Australian Government
Department of Health, Disability and Ageing

National Women's Health Advisory Council

An Approach to Developing a Monitoring and Reporting Framework for the National Women's Health Strategy 2020-30

Contents

Acronyms

Acronym	Full name
ABS	Australian Bureau of Statistics
ACARA	Australian Curriculum, Assessment and Reporting Authority
ACD	Australian Cancer Database
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
ALSWH	Australian Longitudinal Study Women's Health
AMA	Australian Medical Association
CALD	Culturally and linguistically diverse
CVD	Cardiovascular disease
FDSV	Family, domestic, and sexual violence
GP	General Practitioner
HILDA	Household Income Labour Dynamics in Australia
IUD	Intrauterine device
LARC	Long Acting Reversible Contraception
LBTI	Lesbian (and gay), bisexual, transgender and intersex people
MBS	Medicare Benefit Schedule
NACCHO	National Aboriginal Community controlled Health Organisations
NASS	National Ambulance Surveillance System
NBCSP	National Bowel Cancer Screening Program
NCSP	National Cervical Screening Program
NCSR	National Cancer Screening Register
NHMD	National Hospital Morbidity Database
NHMRC	National Health and Medical Research Council
NMDB	National Mortality Database
NNDSS	National Notifiable Disease Surveillance System
NPDC	National Perinatal Data Collection
NSMHW	National Survey of Mental Health and Wellbeing
PBS	Pharmaceutical Benefits Scheme
PSS	Personal Safety Survey
RACGP	Royal Australian and New Zealand College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SES	Lower socioeconomic status
WHO	World Health Organization

Executive Summary

The National Women's Health Strategy 2020-2030

The strategy outlines Australia's national approach to improving the health of women and girls – particularly those at greatest risk of poor health – and to reducing inequities between different groups.

The strategy identifies the current policy gaps and emerging health issues in women's health in Australia, with the aim of informing targeted and coordinated action at the national and jurisdictional levels to address the priority health needs of women and girls in Australia.

The strategy outlines five key priority areas (listed below) with a suite of actions mapped to each priority area. Key measures of success (i.e. population health outcomes) are identified for each priority area.

Priority areas:

1. Maternal, sexual and reproductive health
2. Healthy aging
3. Chronic conditions and preventative health
4. Mental health
5. Health impacts of violence against women.

A Monitoring and Reporting Framework for the National Women's Health Strategy (this document)

Deloitte Access Economics was engaged by the Department of Health, Disability and Ageing (the Department) to develop a Monitoring and Reporting Framework that outlines an approach to evaluating the implementation and outcomes of the strategy.

The purpose of the framework is to enable an assessment of the extent to which key stakeholders have implemented activities in alignment with the strategy, and to monitor change in outcomes measures. To enable this assessment, this framework is structured across two components:

- Implementation monitoring
- Outcome monitoring.

Monitoring and Reporting Framework – Summary of Methodology

The Monitoring and Reporting Framework is structured across two components:

1. **Implementation monitoring and reporting.** Uses a criteria-led approach to assess the strategy's implementation progress at an action-level, informed by stakeholder consultation and evidence of key activities.
2. **Outcome monitoring and reporting**. For each key measure of success outlined in the strategy, key performance indicators are identified and mapped to publicly available data sources.

Implementation monitoring and reporting

The following steps are proposed to assess the extent to which key stakeholders across Australia have implemented activities in alignment with the actions outlined in the strategy:

Step 1. Identify stakeholder implementation partner organisations for each action in the strategy (e.g., state departments of education).

Step 2. Undertake evidence gathering through consultation with all identified stakeholder implementation partners, with a view to understanding what has been achieved across each action. Supplement with desktop review.

Step 3. Summarise evidence at a thematic level, by profiling the extent to which the implementation partners are aware of the strategy and the key actions, and outlining what has been achieved in alignment with the actions.

Step 4. Rate actions and develop scorecard. Use evidence from Step 3 to rate the implementation of each action against a rubric scale of 1 to 3 (see scale below) – these ratings will be included in a scorecard

Table i: Implementation progress rubric scale

Requires stronger focus	Some progress	Meaningful progress
There is minimal progress across priority area, highlighting the need for a more concentrated effort in the future.	There is indication of some progress within this priority area across some, but not all, outlined priority populations or jurisdictions	There is evidence of meaningful progress (including services and investment) aligned to this priority area, sufficiently addressing most relevant priority populations/ actions.

Outcome monitoring and reporting

To monitor change in the strategy's intended outcomes over time, each of the strategy's key 'measures of success' are mapped to key performance indicators and publicly available data sources (see example below).

Table ii: Illustrative outcome indicator framework

Outcome indicator	Data source/s	Data timeliness	Priority group disaggregation
Change in percentage of female adolescents meeting a full-dose HPV (2-dose) immunisation by age 15	National Centre for immunisation Research and Surveillance – Annual Immunisation Coverage Reports	Last published: 2021 Frequency: annual Publication lag: 1-2 years	✓ Aboriginal and Torres Strait Islander

Implementing the Monitoring and Reporting Framework

This framework is intended to be used on an ongoing basis to monitor change over time. The framework will be implemented at the end of 2023 to provide a baseline assessment. A Baseline Report (and a summary scorecard) summarising the findings of this baseline assessment will be delivered mid-2024.

This version of the framework (August 2024) has been updated following the delivery of the Baseline Report in July 2024. Updates largely relate to the outcomes measures listed in Chapter 4, as the process of gathering the outcomes data revealed some sources that were less helpful in practice than initially conceptualised; but also allowed for the identification of additional useful data sources.

1 Introduction

This chapter outlines the overview of the National Women's Health Strategy, and the scope and purpose of the Monitoring and Reporting Framework (this document).

1.1 This document

This document presents the Monitoring and Reporting Framework (the framework) of the National Women's Health Strategy 2020-2030 (the strategy). It outlines the monitoring and reporting activities required to evaluate the implementation and outcomes of the strategy.

In the following chapters, this framework will describe:

- an **overview of the strategy** and the **scope and purpose** of this framework – Chapter 1 (this Chapter)
- the **conceptual approach** to this framework, including a program logic and a description of how the different components of the strategy will be monitored – Chapter 2
- the **implementation monitoring and reporting framework** – Chapter 3
- the **outcome monitoring and reporting framework**, including outcome measurement indicators and data sources – Chapter 4.

1.2 Overview of the strategy

The strategy outlines Australia's national approach to improving health outcomes for all women and girls in Australia. This strategy builds on the National Women's Health Policy 2010 that adopts a dual priority approach, namely of (1) maintaining and developing health services and prevention programs to treat and avoid disease through targeting health issues that will have the greatest impact over the next two decades, and (2) aiming to address health inequities through broader reforms addressing the social determinants of health.

The strategy identifies the current policy gaps and emerging health issues in women's health in Australia, with the aim of informing targeted and coordinated action at the national and jurisdictional levels to address the priority health needs of women and girls in Australia. To this end, the strategy is not itself a delivery vehicle for specific activities, rather it provides relevant government and non-government stakeholders across Australia with a guide to inform focus areas and actions that will improve the health and wellbeing of all women and girls in Australia.

Figure 1.1 provides an overview of the strategy, including its purpose, policy principles, and priority areas. Each priority area is associated with key measures of success and a subset of actions to improve health outcomes for women and girls.

In addition, the strategy takes a life course approach recognising there are a range of health needs, risks and influences experienced by women at different stages of life (described in Section 1.2.1), and highlights priority population groups to address health inequities (described in Section 1.2.2).

Figure 1.1 Overview of the National Women's Health Strategy 2020-2030

Purpose	**Improve the health and wellbeing of all women and girls in Australia, providing appropriate, equitable and accessible prevention and care, especially for those at greatest risk of poor health.**
Policy principles and objectives	
Gender equity	*Highlight the significance of gender as a key determinant of women's health and wellbeing, to strengthen gender-equity and gender-transformative research and services, and women's and girls' engagement with the health system*
Health equity between women	*Recognise the different health needs of priority populations, address gaps in services and target those women's population groups where the worst health outcomes are experienced*
A life course approach to health	*Develop health initiatives that focus on improving health and target risk factors and intervention points most relevant for women across the life course*
A focus on prevention	*Invest in positive primary prevention, secondary prevention and early intervention form childhood, with a focus on the social and gendered drivers of health and holistic person-centered care*
A strong and emerging evidence base	*Support effective and collaborative research, data collection, monitoring, evaluation and knowledge transfer to advance the evidence base on women's health*
Priority areas	
1 | Maternal, sexual and reproductive health	• *Increase access to sexual and reproductive health care information, diagnosis, treatment and services* • *Increase health promotion activity to enhance and support preconception and perinatal health care services* • *Support enhanced access to maternal and perinatal health care services*
2 | Healthy ageing	• *Adopt a life course approach to healthy ageing for women* • *Address key risk factors that reduce quality of life for women as they age* • *Better manage the needs of a diverse ageing population*
3 | Chronic conditions and preventive health	• *Increase awareness and primary prevention of chronic conditions, symptoms and risk factors for women and girls, and embed a life course approach in policy and practice* • *Invest in targeted prevention, early detection and intervention of chronic conditions affecting women and girls* • *Tailor health services to meet the needs of all women and girls* • *Reduce the prevalence and impact of endometriosis and associated chronic pelvic pain*
4 | Mental Health	• *Enhance gender-specific mental health education, awareness and primary prevention* • *Focus on early intervention, diagnosis, integration and access to mental health care services* • *Invest in service delivery for priority populations* • *Adopt a multi-faceted approach to support women and girls with eating disorders* • *Raise awareness and embed practices to reduce stigma and discrimination associated with mental ill-health*
5 | Health impacts of violence against women	• *Raise awareness of the health impacts of violence against women and girls* • *Address health and related impacts of family and sexual violence* • *Co-design and deliver safe and accessible services for women experiencing family, intimate partner and/or sexual violence*

Source: National Women's Health Strategy 2020-2030.

1.2.1 Life course approach

Aligning with the National Women's Health Policy 2010, the strategy takes a holistic and comprehensive approach to viewing women's health across the life course, recognising that women and girls can experience a range of diverse health needs and risks that evolve and change across their lifespan. The life stages are categorised as shown below.

Figure 1.2 Life stages of women and girls

Source: National Women's Health Strategy 2020-2030.

1.2.2 Priority population groups

Improving health equity for women and girls requires consideration of priority population groups, due to differing health needs for different groups. Further, many women and girls fall into more than one of the identified priority population groups which can have a compounding effect on health needs and outcomes. The strategy focuses on the following priority population groups:

- pregnant women and their children
- women and girls from rural and remote areas
- Aboriginal and Torres Strait Islander women and girls
- women and girls from low socio-economic backgrounds and older women with low financial assets
- women and girls living with disability and carers
- culturally and linguistically diverse women and girls
- members of LBTI communities
- women and girls who experience violence and/or abuse
- women and girls affected by the criminal justice system
- women veterans of Australia's armed services.

1.3 Scope and purpose of the Monitoring and Reporting Framework

Deloitte Access Economics was engaged by the Department of Health, Disability and Ageing (the Department) to develop a Monitoring and Reporting Framework that outlines an approach to evaluating the implementation and outcomes of the strategy.

The purpose of the framework is to enable an assessment of the extent to which key stakeholders have implemented activities in alignment with the strategy, and to monitor change in outcomes measures. To enable this assessment, this framework is structured across two components:

1. **Implementation monitoring and reporting**. Uses a criteria-led approach to assess the strategy's implementation progress at an action-level, informed by stakeholder consultation and evidence of key activities.
2. **Outcome monitoring and reporting**. For each key measure of success outlined in the strategy, key performance indicators are identified and mapped to publicly available data sources.

Implementation of this framework will provide the Department and the National Women's Health Advisory Council with an understanding of the strategy's implementation progress against the five key priority areas and performance against the key measures of success. The Department and the Council can then use this information to adapt and innovate on a real-time basis, as the monitoring and reporting activities will identify gaps and highlight areas that require targeted focus over the next ten years. The framework is not intended to be used to evaluate discrete programs or initiatives.

This version of the framework (August 2024) has been updated following the first implementation of the framework through the Baseline Report in July 2024. Updates largely relate to the outcomes measures listed in Chapter 4, as the process of gathering the outcomes data revealed some sources that were less helpful in practice than initially conceptualised; but also allowed for the identification of additional useful data sources.

2 Conceptual approach to the Monitoring and Reporting Framework

This chapter provides a conceptual overview of the framework, including how the different components of the strategy will be monitored.

2.1 Program logic

A program logic is a theory of intended cause and effect and consists of several 'if-then' statements. It is a tool that can be used to link the inputs and activities to the outputs and intended outcomes of a program. Note that where outcomes are expected to be realised over a longer-term horizon, the less attributable they are to the program, as other external factors contribute to these outcomes.

Figure 2.1 illustrates how the different components of the strategy align with program logic theory. Presenting the strategy in a program logic provides a representation of the relationships between the various components of the strategy. The program logic shows how the 'actions' in the strategy represent activities or outputs, which are intended to lead to outcomes (the 'measures of success' in the strategy). This demonstrates the strategy's theory of change, where implementation progress at the action-level is indicative of the extent to which the strategy is contributing to the desired outcomes.

As noted in Section 1.2, the strategy is not itself a delivery vehicle for specific activities, rather it provides relevant government and non-government stakeholders across Australia with a guide to inform focus areas and actions that will improve the health and wellbeing of all women and girls in Australia. As noted on page 8 of the strategy, the strategy 'is designed to provide a gender-specific approach to activities already underway and to guide the development of new and innovative policies and approaches to address specific health needs of women.'

To this end, this Framework is not intended to attribute outcomes to the strategy, but to enable an assessment of the extent to which key stakeholders have implemented activities in alignment with the strategy, and to monitor change in population-level health outcomes measures for women and girls over time.

Figure 2.1. Program logic of the strategy – key components of the strategy mapped to a theory of change architecture

Purpose of the strategy: The strategy aims to inform targeted and coordinated action at the national and jurisdictional levels to address the priority health needs of women and girls in Australia

Intended goal of the strategy: To improve the health and wellbeing of all women and girls in Australia, providing appropriate, equitable and accessible prevention and care, especially for those at greatest risk of poor health

	Inputs *Essential for processes to occur. They include human, financial and organisational resources.*	**Activities & outputs** *Activities are the specific actions that make up the program. They reflect tools, processes or events that are intentional in the program Outputs are the specific processes will produce or create. They are short term and tangible products of the activities or processes.*	**Outcomes** *The changes in the target cohort and related stakeholders as a result of the program activities and outputs. Includes changes in awareness, knowledge, behaviour and experience.*
Maternal, sexual and reproductive health	Stakeholder 'implementation partners' (i.e. relevant government and non-government organisations) direct funding, time and resources to the actions articulated in the strategy	Example: Promote access to resources for students and parents to learn more about sexual and reproductive health	Example: Decrease in the notification rates of sexually transmissible infections for priority populations
Healthy ageing	Stakeholder 'implementation partners' (i.e. relevant government and non-government organisations) direct funding, time and resources to the actions articulated in the strategy	Example: Monitor emerging patterns of multimorbidities in older women and tackle the risk factors that cut across conditions	Example: Reduction in the number of preventable and avoidable deaths
Chronic conditions and preventive health	Stakeholder 'implementation partners' (i.e. relevant government and non-government organisations) direct funding, time and resources to the actions articulated in the strategy	Example: Develop and deliver a national campaign to promote awareness of the different risks for and symptoms of cardiovascular disease in women	Example: Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women - broken down into priority population data
Mental health	Stakeholder 'implementation partners' (i.e. relevant government and non-government organisations) direct funding, time and resources to the actions articulated in the strategy	Example: Focus on access to mental health support services for groups with lower access and greater need	Example: Lower incidents of mental health reporting, self-harm and suicide
Health impacts of violence against women & girls	Stakeholder 'implementation partners' (i.e. relevant government and non-government organisations) direct funding, time and resources to the actions articulated in the strategy	Example: Develop innovative models to address the health impacts of violence against women and girls, particularly focusing on those at greatest risk	Example: Increase in number of services available, and women accessing these services

Source: Deloitte Access Economics (2023).

2.2 Summary of Monitoring and Reporting Framework scope and methodology

The purpose of this framework is to track progress against the strategy's inputs and activities (i.e., extent to which key stakeholders have implemented activities in alignment with the strategy), and to monitor change in health outcomes and impact measures for women and girls over time (i.e., outputs and outcomes of the strategy). To enable this assessment, the framework includes two key components:

1. **Implementation monitoring and reporting**. Implementation refers to the process of planning and delivery of activities against an objective. To assess the strategy's implementation progress, Chapter 3 outlines a criteria-led approach for assessing the extent to which key stakeholders across Australia have implemented activities in alignment with the strategy's actions. This approach:
    - uses a rubric rating scale guided by the implementation domains of **awareness** (i.e., to what extent are key stakeholders aware of the priority areas and actions within the strategy?) and **adoption** (i.e., to what extent have key stakeholders implemented activities in alignment with the action?)
    - leverages stakeholder consultation and desktop review to inform ratings against the rubric.

2. **Outcome monitoring and reporting**. In the context of the strategy, outcomes (the 'measures of success' in the strategy) relate to the desired results or effects of implementation of the strategy's actions. To monitor change in the strategy's desired outcomes over time, Chapter 4 provides an outcome indicator framework that maps each measure of success to key performance indicators and publicly available data sources. These population-level outcome indicators help to assess whether the strategy is contributing to change, noting there are a variety of external factors contributing to the achievement of these outcomes.

The methodology informing these two components is summarised in Table 2.1 and described in more detail in Chapters 3 and 4.

Table 2.1: High-level purpose, scope and approach of the framework's implementation and outcome monitoring and reporting components

	Implementation monitoring and reporting	Outcome monitoring and reporting
Purpose	To assess the implementation progress of each of the strategy's actions	To monitor changes in the strategy's key measures of success (i.e., population-level outcomes for women and girls)
Characteristics	• Related to actions and processes • Evidence gathering requires extensive primary data collection through stakeholder consultation, supplemented with desktop review	• Related to impacts on patients, services and systems • Evidence gathering relies on secondary data collection, drawing on national and jurisdictional data sources that are publicly and/or readily available
Approach and notes	• Criteria-led assessment, where the implementation of each action is summarised qualitatively and then rated on a standardised rubric scale of 1 to 3	• Individual indicators are mapped to each of the strategy's key measures of success • Indicators are primarily quantitative in nature • In cases where there is no data available to assess certain measures in an ideal way, proxy indicator/s are proposed • The ability to monitor change over time is contingent on the frequency of data releases and is thus variable across indicators

Source: Deloitte Access Economics (2023).

2.3 Implementing the Monitoring and Reporting Framework

This Monitoring and Reporting Framework is intended to be used on an ongoing basis to monitor change over time. The framework will be implemented at the end of 2023 to provide a baseline assessment. A Baseline Report (and a summary scorecard) summarising the findings of this baseline assessment will be delivered mid-2024.

Following this, it is proposed the implementation monitoring component is conducted at semi-regular intervals to track progress and to guide implementation. The outcome monitoring component may be conducted again at the five-year mark and again at the ten-year mark – to coincide with the planned evaluation points proposed within the strategy itself (including the end of the 10-year strategy). When conducting the outcome evaluation, the analysis should be supplemented with extensive stakeholder engagement. Opportunities for this type of engagement are signposted in this document.

2.4 Regular progress reporting to governance groups

Both the Department and the National Women's Advisory Council will be kept informed of the progress of baseline monitoring and reporting through regular projects updates. The Department will be updated on a fortnightly basis as part of routine project management meetings. In addition, the Council will be updated as part of the cadence of regular Council meetings. Both the Department and the Council will have the opportunity to provide guidance and feedback on project processes and outputs as part of these progress updates.

3 Monitoring and reporting on implementation progress

This chapter provides a structured approach for assessing the implementation progress of the strategy.

To assess the strategy's implementation progress, this chapter outlines a series of steps for assessing the extent to which key stakeholders across Australia have implemented activities in alignment with the actions outlined in the strategy. The four key steps are summarised below and detailed in the following sections:

1. identify stakeholder 'implementation partners' for each action articulated in the strategy
2. assess each action's implementation progress by undertaking evidence gathering through stakeholder consultation with the identified implementation partners, supplemented with desktop review
3. for each action, summarise outcomes of the evidence gathering process at a thematic level
4. use the evidence summaries (in step 3) to rate each action on a rubric scale (1 to 3) – these ratings will inform an implementation scorecard that covers all actions in the strategy.

3.1 Step 1: Identify stakeholder implementation partners

Stakeholder implementation partners (i.e., relevant government and non-governmental organisations) were identified for each of the actions articulated in the strategy. Table 3.1 provides a summary of the stakeholders identified for each priority area.

Table 3.1: Summary of implementation partners by relevant priority areas

Stakeholder group	Division/organisation	Priority area 1	Priority area 2	Priority area 3	Priority area 4	Priority area 5	Research
Commonwealth Department of the Prime Minister and Cabinet	Office for Women	✓	✓	✓	✓	✓	✓
Commonwealth Department of Health and Aged Care	Primary and Community Care	✓	✓	✓	✓	✓	
	Population Health	✓	✓	✓	✓	✓	✓
	Cancer, Hearing & Chronic Conditions	✓	✓	✓			✓
	First Nations Health	✓	✓	✓			✓
	Home & Residential		✓	✓			
	Mental Health & Suicide Prevention		✓		✓	✓	✓
	Health Workforce	✓	✓		✓	✓	
Commonwealth Department of Education	Australian Curriculum, Assessment and Reporting Authority (ACARA)	✓		✓	✓		✓
	Improving Student Outcomes				✓	✓	
Commonwealth Department of Social Services			✓				
State and Territory Health Departments	Women's Health or Health Equity Divisions	✓	✓	✓	✓	✓	✓
Public Health Organisations	Australian Cervical Cancer Foundation			✓			
	Bowel Cancer Australia			✓			
	Breast Cancer Australia			✓			

Stakeholder group	Division/organisation	Priority area 1	Priority area 2	Priority area 3	Priority area 4	Priority area 5	Research
	Cancer Australia			✓			✓
	Butterfly Foundation				✓		
	Dementia Australia		✓				
	Mental Health Australia				✓		✓
	Black Dog Institute				✓	✓	
	Aged and Community Services Australia		✓				
	Council of the Aged		✓				
	National Seniors Australia		✓				
	National Aboriginal Community Controlled Health Organisations (NAACHO)	✓	✓	✓	✓	✓	
	Australian Chronic Disease Prevention Alliance		✓	✓			
	Continence Foundation	✓	✓				
	Endometriosis Australia		✓	✓			✓
	Heart Foundation		✓	✓			
	Australian Women's Health Alliance	✓		✓	✓		✓
	National LGBTI Health Alliance			✓	✓		
	Jean Hailes Organisation	✓	✓	✓			✓
	Centre for Perinatal Excellence	✓	✓				
	Multicultural Centre for Women's Health	✓	✓	✓	✓		✓
	Women with Disabilities Australia			✓	✓		✓
	Consumers Health Forum	✓	✓	✓	✓		
	National Rural Women's Coalition	✓	✓	✓	✓	✓	✓
Medical groups and colleges	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)			✓			✓
	Royal Australian and New Zealand College of GP (RACGP)		✓	✓			✓
	Australian Medical Association (AMA)		✓	✓			
	National Health and Medical Research Council (NHMRC)						✓
	Australian Nursing and Midwifery Federation	✓	✓	✓		✓	
	Royal Women's Hospital	✓	✓	✓	✓	✓	
	Pharmaceutical Society of Australia	✓	✓	✓			
Research Institutes	E.g., Hunter Medical Research Institute, University of Melbourne Australian Institute of Health and Welfare (AIHW), Australian			✓	✓		✓

Stakeholder group	Division/organisation	Priority area 1	Priority area 2	Priority area 3	Priority area 4	Priority area 5	Research
	Longitudinal Study on Women's Health (ALSWH), The George Institute for Global Health, Centre for Health Equity, Women's Health Research, Translation and Impact Network						

Source: Deloitte Access Economics (2023).

3.2 Step 2: Undertake evidence gathering

The second step involves evidence gathering to assess each action's implementation progress. The process of evidence gathering involves stakeholder consultation with each of the identified implementation partners (identified in Step 1), with the goal of understanding:

- to what extent are key stakeholders aware of the priority areas and actions within the strategy? and
- to what extent have key stakeholders implemented activities in alignment with the actions?

The stakeholder consultation process will involve engagement with identified implementation partners via semi-structured interviews, small group interviews or focus groups, to be held virtually in most cases. The format will depend on the stakeholder group and the number of actions attributed to them. For example, it may be appropriate to conduct a focus group with research institutes, but individual interviews with divisions of the Department.

Depending on the number of stakeholders identified as implementation partners, it may also be efficient to collect views through a short online survey. Care will be taken to ensure that consultations or surveys are not overly burdensome, to increase participation. Given the low-risk nature of the research, there is no expectation of a Human Research Ethics Committee submission, however activities will be conducted in line with ethical obligations and standards.

Stakeholder consultations will be supplemented with desktop review to identify evidence and case studies that demonstrate implementation progress. The types of secondary sources considered as part of the desktop review are described in Table 3.2 below.

Table 3.2: Secondary data sources considered for understanding implementation of the strategy

Data source	Description and purpose
Academic papers	Academic papers may offer insights into the implementation of different actions.
State or federal budget papers	Budget papers provide insight into the allocation of financial resources and funding priorities related to actions. Commitments to financing serve as a measure of intent and signpost future implementation of programs, services or resources aligned to actions.
Media releases	Media releases can identify potential future developments, initiatives and resources related to the implementation of certain actions.
Organisational annual reports and annual research reports	Annual reports may highlight existing or announced activities or programs that align to the actions in the strategy.

Source: Deloitte Access Economics (2023).

3.3 Step 3: Summarise evidence at a thematic level

This step involves summarising insights collected through the evidence gathering process (Step 2) using a structured process of thematic analysis. Key findings will be summarised qualitatively in a Report. The Report will cover the following for each action:

- the extent to which implementation partners are aware of the strategy and the action
- a profile of what has been achieved/implemented in alignment with the action, including any case studies.

3.4 Step 4: Rate actions and develop scorecard

The final step involves rating each action against a standardised rubric scale of 1 to 3, as outlined in Table 3.3. The evidence summaries from Step 3 will inform the ratings. The scale ranges from 1 (no progress – limited awareness and nothing achieved) to 5 (complete implementation – completed or embedded in business-as-usual activities).

The ratings will inform a summary scorecard – an interactive dashboard with drilldowns for priority area and other variables. Illustrative screenshots of this dashboard are provided in **Error! Reference source not found.**. The Scorecard could also include a sample of headline outcome indicators (from the list of outcome indicators outlined in Chapter 4), if considered appropriate.

Table 3.3: Implementation progress rating scale for each action

Requires stronger focus	Some progress	Meaningful progress
There is minimal progress across priority area, highlighting the need for a more concentrated effort in the future.	There is indication of some progress within this priority area across some, but not all, outlined priority populations or jurisdictions	There is evidence of meaningful progress (including services and investment) aligned to this priority area, sufficiently addressing most relevant priority populations/ actions.

Source: Deloitte Access Economics (2023).

The ratings will inform a summary scorecard – an interactive dashboard with drilldowns for priority area and other variables. Illustrative screenshots of this dashboard are provided in **Error! Reference source not found.**.

The Scorecard developed for the Baseline Report (in PowerBI) is segmented by priority areas. It includes a summary of implementation progress for each action as well as interactive charts of all the outcome indicators outlined in Chapter 4.

4 Monitoring and reporting on outcomes

This chapter outlines a set of key performance indicators for each key measure of success outlined in the strategy.

In the context of the strategy, outcomes (the 'measures of success' in the strategy) relate to the desired results or effects of implementation of the strategy's actions. To monitor change in the strategy's intended outcomes over time, this chapter provides an outcome indicator framework (see Table 4.5 to 0), where each measure of success is mapped to key performance indicators and publicly available data sources.

A summary of the key data sources used to inform the key performance indicators is provided in Table 4.1. Recommended data sources are limited to those that are publicly available and/or readily accessible.

Table 4.1: Key data sources informing outcome indicators

National cross-sectional surveys

Data source	Description
Australian Bureau of Statistics (ABS) National Census	Every 5 years, the national census counts every person and household in Australia and collects socio-demographic information about Australian residents.
ABS National Health Survey	The survey is conducted every 3-4 years and collects information from over 11,000 households about the health and wellbeing of people in Australia and how they use health services and programs.
ABS National Aboriginal and Torres Strait Islander Health Survey	The survey is conducted every 6-8 years and collects information about the health and wellbeing of Indigenous Australians and how they use health services and programs.
ABS National Survey of Mental Health and Wellbeing	This survey measures prevalence of mental disorders among Australians aged 16 to 85 years, surveying more than 5,500 people. This survey is conducted on an irregular basis, typically every 6-7 years.
ABS Personal Safety Survey	This survey information from people over the age of 18 about the nature and extent of violence experienced. The survey is typically conducted every 4 to 5 years. The most recent 2021-22 iteration of the survey surveyed 12,000 people.
ABS Patient Experiences Survey	This survey is conducted annually as a supplement to the monthly Labour Force Survey and collects data from almost 24,000 people aged 15 years and older. The survey aims to assess selected aspects of the health system, including access and barriers to a range of services.

National longitudinal surveys

Data source	Description
Australian Longitudinal Study Women's Health (ALSWH)	A longitudinal, population-based survey that examines the health of more than 57,000 women across four age cohorts for over 20 years. The survey takes a comprehensive view of all aspects of health across a woman's lifespan. DSS provides unit-record survey data files to researchers, on request. The Baseline Report used some key measures from the ALSWH that were not publicly available elsewhere. Future iterations of reporting against the monitoring and reporting framework should consider the incorporation of ALSWH's range of longitudinal datasets with linked health records and data governance protocols.
Household Income Labour Dynamics in Australia (HILDA) survey	Survey that follows 17,000 Australians per year and collects information on various aspects of life in Australia including employment, income, health and education. DSS provides unit-record survey data files to researchers, on request.

National publications and summary statistics from administrative data

Data source	Description
AIHW reports and summary statistics	The AIHW analyses, summarises and publishes statistics from administrative data sources concerning a range of subjects related to health and wellbeing. Relevant publications and reports include: Cancer Screening Program Monitoring Reports, National Perinatal Data Collection Reports, Burden of Disease Reports, hospital and health service use summary statistics from the National Mortality Database and National Admitted Patient Data Collection (among others).
AIHW National Perinatal Data Collection	The National Perinatal Data Collection (NPDC) is a national population-based cross-sectional collection of data on pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory in Australia. Midwives and other birth attendants, using information obtained from mothers and from hospital or other records, complete notification forms for each birth. A standard de-identified extract is provided to the Australian Institute of Health and Welfare (AIHW) on an annual basis to form the NPDC.
National Centre for Immunisation Research and Surveillance (NCIRS) – Annual Immunisation Coverage Reports	The NCIRS produces annual immunisation coverage reports, summarising National Immunisation Program coverage and statistics, key trends and issues.
Kirby Institute – sexually transmissible infection statistics	The National Notifiable Disease Surveillance System routinely collects data on notification rates for chlamydia, gonorrhoea, syphilis, hepatitis B, hepatitis C and the human immunodeficiency virus. The Kirby Institute analyses this data and publishes annual age-standardised notification rates for sexually transmissible infections.
Medicare Benefit Schedule (MBS) / Pharmaceutical Benefits Scheme (PBS) – online statistics	Services Australia publishes MBS and PBS benefit claim statistics for healthcare services, patients and providers.
Australian Institute of Criminology – Homicide in Australia Reports	The National Homicide Monitoring Program is a national data collection tool that collects data on homicide incidents, victims and offenders. The program uses two key data sources including offence records and state coronial records. The Australian Institute of Criminology analyses this data and publishes summary statistics in its annual Homicide in Australia Reports.

Other sources

Data source	Description
Australian Longitudinal Study Women's Health (ALSWH)	A longitudinal, population-based survey that examines the health of more than 57,000 women across four age cohorts for over 20 years. The survey takes a comprehensive view of all aspects of health across a woman's lifespan. DSS provides unit-record survey data files to researchers, on request. The Baseline Report used some key measures from the ALSWH that were not publicly available elsewhere. Future iterations of reporting against the monitoring and reporting framework should consider the incorporation of ALSWH's range of longitudinal datasets with linked health records and data governance protocols.
Household Income Labour Dynamics in Australia (HILDA) survey	Survey that follows 17,000 Australians per year and collects information on various aspects of life in Australia including employment, income, health and education. DSS provides unit-record survey data files to researchers, on request.

Source: Deloitte Access Economics (2023).

4.1 Summary of data availability and quality by outcome area

A full outcome indicator framework is provided in Table 4.5 to 0. A high-level summary of data availability to monitor and track each measure of success is provided in Table 4.3. Overall, high quality data is available to inform indicators related to change in uptake rates or physical health. Data availability is more limited for the assessment of indicators related to change in access rates (e.g., to what extent is someone in need of a service able to access that service?) and attitudinal shifts (e.g., de-stigmatisation of urinary and faecal incontinence). In cases where ideal data types are unavailable, proxy indicators are proposed. Many of the areas where data gaps exist could be addressed by including additional questions in national survey instruments (e.g., ALSWH). Opportunities to address the key data gaps are described further in Section 4.7.

Table 4.2: Rating scale of data quality for each key measure of measure

Definition	Data availability	Data frequency/timeliness	Priority group disaggregation
Low	No data available	Data reporting is highly irregular	Data does not disaggregate into priority groups
Medium	Partial data available, typically relies on proxy indicators	The frequency or lag of data release or reporting is more than 3 years	Data disaggregates by 1 to 3 key priority groups*
High	Ideal data available	The frequency and lag of data release or reporting is 3 years or less	Data disaggregates by 4 or more key priority groups*

Source: Deloitte Access Economics (2023).

Note: *These ratings assume access to more granular data records for ABS' cross-sectional surveys (e.g., TableBuilder or microdata).

Table 4.3: Summary of data quality by each key measure of success

Priority area 1 - Maternal, sexual and reproductive health

Outcome	Data availability	Data frequency/ timeliness	Priority group disaggregation
Decrease in the notification rates of sexually transmissible infections for priority populations	High	High	High
Increase in the availability and uptake of Long Acting Reversible Contraception (LARCs)	High	High	Medium
Equitable access to pregnancy termination services	Medium	Medium	Medium
A continued increase in the rate of vaccinations under the National HPV Program	Medium	High	High
Increased early access to antenatal services by Aboriginal and Torres Strait Islander women and culturally and linguistically diverse women	High	Medium	Medium
De-stigmatisation of urinary and faecal incontinence and improved access for women to care for these conditions, including pelvic floor physiotherapy	Medium	Low	Low
Improved access to counselling and care of adult women with sexual function concerns	Low	Medium	Low

Priority area 2 – Healthy ageing

Outcome	Data availability	Data frequency/ timeliness	Priority group disaggregation
Reduction in the number of preventable and avoidable deaths	High	High	Medium
Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease	Medium	High	Medium
Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity	High	Medium	Medium

Priority area 3 – Chronic conditions and preventive health

Outcome	Data availability	Data frequency/ timeliness	Priority group disaggregation
Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women.	Medium	Medium	Medium
Lower incidence of cancers	Medium	High	Medium
Improved rates of breast, cervical and bowel cancer screening for under-screened populations including women from Aboriginal and Torres Strait Islander, culturally and linguistically diverse rural and remote and LBTI communities	High	High	Medium
Decrease in prevalence of chronic conditions in women	High	High	Medium
Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and managing these conditions.	Medium	High	Medium

Priority area 4 – Mental health

Outcome	Data availability	Data frequency/ timeliness	Priority group disaggregation
Reduction in the number of preventable and avoidable deaths	High	High	High
Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease	High	High	Medium
Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity	High	High	Low

Priority area 5 – Health impacts of violence against women and girls

Outcome	Data availability	Data frequency/ timeliness	Priority group disaggregation
Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women	Medium	Low	Medium
Lower incidence of cancers	High	High	Medium
Improved rates of breast, cervical and bowel cancer screening for under-screened populations including women from Aboriginal and Torres Strait Islander, culturally and linguistically diverse rural and remote and LBTI communities	High	Medium	Medium
Decrease in prevalence of chronic conditions in women	Medium	Low	Low
Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and managing these conditions	High	Medium	Low

Source: Deloitte Access Economics (2023).

Measuring outcome progress

Identified indicators were analysed at an aggregate outcome level over the last five- or 10-year period depending on the most recent data publication and data availability. Below is the assessment framework used to measure progress in the trend of the outcome.

Table 4.4: Assessment framework used to measure progress in the trend of each outcome

Outcome rating	Definition
Positive trend	There is a pronounced trend, either upward or downward, which is consistent with the specified direction in the measure of success.
No trend	There is a weak or inconclusive trend for the indicator (no clear upward or downward direction).
Negative trend	There is a pronounced trend, either upward or downward, which is inconsistent with the specified direction in the measure of success.
Insufficient data	There is insufficient data available to determine the trend.

4.2 Priority area 1 – Maternal, sexual and reproductive health

4.2.1 Measure of success 1.1 – Decrease in the notification rates of sexually transmissible infections for priority populations

The National Notifiable Disease Surveillance System (routinely collects data on notification rates for chlamydia, gonorrhoea, syphilis, hepatitis B, hepatitis C and the human immunodeficiency virus. The Kirby Institute analyses this data and publishes annual age-standardised notification rates for sexually transmissible infections, with disaggregations for Aboriginal and Torres Strait Islander status, remoteness and whether a person is transgender.

Table 4.5: Measure of success 1.1 – indicators, data sources and data considerations

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
1.1.1	Age-standardised notification rate of STIs per 100,000 women by disease, including: • chlamydia • gonorrhoea • syphilis • hepatitis B • hepatitis C HIV	Kirby Institute	Last year of available data: 2022 Frequency: annual Publication lag: 2 years Data on chlamydia is only available for ACT, NT, SA and WA. Data on hepatitis B and C is only available for ACT, NT, Qld, SA, Tas, and WA.	Aboriginal and Torres Strait Islander Remoteness
1.1.2	Age standardised notifications of STIs per 100,000 women, by priority group	Kirby Institute	As above	As above
1.1.3	Age standardised notifications of STIs per 100,000 women, by Jurisdiction	National Notifiable Disease Surveillance Dashboard	Last year of available data: 2024 Frequency: monthly Publication lag: <6 months	Jurisdiction

4.2.2 Measure of success 1.2 – Increase in the availability and uptake of Long Acting Reversible Contraception

Long-acting reversible contraception (LARC) is defined as a contraceptive method administered less frequently than monthly.[i] It includes the copper intrauterine device (IUD), levonorgestrel IUD, subdermal etonogestrel implant and medroxyprogesterone injection. There is limited data available to inform an assessment of the availability of IUD contraception (e.g., data on the number of GPs that are trained in IUD insertion), however estimates of per capita uptake rates can be generated by analysing relevant questions in the ALSWH.

Priority group disaggregation is unavailable for the first two sources below. Indicator 1.2.3. was used in the baseline report to depict LARC prescribing disaggregated by regionality for 2018, 2019, 2020 and 2021. Future monitoring reports will be unable to show the trend in this disaggregation as this is from a singular study.

Table 4.6: Measure of success 1.2 – indicators, data sources and data considerations

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
1.2.1	Percentage of women who report using contraception, by type (born between 1989 and 1995)	Australian Longitudinal Study Women's Health	Last year of available data: 2020 Frequency: Every 5 years Publication lag: 1-2 years	Unavailable
1.2.2.	Number of prescriptions dispensed for LARCs for all patient types per 100,000 women	Prescriptions of Mirena & Implanon & Kyleena from PBS online statistics codes 8633J (Mirena), 8487Q (Implanon NXT), 11909T (Kyleena); Population data from ABS Estimated Resident Population data (using June of every year)	Last year of available data: 2023 Frequency: annual Publication lag: 1 year	Unavailable
1.2.3.	Proportion of LARC prescribing by nurse practitioners and midwives	James, S., Kunnel, A., Tomnay, J., Mazza, D., & Grzeskowiak, L. (2023).[ii]	One-off study from 2023	Remoteness

4.2.3 Measure of success 1.3 – Equitable access to pregnancy termination services

The ideal way to assess equity in access to termination services is to understand the proportion of females seeking termination services who were able to access a service (i.e., met demand), however no data sources provide information on this indicator. Per capita utilisation rates by priority population can proxy equity in access to termination services, with the caveat that this indicator does not account for any variation in demand rates by priority populations. Estimates of per capita utilisation rates can be generated by analysing relevant questions in the ALSWH. Some jurisdictions (South Australia and Western Australia) publish utilisation rates on an ad hoc basis which can be used for data triangulation.

Table 4.7: Measure of success 1.3 – indicators, data sources and data considerations

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
1.3.1	Percentage of women who have ever reported pregnancy	Australian Longitudinal Study Women's Health	Last year of available data: 2020 Frequency: Triennial Publication lag: 1-2 years	Unavailable
1.3.2	Number of medical termination of pregnancy services per 100,000 women	PBS online statistics	Last year of available data: 2023 Frequency: annual Publication lag: 1 year	Unavailable
1.3.3	Pregnancy termination rate per 1,000 women per year in Western Australia	Western Australia Department of Health – Western Australian Abortion Notification System	Last year of available data 2018 Frequency: annual Publication lag: 1 year	Remoteness First Nations

4.2.4 Measure of success 1.4 – A continued increase in the rate of vaccinations under the National HPV Program

Vaccinations under the National HPV Vaccination Program is collected via the Australian Immunisation Register (AIR). Prior to 2019, this data was collected via the National Human Papillomavirus Vaccination Program Register (HPV Register). Statistics on National HPV vaccination rates are regularly reported by the National Centre for immunisation Research and Surveillance.

Table 4.8: Measure of success 1.4 – indicators, data sources and data considerations

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
1.4.1	Percentage of female adolescents meeting a full-dose HPV (2-dose) immunisation by age 15	Australian Immunisation Register (AIR) from National Centre for Immunisation Research and Surveillance annual report	Last year of available data 2022 Frequency: annual Publication lag: 1-2 years	Aboriginal and Torres Strait Islander (post 2020) Remoteness (post 2020)

4.2.5 Measure of success 1.5 – Increased early access to antenatal services by Aboriginal and Torres Strait Islander women and culturally and linguistically diverse women

Early access to antenatal services is defined as: use of an antenatal service within the first trimester of pregnancy.[iii,iv] Research shows that Aboriginal and Torres Strait Islander and CALD women face unique barriers in accessing antenatal services.[v,vi] The AIHW's National Perinatal Data Collection (NPDC) regularly collects data on access to antenatal services. This data is published on an annual basis with disaggregations for priority populations.

Table 4.9: Measure of success 1.5 – indicators, data sources and data consideration

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
1.5.1	Percentage of women accessing antenatal care before 20 weeks pregnancy	AIHW- National Perinatal Data collection reports	Last year of available data 2020 Frequency: annual Publication lag: 2 years	Aboriginal and Torres Strait Islander CALD (Born overseas)
1.5.1	Percentage distribution of women who gave birth by number of antenatal visits	AIHW – National Perinatal Data Collection Reports	As above	Unavailable

4.2.6 Measure of success 1.6 – De-stigmatisation of urinary and faecal incontinence and improved access for women to care for these conditions, including pelvic floor physiotherapy

Societal attitudinal shifts such as de-stigmatisation of urinary and faecal incontinence are ideally measured through a national survey that collects information on people's experiences. The Continence in Australia Snapshot published in 2019 by the Continence Foundation of Australia contains relevant data, however this was a one-off survey.

In addition, there is limited data available to provide a measure on access to continence care, which covers a range of services including pelvic floor physiotherapy, surgery procedures, medication, and consumer products. While physiotherapy utilisation rates can be obtained through MBS claim data, there is no specific MBS item for pelvic floor physiotherapy.

Table 4.10: Measure of success 1.6 – indicators, data sources and data considerations

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
1.6.1	Percentage of adult women who experience stigma related to incontinence	Continence Foundation of Australia - Continence in Australia Snapshot	Last year of available data 2019 Frequency: one-off/irregular Publication lag: unclear	Unavailable

4.2.7 Measure of success 1.7 – Improved access to counselling and care of adult women with sexual function concerns

Sexual function is the ability to experience sexual pleasure and satisfaction when desired.[vii] As with other access indicators, the ideal way to assess change in access to counselling and care of adult women with sexual function concerns is to understand the proportion of women seeking access to this care who received it (i.e., met demand), however no data sources provide information on this indicator. Access can be proxied by per capita utilisation rates of sexual and reproductive health consultations using MBS claim data. However, this data is not fully representative of utilisation of counselling and care services for sexual health concerns, as MBS claim data for some services (e.g., psychology) cannot be disaggregated by type of concern.

Table 4.11: Measure of success 1.7 – indicators, data sources and data considerations

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
1.7.1	Rate of sexual health medicine attendances per 100,000 women	Medicare Australia online statistics	Last year of available data 2023 Frequency: quarterly Publication lag: no lag	Unavailable

4.3 Priority area 2 – Healthy ageing

4.3.1 Measure of success 2.1 – Reduction in the number of preventable and avoidable deaths

The number of preventable and avoidable deaths is routinely collected by the AIHW's National Mortality Database (NMDB). Potentially avoidable deaths are defined as causes of death that can be avoided through timely and effective public health care and primary prevention interventions.[viii] The strategy highlights Alzheimer's disease, dementia, and cardiovascular disease as the leading contributors to premature mortality in women.[ix] The AIHW provides annual reports on age-standardised death rates of avoidable deaths for women, with disaggregations for key priority groups.

Table 4.12: Measure of success 2.1 – Reduction in number of preventable and avoidable deaths

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
2.1.1	Age-standardised death rate of potentially avoidable deaths among women aged less than 75 per 100,000 people	AIHW – Deaths in Australia	Last published: 2021 Frequency: annual Publication lag: 2 years	Aboriginal and Torres Strait Islander (up till 2019)
2.1.2	Leading underlying causes of death, number and age-standardised death rates (deaths per 100,000 women)	AIHW- Deaths in Australia	Last published: 2021 Frequency: NA Publication lag: 1 years	Unavailable

4.3.2 Measure of success 2.2 – Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease

Cardiovascular disease (CVD) and dementia are both complex conditions with significant overlapping comorbidities and risk factors, including hypertension, diabetes, high cholesterol, obesity, alcohol use and physical inactivity.

'Heart Health Checks' is a screening service for CVD risk factors conducted by a GP or specialist physicians in adults aged 45+ years, Indigenous peoples aged 30+ years and those with diabetes aged 30+ years. MBS claim data for Heart Health Checks items thus provides an indicator of screening for common risk factors. In addition, measures related to use of GP services provide a proxy indicator of screening for common conditions, given a GP will typically screen for risk factors of common chronic conditions.

Table 4.13: Measure of success 2.2 – Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
2.2.1	Rate of Heart Health Checks per 100,000 women eligible for a heart health check	MBS online statistics	Last year of available data: 2023 Frequency: Monthly Publication lag: 1 month	Unavailable
2.2.2	Rate of health assessment for people aged 75 years and older per 100,000 eligible women	MBS online statistics	Last year of available data: 2023 Frequency: Monthly Publication lag: 1 month	Unavailable
2.2.3	Rate of GP visits per 100 women in the past 12 months	AIHW – Medicare-subsidised GP, allied health and specialist health care	Last year of available data: 2022-23 Frequency: annually Publication lag: 1 year	Remoteness SES
2.2.4	Percentage of adult women who saw a GP for chronic disease management in the past 12 months	AIHW – Medicare-subsidised GP, allied health and specialist health care	Last year of available data: 2022-23 Frequency: annually Publication lag: 1 year	Remoteness SES

4.3.3 Measure of success 2.3 – Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity

The WHO's Global Action Plan on Physical Activity outlines a target to reduce the global prevalence of physical inactivity in adults and adolescents by 10% in 2025 and 15% by 2030, from a baseline year of 2016.[x] Insufficient physical activity for both genders is defined as:

- for children aged 2-17: not completing 60 minutes per day of physical activity daily.
- for adults aged 18–64: not completing 150 minutes of moderate to vigorous activity across 5 or more days a week.
- for adults aged 65 and over: not completing 30 minutes or more of physical activity on at least 5 days each week.[x]

The ABS' National Health Survey routinely collects data on physical activity in line with these guidelines. This survey data is released by the ABS every two years.

Table 4.14: Measure of success 2.3 – Increase in the proportion of women and girls meeting the physical activity guidelines in line with the WHO Global Action Plan on Physical Activity

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
2.3.1	Percentage of women who meet the criteria for 'sufficient physical activity'	AIHW- Physical Activity	Last year of available data 2020-21 (for 2017-18 for priority groups) Frequency: 3 years Publication lag: 2 years	Age Remoteness SES

4.4 Priority area 3 – Chronic conditions and preventive health

4.4.1 Measure of success 3.1 – Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women.

The prevalence of chronic conditions and common risk factors (e.g., physical activity and nutrition) is routinely collected through national surveys, such as the ABS' National Health Survey and the National Aboriginal and Torres Strait Islander Health Survey, however some questions are not repeated in every survey iteration (e.g., physical measurements were not collected in 2021-22). The ABS regularly publishes summary statistics from these surveys. HILDA and the ALSWH also collect data on the physical health and health behaviours of their surveyed populations, which can be used for triangulation and to address gaps in the AHS.

Table 4.15: Measure of success 3.1 – Reductions in the prevalence of obesity, tobacco use, alcohol consumption, increased physical activity and improved eating behaviours for women

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
3.1.1	Percentage of adults women (18+) living with overweight or obesity	AIHW Overweight and Obesity data tables, ABS National Health Survey National Aboriginal and Torres Strait Islander Health Survey	Last year of available data 2022 Frequency: 3 years Publication lag: 2 years Last year of available data 2019 Frequency: Every 6 years Publication lag: 4 years	Aboriginal and Torres Strait Islander
3.1.2	Percentage of adult women (18+) who are daily smokers	ABS National Health Survey National Aboriginal and Torres Strait Islander Health Survey	Last year of available data 2022 Frequency: biannual Publication lag: 2 years Last year of available data: 2019 Frequency: annually Publication lag: 4 years	Aboriginal and Torres Strait Islander
3.1.3	Percentage of women who engage in risky drinking behaviour	National Drug Strategy Household Survey 2010-2022-2023 National Aboriginal and Torres Strait Islander Health Survey	Last year of available data: 2023 Frequency: 2-3 years Publication lag: 2 years Last published: 2019 Frequency: every 6 years Publication lag: 4 years	Aboriginal and Torres Strait Islander
3.1.4	Percentage of women who meet the criteria for insufficient physical activity (AIHW)	AIHW Physical Activity Tables	Last year of available data 2018 Frequency: 2-3 years Publication lag: 5 years	SES
3.1.5	Percentage of women that meet both fruit and vegetable intake guidelines (2013 NHMRC Guidelines)	ABS National Health Survey National Aboriginal and Torres Strait Islander Health Survey	Last year of available data: 2022 Frequency: biannual Publication lag: 2 years Last year of available data: 2019 Frequency: Every 6 years Publication lag: 4 years	Aboriginal and Torres Strait Islander

Note: The HILDA survey and ALSWH provide alternative data source for all indicators listed in this table.

4.4.2 Measure of success 3.2 – Lower incidence of cancers

The Australian Cancer Database (ACD) routinely collects data on new cases of cancer diagnosed in all states and territories. Summary statistics from the ACD such as age-standardised incidence rates are published by the AIHW on an annual basis.

Table 4.16: Measure of success 3.2 – Lower incidence of cancers

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
3.2.1	Age-standardised incidence rate of cancer per 100,000 women, and by cancer type • Breast • Cervical • Colon • Gynaecological • Ovarian	AIHW - Cancer in Australia	Last year of available data: 2023 Frequency: annual Publication lag: 1 years	Unavailable

Note: Data for Indigenous populations is limited to NSW, VIC, QLD, WA and NT

4.4.3 Measure of success 3.3 – Improved rates of breast, cervical and bowel cancer screening for under-screened populations including women from Aboriginal and Torres Strait Islander, culturally and linguistically diverse rural and remote and LBTI communities

The Department currently administers three national cancer screening programs:

- BreastScreen Australia – women aged 50-74 years are invited for a screening mammogram every two years.[xi]
- National Cervical Screening Program (NCSP) – women aged 25- 74 years are invited to have a cervical screening test every five years.[xii]
- National Bowel Cancer Screening Program (NBCSP) – women aged 50-74 years are invited to participate in bowel screening every two years.[xiii]

Participation data for the NCSP and NBCSP is routinely collected by the National Cancer Screening Register, while BreastScreen collects participation data through state and territory registries. AIHW produces summary statistics on program participation rates on a six-monthly basis as part of its Cancer Screening Program Monitoring Reports.

Note that participation in national cancer screening programs is not the only form of cancer screening available to women. For example, some women may screen for bowel cancer by using an over-the-counter immunochemical faecal occult blood test (iFOBT) or colonoscopy. However, there is limited data available to reliably measure participation in these alternative forms of screening.

Table 4.17: Measure of success 3.3 – Improved rates of breast, cervical and bowel cancer screening for under-screened populations

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
3.3.1	Proportion of eligible female population who participated in BreastScreen Program	AIHW – BreastScreen Monitoring Reports	Last year of available data: 2020-21 Frequency: 6 months Publication lag: 3 years	Aboriginal and Torres Strait Islander SES Remoteness CALD
3.3.2	Proportion of eligible female population who participated in NCSP Program	AIHW – NCSP Monitoring Reports	Last year of available data: 2018-22 Frequency: 6 months Publication lag: 2 years Since 2018, the data has been published in increments starting from 2018.	SES Remoteness
3.3.3	Proportion of eligible female population who participated in NBCSP	AIHW – NBCSP Monitoring Reports	Last year of available data: 2020-21 Frequency: annually Publication lag: 2 years	SES Remoteness CALD

4.4.4 Measure of success 3.4 - Decrease in prevalence of chronic conditions in women

The ABS National Health Surveys routinely collects data on the prevalence of common chronic conditions, such as: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, chronic kidney disease, mental health conditions and osteoporosis. The AHS also collects data on the prevalence of multimorbidity (two or more conditions), which is commonly associated with chronic conditions.

Table 4.18: Measure of success 3.4 - Decrease in prevalence of chronic conditions in women

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
3.4.1	Prevalence of self-reported chronic conditions, across top 10 chronic conditions	ABS National Health Survey	Last year of available data: 2021-22 Frequency: 3 years Publication lag: 2 years	Unavailable
3.4.2	Proportion of women living with a chronic condition, by number of selected conditions	ABS National Health Survey	As above	Unavailable

4.4.5 Measure of success 3.5 – Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and managing these conditions.

The identification and detection of hidden conditions such as endometriosis is difficult to measure, as there is no national estimate of undiagnosed cases. Measuring change in endometriosis prevalence provides a proxy, with the caveat that any observed increase may reflect a growing proportion of women with endometriosis rather than increased rates of detection.

The following two key data sources provide measures of endometriosis prevalence:

1. The ALSWH collects data on the number of women who have experienced endometriosis.
2. The NHMD collects data on endometriosis related hospitalisations. The AIHW publishes summary statistics from this database, including the rate of endometriosis per 100,000 females and length of stay by population group.[xiv]

The treatment and management of endometriosis is also difficult to measure given the current state of research into the condition and high self-management rates.[xv] Indicator 3.5.3. was used in the baseline report to present the diagnosis time for endometriosis and chronic pelvic pain in 2020. Future monitoring reports will be unable to show the trend in these measures as this is from a singular study.

Table 4.19: Measure of success 3.5 – Better identification and detection of hidden conditions such as endometriosis and associated chronic pelvic pain, and improved mechanisms for treating and managing these conditions.

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
3.5.1	Percentage of women who have experienced endometriosis at some point during their lifetime	Australian Longitudinal Study Women's Health	Last year of available data: 2020 Frequency: triennial Publication lag: 1-2 years	Unavailable
3.5.2	Age-standardised rate of hospitalisations per 100,000 women with diagnosis of endometriosis	AIHW – Endometriosis in Australia: Prevalence and Hospitalisations	Last year of available data: 2021-22 Frequency: annually Publication lag: 2 years	Aboriginal and Torres Strait Islander SES Remoteness
3.5.3	Change in time from onset of symptoms to diagnosis and year of first presentation and diagnosis of endometriosis	Armour (2020)[xvi]	One-off study from 2020	Unavailable
3.5.4	Proportion of women who have been diagnosed or treated with endometriosis, by year first diagnosed	Australian Longitudinal Study Women's Health	Last year of available data: 2020 Frequency: triennial Publication lag: 1-2 years	Unavailable

4.5 Priority area 4 – Mental health

4.5.1 Measure of success 4.1 – Lower incidents of mental health reporting, self-harm and suicide.

For the purpose of this measure, mental health incidents are defined as serious or critical mental health incidents such as anxiety attacks, psychotic episodes and threats of self-harm and suicide (measure of success 2 below includes reporting of less severe mental health incidents).

ABS' National Heath Survey collects data the proportion of women who have ever self-harmed, informed by self-reports. In addition, the AIHW's Suicide and Self-harm Monitoring Project regularly publishes data on the incidence of suicide and self-harm by collating and analysing data following data administrative sources:

- incidence and prevalence of death by suicide from ABS Causes of Death or state-based suicide registers
- ambulance attendances of suicidal and self-harm behaviours from the National Ambulance Surveillance System (NASS)
- intentional self-harm hospitalisations from the NHMD.

Table 4.20: Measure of success 4.1 – Lower incidents of mental health reporting, self-harm and suicide

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
4.1.1	Percentage of women who have ever self-harmed	ABS – National Study of Mental Health and Wellbeing	Last year of available data: 2020-22 Frequency: 3 years Publication lag: 2 years	Unavailable
4.1.2	Suicide rate per 100,000 women	ABS – Causes of Death, Australia	Last year of available data: 2022 Frequency: annual Publication lag: 1 year	Aboriginal and Torres Strait Islander Remoteness
4.1.3	Rate of ambulance attendances due to suicidal ideation and self-harming behaviours per 100,000 women	AIHW – Suicide & self-harm monitoring data: Deaths by suicide in Australia	Last year of available data: 2020 Frequency: annual Publication lag: 2-3 years	Unavailable

4.5.2 Measure of success 4.2 – A reduction in mental health related illness

Estimates of the prevalence mental health related illness can be drawn from three sources: the National Survey of Mental Health and Wellbeing (NSMHW), the National Health Survey and the ABS National Census. The NSMHW, conducted in 2020-21 and previously in 2007, is the preferred data source for measuring the prevalence of mental health-related illnesses as it draws on diagnostic criteria, rather than self-reporting. The ABS regularly provides summary statistics from the NSMHW. Data sources that draw on self-report, such as the ABS' National Census and the National Health Survey should use be used as supplementary data sources for more frequent estimates.

Table 4.21: Measure of success 4.2 – A reduction in mental health related illness

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
4.2.1	Percentage of woman diagnosed with a mental health condition, including: • Panic Disorder • Agoraphobia • Social Phobia • Generalised Anxiety Disorder • Obsessive-Compulsive Disorder • Post-Traumatic Stress Disorder • Affective disorders • Depressive Episode • Dysthymia • Bipolar Affective Disorder • Substance Use disorders • Alcohol Harmful Use • Alcohol Dependence and Drug Use Disorders.	AIHW analysis of Household, Income and Labour Dynamics in Australia (HILDA) Survey (Wave 21) data from University of Melbourne (2021) 'Household, Income and Labour Dynamics in Australia Survey', University of Melbourne. National Study of Mental Health and Wellbeing 2020–2022	Last year of available data: 2020-22 Frequency: annual Publication lag: 1-2 years	Unavailable
4.2.1	Percentage of women with a reported mental health illness	As above	Last year of available data: 2020-22 Frequency: annual Publication lag: 1-2 years	Unavailable

4.5.3 Measure of success 4.3 – Increase in the number of mental health services and the ability for priority populations to access these

There is no direct measure of the number of mental health services available across Australia by type, location or target population, however ABS' Patient Experiences survey collects annual data on the proportion of women (in different priority populations) who needed to access a mental health provider who were able to access a mental health provider, and if not, why not (with 'service not available when required' provided as one option).

In addition, the AIHW regularly reports on utilisation of mental health-related services including Medicare-subsidised mental health-related services (psychiatrists, GPs, psychologists, and other allied health services), mental health-related prescriptions (under the PBS and RPB scheme), public sector community mental health care service contacts (such as Lifeline or Kids Helpline), emergency department services (public hospitals), overnight admitted patient hospitalisations and same day admitted patient hospitalisations. However, priority group disaggregations are limited.

Table 4.22: Measure of success 4.3 – Increase in the number of mental health services and the ability for priority populations to access these

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
4.3.1	Percentage of women aged 15 or above who did not see any mental healthcare providers but needed to in the last 12 months	ABS – Patient Experiences Survey	Last year of available data: 2022-23 Frequency: annual Publication lag: 1-2 years	Age
4.3.2	Percentage of women who have accessed mental health services via digital technologies	ABS, National Study of Mental Health and Wellbeing	Last year of available data: 2020-22 Frequency: Infrequent Publication lag: 2 years	Age
4.3.3	Rate of MBS mental health services per 100,000 women	AIHW – Mental health services activity monitoring: quarterly data	Last year of available data: 2021-22 Frequency: quarterly Publication lag: 6 months	Unavailable
4.3.4	Rate of crisis support- aggregate lifeline and kids helpline contact	AIHW – Mental health services activity monitoring: quarterly data	Last year of available data: 2023 Frequency: quarterly Publication lag: 6 months	Unavailable

4.5.4 Measure of success 4.4 – Greater integration of mental and physical health care

Service integration refers to the "processes, methods and tools" facilitating integrated care, which involves the coordination of services to achieve improved patient care.[xvii] It is challenging to measure greater integration of mental and physical care through secondary datasets. It is suggested that evidence to address this measure of success is assessed qualitatively through stakeholder consultation or desktop review to identify shifts toward innovative models of integrated mental healthcare.

4.6 Priority area 5 – Health impacts of violence against women and girls

4.6.1 Measure of success 5.1 – Increase in number of services available, and women accessing these services

Family, domestic and sexual violence services may include specialist FDSV services, emergency departments and primary healthcare providers. There is no direct measure of the number of FDSV services that exist across Australia, however the AIHW regularly reports on the percentage of women who sought advice or support after their most recent incident of physical and/or sexual violence in the last 10 years, based on responses to ABS' Personal Safety Survey (PSS). These responses may be informal, and may be taken by victims, perpetrators and others.

Table 4.23: Measure of success 5.1 - Increase in number of services available, and women accessing these services

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
5.1.1	Percentage of women who sought help after most recent incident of family and domestic violence	ABS – Personal Safety Survey, AIHW	Last year of available data: 2016 Frequency: typically 4 years Publication lag: 1-2 years	Unavailable
5.1.1	Sources of advice or support received by female victims (given advice or support was sought) after the most recent incident of family and domestic violence	As above	As above	Unavailable
5.1.2	Number of women who called a family violence hotline by gender between 2019-20 and 2020-21	AIHW- Family, domestic and sexual violence data in Australia	Last year of available data: 2020-21 Frequency: yearly Publication lag: 2 years	Unavailable

4.6.2 Measure of success 5.2 – Decrease in deaths from physical violence on women

The Australian Institute of Criminology regularly collects, summarises, and publishes data on physical violence related incidents through its Australian Institute of Criminology National Homicide Monitoring Program. This data is based on information on homicides from police records and coronial records. It indicates the number and rate of domestic homicide incidents and intimate partner homicides over time, with domestic homicide incidents including intimate partner violence as one of five sub-classifications.

In addition, the AIHW's Australian Burden of Disease Study occasionally provides estimates of the total burden of disease attributable to intimate partner violence, however this data point was not reported in the most recent iteration of the Burden of Disease Study in 2022.

Table 4.24: Measure of success 5.2 – Decrease in deaths from physical violence on women

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
5.2.1	Number of deaths attributed to intimate partner homicide per 100,000 women	Australian Institute of Criminology – Homicide in Australia	Last year of available data: 2020-21 Frequency: yearly Publication lag: 2 years	
5.2.2	Total number of homicides of Indigenous women aged 16 years or older from 2004-21	Australian Institute of Criminology – Homicide in Australia	Last year of available data: 2020-21 Frequency: yearly Publication lag: 2 years	Aboriginal and Torres Strait Islander

4.6.3 Measure of success 5.3 – Reduction in the proportion of women who have experienced abuse or trauma in their life

The ABS' PSS regularly collects information from persons aged 18 years and over about the nature and extent of their experiences of violence, including: intimate partner (current, previous or cohabiting) or family member violence; physical violence; and sexual violence (threat and/or sexual assault). The ABS regularly provides summary statistics on the prevalence of these incidents.

Table 4.25: Measure of success 5.3 – Reduction in the proportion of women who have experienced abuse or trauma in their life

#	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
5.3.1	Proportion of women who experienced intimate partner violence in last 12 months	ABS – Personal Safety Survey	Last year of available data: 2021-22 Frequency: typically 4 years Publication lag: 1-2 years	Unavailable
5.3.2	Proportion of women who experienced cohabitating partner violence in last 12 months	ABS – Personal Safety Survey	As above	Unavailable
5.3.3	Proportion of women who experienced sexual violence in last 12 months	ABS – Personal Safety Survey	As above	Unavailable
5.3.4	Proportion of women who experienced sexual harassment in last 12 months	ABS – Personal Safety Survey	As above	Unavailable

4.6.4 Measure of success 5.4 – Reduction in the rate of reproductive coercion

Reproductive coercion is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.[xviii] Reproductive coercion includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making. This can take a variety of forms, for example sabotage of another person's contraception, or pressuring another person into pregnancy.

Data on incidence of reproductive coercion is currently not collected by any national survey instruments or other data sources.[xix] Currently there are only emerging insights from small studies in Australia, as reproductive coercion is a relatively new yet rapidly evolving concept. Indicator 5.4.1. was used in the baseline report to present some of these emerging insights in 2014 and 2019. Future monitoring reports will be unable to show trends in this data as it is from singular studies.

Table 4.26: Measure of success 5.4 – Reduction in the rate of reproductive coercion

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
5.4.1	Proxy measurements to the rate of reproductive coercion experienced by women and girls	De Visser, R.O et al., (2014) and Fisher, C. M. et al. (2019).	One-off studies from 2014 and 2019	Unavailable

4.6.5 Measure of success 5.5 – Reduction in the gap in mental and physical health trajectories between women who have and have not experienced violence

The ALSWH collects data on a variety of variables that can be used to assess the gap in mental health trajectories between women who have and have not experienced violence, including:

- Women's experiences of FDSV at any point in their lifetime
- Women's engagement in behaviours that may affect their physical and mental health (e.g., smoking, alcohol consumption, illicit drug use, physical activity, obesity, and health screening) as well as measures of health outcomes (e.g., general health and wellbeing, bodily pain, sexually transmitted infections, depression, anxiety, stress, and psychological distress).

These variables can be cross-tabulated to understand the gap in mental and physical health trajectories between women who have and have not experienced violence.

Indicator 5.5.3. was used in the baseline report to present health risk behaviours for young people who have and have not experienced child maltreatment. Future monitoring reports will be unable to show the trend in this measure as this is from a singular study.

Table 4.27: Measure of success 5.5 – Reduction in the gap in mental and physical health trajectories between women who have and have not experienced violence

	Indicator	Data source	Data timeliness and other considerations	Priority group disaggregation
5.5.1	Difference in percentage of women (born between 1973-78) who have and have not experienced violence by mental health behaviours: • Anxiety • Depression • Self-harm	Australian Longitudinal Study Women's Health	Last year of available data: 2019 Frequency: 2-7 years Publication lag: 1-2 years	Unavailable
5.5.2	Difference in percentage of women (born between 1973-78) who have and have not experienced FDSV engaging in the following health-related behaviours (examples only): • Smoking • High risk drinker • Miscarriage	Australian Longitudinal Study Women's Health	Last year of available data: 2019 Frequency: 2 – 7 years Publication lag: 1-2 years	Unavailable
5.5.3	Percentage of women who have and have not experienced child maltreatment and mental and physical health risk behaviours throughout life • Binge drink • Smoking • Obesity • Suicide • Self-harm • Cannabis	Australian Child Maltreatment Study	One-off study from 2023	Unavailable

4.7 Recommendations to address data gaps

Of the 24 measures of success across the five priority areas, there is ideal data available to assess more than half of the measures. Proxy indicators are available for almost all other measures, expect for two measures where no relevant routinely collected secondary data was identified. The priority area with the most complete data is Priority area 3 – Chronic condition and preventive health.

The key outcome areas with data gaps relate to:

Indicators related to access rates (i.e., to what extent is someone in need of a service able to access that service?):

- Equitable access to pregnancy termination services
- Increase in number of services available (to address health impacts of violence against women and girls), and women accessing these services
- Increased screening for a wider spread of comorbidities, inclusive for dementia and cardiovascular disease.

Indicators related to attitudinal shifts:

- De-stigmatisation of urinary and faecal incontinence and improved access for women to care for these conditions, including pelvic floor physiotherapy.

Other indicators:

- Greater integration of mental and physical health care
- Reduction in the rate of reproductive coercion.

Where data gaps exist for indicators related to access rates or and attitudinal shifts, these could be addressed by including additional questions in the ALSWH or other health-related national survey instruments. To assess the prevalence of reproductive coercion, the Personal Safety

Survey could consider including additional targeted items related to coercive control. Greater integration of mental and physical health care requires systems-level change. Qualitative assessment informed through consultation with industry stakeholders is likely to provide the best indicator of the extent to which this change is occurring.

Endnotes

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