress and may lead to depression. Limited access to basic material necessities and psycho social resources have been found to be associated with increased risk of depression in studies undertaken since the 1970s (WHO, 2000a: 55). Multiple risk factors can cluster together in particular population groups who experience economic and social disadvantage, discrimination and marginalisation from the wider society.

Studies have reported that more than 63 per cent of people presenting to Aboriginal medical services have a significant level of distress, principally depression. Trauma, loss and grief derive from the history of invasion, loss of land and culture, high rates of premature mortality, high levels of incarceration and high levels of family separations. Domestic violence, sexual and physical abuse and a range of other traumas also contribute, together with the continuing economic and social disadvantage experienced by Aboriginal peoples (Commonwealth Department of Health, 1999b: 51).

A high prevalence of depression, anxiety, suicide attempts and completed suicide among lesbian, gay, bisexual and transgender communities have been reported. A study at Adelaide University examined levels of depression amongst 408 gay men and found that 27 per cent were suffering major depression, which is eight times higher than the general population. A survey of 503 lesbians in the USA showed that 66 per cent had suffered depression (McNair, Anderson and Mitchell, 2001).

Women and men who have been accepted for resettlement as refugees; ie satisfied criteria of having suffered persecution and human rights violations, are likely to be vulnerable to depression due to multiple factors.

National level statistics on depression among women and men from Culturally and Linguistically Diverse (CALD) backgrounds were produced by the Australian Bureau of Statistics in 1998. These rates were lower than rates for people born in Australia. Sampling issues, including the exclusion of people with poor English and cultural differences in the definition, conceptualisation, experience and reporting of depression are likely to account for these statistics. CALD communities are diverse, in terms of community size, length of establishment in Australia, nature of migration experiences, English language competency and level of specific ethnic community support (Commonwealth Department of Health, 1999b: 52). Consequently community based research is needed to produce useful information to determine needs and map current access to primary care, specialist and health promotion programs.

**Mental Health Promotion**

Research has identified the following factors that act to protect individuals from experiencing depression:

- sufficient autonomy to exercise some sense of control over one’s life in response to severe events
- access to adequate material resources, to enable choice in response to severe life events
- presence of emotional and social support (WHO, 2000a: 45).
It is important to note that programs that focus on reduction of individual lifestyle risk factors may neglect the very factors that contribute to the lifestyle (WHO, 2000a: 8). Programs that aim to reduce or prevent depression need to address structural factors as well as individual factors, such as personal behaviour and skills, and have a strong gender focus.

Availability and access to health services, community and social support, socio cultural and environmental factors that influence stressors and experience of life events, and public policy including economic, housing and employment policies are among the range of multisectoral actions that can address the determinants of depression.

Programs addressing depression and promoting mental health should facilitate increased social equity and gender equality, to promote changes in gendered experiences and life situations that have been identified as risk factors for depression. Attention to gender needs to be explicitly mainstreamed into mental health promotion plans such as the following outlined by VicHealth:

- focus on increasing social connectedness, positive regard and security
- foster community based initiatives for socially isolated individuals and communities, or for individuals experiencing high stress due to adverse personal, economic or social circumstances
- apply principles of community development
- build on existing community based initiatives
- give structural support
- develop intersectoral alliances
- provide information and training to foster good practice
- foster positive working relationships with relevant professionals
- provide education to increase awareness of key issues relevant to mental wellbeing, (VicHealth, 1999: 4).

On the basis of a review of current research, has identified the following objectives for the effective promotion of women's mental health:

- assist women to increase control over the determinants of their mental health, particularly elimination of any situations in which devaluation and discrimination occur
- decrease exposure to risk factors which erode or compromise health, through education and changes to policy and legislation to actively improve women's material wellbeing, status and available life choices
- involve women in decision making in health treatments and interventions, and in events and decisions that affect their lives and health more broadly
- ensure that any treatment directed towards women's mental health is obtained on the basis of informed consent and guarantees dignity and confidentiality
- strengthen social networks and communities that provide practical and emotional support
- preserve and strengthen social capital, and a public good, and reduce income inequalities (WHO, 2000a: 45)
References:


World Health Organisation. (2000a), Women’s Mental Health: An Evidence Based Review, Geneva

A Gender Agenda: Planning for an Inclusive and Diverse Community

Smoking and Gender Issues: Research Paper

Smoking represents the most extensively documented cause of disease in the history of biomedical research. Sex differences in responses to tobacco have been identified, together with differences in smoking rates and lung cancer disease rates among women and men. However gender issues in smoking adoption, smoking habits and cessation have received relatively little attention.

Adverse Effects of Smoking

Smoking has been identified as a major cause of heart disease, stroke, several different forms of cancer, and a wide variety of other health problems. The vast majority of deaths caused by smoking occur through the development of heart disease and lung cancer, followed by chronic bronchitis, stroke, peripheral vascular disease and other circulatory diseases, and cancers other than the lung (ASH, 2001).

Sex Differences

While there are many similarities in disease processes, women and men respond differently to tobacco in relation to the following issues:

- women who smoke are 20-70 per cent more likely to develop lung cancer than men who smoke the same amount of cigarettes
- girls born to mothers who smoke have worse lung function than comparable boys
- women who smoke are more likely to develop chronic obstructive pulmonary disease (COPD) than their male counterparts and more likely to have symptoms of COPD at lower levels of tobacco smoke exposure.
- when women smoke and drink alcohol, the nicotine appears to enhance the effects of alcohol. In men, the nicotine appears to dilute some of the sedating and intoxicating effects of alcohol (Society for Women's Health Research).

Women are at risk of developing a number of sex-specific problems due to smoking:

- Women smokers over 35 who use oral contraceptives have a greater risk of dying from a cardiovascular disease than non smokers who use oral contraceptives in the same age group.
- women who smoke have decreased fertility
- women smokers experience a greater prevalence of absence of menstruation and irregularity of periods
- women who smoke reach natural menopause two years earlier than non smokers or ex-smokers
- women who smoke are believed to have reduced bone density by the time they reach menopause, contributing to osteoporosis, and increased risk of fracture.
- women who smoke have a greater risk of developing cancer of the cervix and vulva (Quit, 1998).
Effects of Smoking on Children

Smoking affects wellbeing in pregnancy, and foetal and infant health:
• women who smoke during pregnancy have a 25-50 per cent higher rate of foetal and infant death compared with non-smokers
• maternal smoking exerts a growth retarding effect on the foetus, with smokers having double the risk of a low birthweight baby
• spontaneous abortions and complications of pregnancy and labour occur more frequently in smokers.

Smoking by either parent during pregnancy is associated with a higher incidence of all childhood cancers combined. Parental smoking has been linked with decreased pulmonary function and asthma in children.

Lung Cancer Death and Disease Rates

Lung cancer was responsible for the second highest Years of Life Lost (YLL) for men (13,986) and fourth highest YLL for women (7,240) in Victoria (DHS, 1999: 21).

Trends in lung cancer mortality reflect smoking patterns of earlier decades, with a lag of approximately 20 to 30 years between cigarette smoke exposure and lung cancer mortality. In Australia lung cancer in men began to increase during the 1930s and 1940s, reflecting a large uptake of smoking among men from around 1910 to the 1920s. Women took up smoking from the 1920s. In the 1960s there was an upswing in lung cancer mortality among women, which has continued to increase overall, although the rate of increase has begun to slow down (Quit, 1998).

Men's death rates still far exceed those of women. This is because men began smoking in larger numbers before women, and have always had a higher prevalence of smoking. Moreover, men tend to smoke more heavily than women, to choose cigarettes with a higher tar content, and to report longer duration of smoking than women, probably reflecting an earlier age of uptake. Duration of smoking and smoking early in life are considered most significant among the known factors which influence lung cancer risk (Quit).

Changing Patterns in Smoking

Smoking habits of women and men have varied significantly over the past 30 years, and there is some debate about what future trends may be. For most of the 20th century, smoking was more socially acceptable behaviour in men than in women. In the 1940s around 70 per cent of men smoked; the proportion of men smoking has since declined substantially. However smoking by women has remained relatively stable between 1945 until 1989. By 1977 women made up 40 per cent of smokers in Australia.

In 1999, 23 per cent of Victorian men and 18 per cent of women were regular smokers (20.7 per cent overall), slightly lower than the national rate of almost 22 per cent (Quit, 2001).

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
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<tr>
<td>1945</td>
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<td>1964</td>
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<td>1980</td>
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While smoking was less prevalent in 1995 than in 1977, the greatest proportional decline has been among people aged 45 years and over and the least among young people aged 18-24. Other surveys that have looked at teenage smoking patterns indicate that young women are now smoking in equal if not greater numbers than young men. The 1998 National Household Drug Survey found that 24 per cent of males and 26 per cent of females aged 14-19 were current smokers (ABS, 2000).

Population Groups and Smoking

Smoking is not evenly spread in the population. Patterns vary internationally and change over time. Various studies have identified differences in smoking behaviour based on age, ethnic background, educational level, socioeconomic status and sexual orientation. In Australia people with less education, less skilled jobs or who are unemployed are more likely to smoke than people of higher socioeconomic status (ABS, 2000). Increased education levels are associated with decreasing smoking prevalence.

High rates of smoking have been reported in some adult ethnic groups in Australia. Gender differences in smoking prevalence which relate to community acceptance of male smoking and gender roles within community cultures, have been identified in the Greek and Chinese communities in Melbourne (Trotter 1996/97), and Vietnamese and Arabic communities in Sydney (Rissel, McLennan, Bauman, Tang 2001).

Intergenerational changes in smoking prevalence have been found, in that both male and female secondary school students from non-English speaking backgrounds (NESB) have been found to have lower rates of current and daily smoking than those from English speaking backgrounds (ESB). NESB students are more likely to report having never smoked (70 per cent) than those from ESB students (57 per cent). NESB students report higher paternal smoking rates (35 per cent for NESB fathers compared to 29 per cent for ESB fathers), smoking rates among mothers of NESB students are lower (18 per cent NESB compared with 28 per cent ESB) (Rissel et al). Whether these differences are maintained over time as students become accepted as adults in their families and communities is an issue for further research.

The 1994 National Aboriginal and Torres Strait Islander Survey found that 54 per cent of Aboriginal and Torres Strait Islander peoples aged 14 and over said they were current or regular smokers. Of the 76 per cent who had ever smoked, the majority had their first full cigarette before the age of 16, and more than one third before the age of 14, indicating a younger take up rate among this population than among the general population (The Cancer Council Australia et al, 2002).

A 1998 study by the Australian Drug Foundation found that lesbians demonstrated higher rates of smoking and smoked for longer than the general community: 40 per cent of lesbians aged 20-39 were smoking compared to 29 per cent of the general community, and 21 per cent of 50-59 year olds were smoking, compared with 9 per cent of the general population (McNair, Anderson and Mitchell, 2001: 34).

Smoking has been found to be three times more prevalent among people with schizophrenia than the general population. A 1996 study at the Centre for Young
People’s Mental Health found that 75 per cent of their sample were smokers. Other research conducted in 1996 in an outpatient setting in Melbourne found that 76 per cent of those surveyed were smokers (Quit).

Social Meanings, Identities and Gender Issues

‘Smoking has different social meanings and symbolic power among different sectors of the population, and some of those differences are gendered’ (Broom, 1995: 11). Although substantial research has been undertaken on the effects of smoking on health, much less is known about the behavioural factors influencing tobacco use. The question of whether women smoke for different reasons to men is an important area of enquiry. Research does not provide consistent findings and few studies take account of gender along with socioeconomic status, educational levels, ethnic background and other social factors.

Peer pressure and a desire to appear older, more adult and ‘cool’ are generally regarded as the reasons why teenagers start smoking, as indicated by these two smokers interviewed on Health Matters:

‘At school we’d nick off to the alleys at lunchtime and have a ciggy, that was good; parties and pubs, anywhere where I’m drinking I’ll have a ciggy because it complements the tastes; cafes, always with coffee; bus stops waiting for the bus because the train or the bus always comes quicker if you’re having a ciggy’ (man).

‘The reasons why I smoke I think it did start off to be something that I wanted to just try and I got a headspin and thought it was pretty cool. But now I use smoking as a relaxing sort of form of, yes, coming down from a stressful day, I like a cigarette, or over a coffee, like something calming’ (woman).

Higher prevalence of smoking among girls than boys has been noted in a number of Western countries. Some of the reasons advanced include:

• girls may be more responsive to societal pressures to be slim compared to boy’s greater concern with fitness.
• girls mature earlier than boys and tend to associate with boys of older ages (who tend to have higher smoking rates) (Quit, 1995).

An Australian study (1995) of 60,000 students from grades 7, 9 and 11 indicated that teenage girls who smoke cigarettes do so because it is a balm for depression and anxiety (PAHO, 1997).

Smoking may play different roles in the lives of women and men and the contexts in which particular women and men tend to smoke:

• men may be more likely to smoke while dealing with external pressures, and women in response to the emotional consequences of such pressures
• women smoke more in situations of difficulty and negative emotion, while men smoke more for stimulation and in pleasurable settings
• women and men tend to relapse (start smoking again) while feeling sadness or depression; men are more likely to do so when they are at work or when drinking alcohol (Borland, 1995).

The effect of smoking on body weight may be significant for more women than men, given societal pressures on women to be slim. Nicotine affects body metabolism and food intake, with smokers weighing on average 3kg less than non-smokers. Female smokers are more likely to take up smoking as a means of weight control, and to continue smoking rather than risk putting on weight. Women smokers mention weight
gain as a disadvantage of quitting more frequently than men, despite the fact that men are more inclined to be overweight (Quit, 1995).

However international studies show that women have more difficulty quitting smoking than men, and nicotine replacement therapy is less effective in women than in men. Women may be more responsive than men to non-nicotine stimuli associated with smoking, such as social and behavioural cues (Society for Women's Health Research, 1999).

The women most likely to smoke in developed countries are those on low incomes with low status jobs or who are not in the paid workforce. Studies from the UK show that spending on tobacco among low income households with children is higher than among low income households without children. Qualitative studies of caring highlight the experiences that underlie the association between smoking, poverty and caring for children. Cigarettes were reported by mothers caring for children in low-income households as the way women coped when their children's demands became 'too much to cope with' (Graham, 1987, 1993 in Popay and Groves, 2000). In a social and cultural context where women have few financial resources of personal spending, cigarettes maybe the only item that women bought for themselves.

Health Promotion Issues

Social and particularly gender influences have been important in influencing both smoking uptake and decisions to stop smoking among women and men in Australia. Health education and smoking advertisements have targetted men and women to differing extents, and tobacco advertisements have actively used particular images of women to promote the sale of cigarettes.

During the 1960's rates of quitting smoking were, at the time, higher for men than women. It has been suggested that the health education campaign provided was more directed towards men. Men's greater responsiveness to public health campaigns has been attributed to the fact that more information was available concerning the health damaging effects of smoking for men. Men may have been more responsive to anti-smoking messages since they were more likely to have known someone of their own sex whose health had been adversely affected by smoking (Waldon, 2000: 159).

While cigarette advertising has been based on themes of success and sex appeal for both men and women, women have been extensively targetted in tobacco marketing. Smoking has been portrayed as both a passport to and a symbol of the success and independence of the modern woman. There was a high level of advertising in Australian women's magazines prior to the ban on advertising at the end of 1990.

Despite the concern with teenagers continuing to take up smoking, there has been little done in relation to youth-specific campaigns. The current Federal Government anti-smoking campaign ‘Every cigarette is doing you damage’ is aimed at 18-40 year olds, and focuses on the health effects of smoking, an approach which has been very successful with older smokers. This approach is considered to be ineffective for adolescents and young people who think they are immortal, like to take risks, don't like the word 'don't' and have a short term focus (Swan, 2001).

The former US Surgeon-General has suggested that health education on the dangers of smoking should start in preschool, as children are introduced to tooth brushing at a young age. School-based programs can utilise peer pressure in a positive way, as in University of Minnesota studies that taught the non smokers to be the tough kids in school, to have the best arguments and to get the best grades (Swan, 2001). Recent British research has suggested that smoking rates among young people may also be
affected by other socially valued indicators of adult status, such as mobile phones. A fall in smoking rates was put down to the fact that young people have increased their use and ownership of mobile phones (Borthwick, 2001).

It has been argued that women and men smokers in poor families should not be the target of smoking cessation activities unless programs are put in place to improve their life situations (Breen, 1999). Single issue individualistic approaches to smoking cessation may well be less effective than intersectoral programs, for example, a program that improve the daily lives of mothers caring for children in low income households.

Health promotion work with particular groups should be informed by an understanding of gender differences in the social meanings around smoking, along with the multiple social roles, responsibilities and peer and wider social expectations. Demographic, economic, social and cultural factors) that impact on particular generations or groups in society are important to consider in developing appropriate campaigns.
References


Popay, J. Groves, K. (2000), ‘Narrative research on gender inequalities in health’, in Ellen Annandale and Kate Hunt, Gender Inequalities in Health


Quit. (2001), Media Release, February


The Cancer Council of Australia, Action on Smoking and Health, VicHealth Centre for Tobacco Control. (2002), ‘Submission to the National Aboriginal and Torres Strait Islander Tobacco Control Project’,


A Gender Agenda: Planning for An Inclusive and Diverse Community

Useful websites

ARROW (Asian Pacific Resource and Research Centre for Women)
http://www.arrow.org.my
ARROW produced a Resource Kit in 1996 comprising a number of gender and women-focused tools for use in health settings. The Kit is available for sale from ARROW (email: arrow@arrow.po.my). Some of the tools are likely to be placed on the website in future.

Note: the Gender Agenda Resource Kit includes three of ARROW's tools:
- Checklist for Women-centred Programme Design
- Women-centred and Gender-sensitive Programme Management Cycle
- Checklist to Determine How Gender-Sensitive is a Health Programme.

AusAID (Australian Agency for International Development)
www.ausaid.gov.au
Available on the website is AusAID's Guide to Gender and Development, a practical guide to assist AusAID staff and contractors to implement its gender and development policy in overseas development projects and programs. The Guide includes guiding questions for both sectoral areas and stages in the project cycle.

Note: the Gender Agenda Resource Kit includes three of AusAID's project tools from the Guide to Gender and Development:
- implementation and identification,
- implementation and monitoring, and
- evaluation.

Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD)
http://www1.oecd.org/dac/htm/marcia1.htm
The free publications section of the website provides a number of excellent publications including
- Tipsheets for Improving Gender Equality: two page "tip sheets" on various issues prepared by the Swedish International Development Agency (Sida) to assist in considering gender in development cooperation
- DAC Source Book on Concepts and Approaches Linked to Gender Equality (1998) which provides definitions and outlines key concepts.

Note: the Gender Agenda Resource Kit includes two of the tip sheets prepared for Sida by B. Woroniuk and J. Schalkwyk:
- Organisational Change and Equality between Women and Men,
- Participation and Equality between Women and Men.

Harvard Centre for Population and Development Studies
http://www.hsph.harvard.edu/Organizations/healthnet/HUpapers/index.html
The Global Health Equity Initiative (GHEI) Project is an interdisciplinary project that combines conceptual work on health equity with country case studies. Some of the working papers on Gender and Health Equity are available on the Harvard website.
InterAction (American Council for Voluntary International Action)
http://www.interaction.org see the Commission on the Advancement of Women section of the website
Available for purchase from InterAction (US$10 each) are two InterAction publications:
Best Practices for Gender Integration in Organisations and Programs in the InterAction Community
The Gender Audit: A Process for Organisational Self-Assessment and Action Planning
Contact: publications@interaction.org

Note: the Gender Agenda Resource Kit includes InterAction's
- checklist for Gender Integration in Programming and Management from InterAction's Best Practices for Gender Integration in Organisations and Programs from the InterAction Community

Ministry for Women's Affairs, New Zealand

Note: the Gender Agenda Resource Kit includes
- an extract from the Ministry's Guidelines for Action

Liverpool School of Medicine and Tropical Hygiene
http://www.liv.ac.uk/lstm
This website includes Guidelines for the Analysis of Gender and Health, which presents an overview of gender and how it relates to health, gender analysis and gender sensitive health planning, and case studies in three developing countries.

Pan American Health Organisation (PAHO) - Regional Office of the World Health Organisation
This comprehensive training package including workshop outline, instructions for facilitator plus exercises with handouts and overheads. Designed for use in developing countries, it has many exercises that could be used as outlined or adapted for use in an Australian context.

Note: the Gender Agenda Resource Kit includes PAHO's:
- Guidelines to analyse a project case study from the Workshop on Gender, Health and Development.

Status of Women Canada (SWC)
http://www.swc-cfc.gc.ca/
Various useful documents on the website, including
- Discussion Paper on Approaches to Consultation

Note: the Gender Agenda Resource Kit includes
- an extract from the Discussion Paper on Approaches to Consultation: Approaches to Consultation and Consultation Methods
Society for Women's Health Research Sex-Based Biology (US based organisation)
http://www.womens-health.org/
This website which deals primarily with sex based differences includes:
• Top Ten Differences That Make a Difference
• Just the Facts: Sex Based Biology (CVD, Cancer, Autoimmune Diseases, Neurology and Mental Health, HIV/AIDS, Response to Pharmaceuticals, Tobacco, Alcohol and Illicit Drugs, Obesity, Musculoskeletal Health

United Nations Development Program (UNDP)
http://www.undp.org/gender/capacity/gm_info_module.html#GA
UNDP has produced a Gender Learning and Information Package (2001) available on the website.

Note: the Gender Agenda Resource Kit includes UNDP's:
• Resource 3b Gender Analysis - What to Ask from the UNDP Learning and Information Pack

World Bank