



Priorities for Victorian women's health 2014–2018

Developed by
Victorian women's health services

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1. Introduction

Clear disparities in health outcomes exist in Victoria and across the world, with different groups experiencing wellbeing and illness in unequal ways. Women are one of those groups. While Victorian women are more likely to live longer than Victorian men, their higher prevalence and incidence of non-fatal health problems result in more years lived with ill health and disability. For Victorian women aged 15 to 44 years, for instance, intimate partner violence is the leading contributor to disability and illness and, tragically, death.

Gendered differences in population health status means there remains significant scope in 2014 to improve the health of Victorian women.

Victorian women's health services commend successive Victorian governments for their leadership on women's health to date and encourage government to continue to partner with the women's health sector to reduce the burden of ill health and disease for better health outcomes for Victorian women.

The Victorian women's health sector continues this work through *Priorities for Victorian Women's Health 2014–2018*, which recommends the development of a comprehensive women's health policy and action platform for 2014–2018 that includes a set of specific actions for government.

The Victorian women's health sector seeks commitment to the development of a comprehensive women's health policy and action platform for 2014–2018.

What should the women's health policy and action platform include?

In order to reduce the burden of ill health and disease for better health outcomes for Victorian women, the women's health policy and action platform should include five specific actions for government. These are:

1. Development of a statewide sexual and reproductive health strategy.
2. Investment and leadership in the primary prevention of violence against women.
3. Research and action on women in a changing society, specifically the impacts of climate change on the health of Victorian women
4. Development of a gendered mental health and wellbeing plan.
5. Further investment in the Victorian Women's Health Program to implement initiatives arising from the actions above.

How must the women’s health policy and action platform be developed and implemented?

In order to succeed, the women’s health policy and action platform must be developed and implemented in the following way. It must:

- be led by Government – with the Office of Women’s Affairs returned to the Department of Premier and Cabinet to assure a whole-of-government approach;
- focus on gender equity across the whole of government and at all levels of government;
- include clear performance goals or targets for measuring achievements;
- ensure collection and analysis of gendered data; and
- invest in Victorian women’s health services to lead local and statewide strategies.

2. Recommendation for a women's health policy and action platform for 2014–2018

The recommendation for a comprehensive women's health policy and action platform contains a set of specific actions for government in response to the most pressing concerns for Victorian women's health. These issues have been identified by the Victorian women's health sector through an examination of the existing evidence (see Appendix 2 to Appendix 5).

Overall features

The platform must squarely tackle gender-based inequities since evidence shows that gender-based inequities are both the underlying cause of poor health outcomes for Victorian women *and* the barriers to achieving improvements in Victorian women's health (and thus Victoria's health) (see Appendix 1).

The platform must be whole-of-government in its approach with its development and monitoring led by the Office of Women's Affairs. As such, it is critical that the Office of Women's Affairs is returned to the Department of Premier and Cabinet.

The platform must include, among the specific actions for government detailed below, the consistent application of a gender equity score card (to be developed by Victorian women's health services) to *all* government policy development and implementation.

Victorian women's health services should lead the implementation of initiatives arising from the platform and its specific actions – with sufficient resources from government.

Action 1: Development of a statewide sexual and reproductive health strategy

Develop a statewide sexual and reproductive health strategy that:

- invests in Victorian women's health services to lead the development, implementation and evaluation of regional sexual and reproductive health plans in partnership with others;
- establishes a comprehensive and uniform Victorian sexual and reproductive health data collection system to ensure that prevention (and intervention) efforts are evidence based; and
- addresses the social determinants of sexual and reproductive health with a focus on primary prevention.

Action 2: Investment and leadership in the primary prevention of violence against women

Build on current Victorian efforts in preventing violence against women *before* it occurs by:

- committing to the prevention of violence against women as a priority in Victorian health planning; and
- continuing to commission the Victorian women's health sector to lead and coordinate a sustained statewide and regional approach to primary prevention initiatives over the 2014–2018 period.

Action 3: Research and action on women in a changing society and the impacts of ageing and climate change on Victorian women

Invest in a comprehensive analysis of women in a changing society to:

- investigate the impacts of climate change (and related natural disasters) on the health of Victorian women;
- understand broader environmental justice issues for women;
- investigate and recommend sustainable strategies to address economic and financial hardship for women in retirement and as they are ageing; and
- feed research findings into the women's health policy and action platform to produce further actions for government.

Action 4: Development of a gendered mental health and wellbeing plan

Develop, implement and evaluate a *gendered* mental health and wellbeing plan for Victoria to:

- eliminate discrimination, stigma and inequities faced by Victorian women;
- address other risk factors for women's poor mental health and wellbeing; and
- enhance the social inclusion of Victorian women.

Action 5: Increased funding for the Victorian Women's Health Program

Continue to lead the way for other jurisdictions in Australia through increased funding to the Victorian Women's Health Program, in recognition that:

- the activities of Victorian women's health services are directed at the social determinants of women's health and the gender-based inequities that shape them;
- Victorian women's health services are critical for the development of a women's health policy and action platform and the implementation of initiatives arising from it; and
- Victorian women's health services have a vital role in leading and supporting responses to women's health and wellbeing across regions and the state.

3. Principles underpinning the recommendation

Principle 1: Victorian women's health services are uniquely positioned for prevention

Victorian women's health services have a unique place in the health service system. As a sector, these services have reach into metropolitan and regional areas and are well positioned to implement government prevention initiatives on women's health. As a network, Victorian women's health services lead coordinated and consistent strategies across the state.

Within their group (funded and associated services) Victorian women's health services have expertise in multicultural women's needs, the needs of women with disabilities, and the needs of rural women. As regionally located organisations they engage with health and community planning and lead area-based health prevention and community based initiatives in tandem with community, local, state and federal governments, and other organisations.

With their emphasis on and strong skills in integrated health promotion, Victorian women's health services straddle the health, human services and development sectors. Their partnerships with local government, community health, community organisations and peak bodies, as well as with the acute sectors in health, family violence, sexual assault, crime, emergency relief and mental health, result in alliances and expertise that enable effective prevention approaches (see Appendix 7).

With greater recognition of the value of these unique capacities, Victorian women's health services can be further employed to support government prevention initiatives on women's health.

Principle 2: Health is socially determined

Health is influenced by the socio-economic circumstances in which people are born, live, work and age. There is a strong correlation, for instance, between socio-economic disadvantage, on the one hand, and shorter life expectancies and related morbidities, on the other (the social gradient in health).

Principle 3: Investing in equity reduces health expenditure

The social ingredients for health include economic participation, civic participation, social connection and freedom from violence – to name a few. Not everyone in society, however, has the same access to such resources for health. The socio-economic conditions of people's lives are often unfair and inequitable. Addressing social inequities – ensuring there is fairness in access for all – is a key way to reduce government expenditure on health.

Principle 4: Gender-based inequities have serious consequences for women's health

The social construction of gender refers to how we live our biological sex as women and men according to prevailing norms, institutions, expectations and behaviours. In everyday life, throughout the life stages, the social construction of gender operates to position women and men *differently* and *unequally* in society. This gives rise to gender inequities – the uneven distribution of power, prestige and opportunities between the genders – with women as the less advantaged group (for example, in pay and superannuation disparities). *Gender-based inequities give rise to poor health outcomes for women.*

Principle 5: Gender equity improves health outcomes

It stands to reason that addressing gender-based inequities is central to diminishing disparities within a population's health status. In short, *gender equity measures improve population health outcomes.* Given the numbers of women who stand to benefit, action to mitigate gender inequity is an efficient and effective use of health resources for jurisdictions around the world – including Victoria.

Principle 6: There must be equity for all women

The achievement of gender equity must extend to *all* women. Gender inequity has differential impacts on women, depending on the intersection of factors such as race, ethnicity, immigration and visa status, disability, rurality, socioeconomic circumstances, age and sexual identity. This difference results in an unequal distribution of power, privilege and access to resources between women, leading to relatively poorer health outcomes among those who experience intersectional disadvantage. Improving health outcomes for all women requires a focus on women with least access to health resources and who are most at risk for poor health.

Principle 7: Health policy and action are most effective when applied 'upstream'

Health policy and action can prevent poor health outcomes from arising in the first place. In sound health policy and action, primary prevention impacts on the causes of the problem, aiming to prevent them from occurring. This means applying efforts 'upstream' to the source of what causes health disparities. Some of these structural causes include uneven distribution of power, prestige and opportunities in society. Understood in this way, *tackling gender-based inequities through gender equity measures is prevention of the highest order.*

4. Snapshot of Victorian women

In June 2013, there were 2,898,007 females in Victoria, comprising 50.5% of the state population.¹ Aboriginal and Torres Strait Islander women make up 0.85% of Victorian women² and 27.8% were born overseas.³

Despite living in a prosperous state and having access to a wide range of generalist and specialist health services, there are still many areas of social, economic and health inequities faced by Victorian women. Some of the differences and inequities that must still be redressed are outlined below.

Women's health outcomes

- Unlike men, who experience more fatal injuries and diseases, women experience a higher prevalence and incidence of non-fatal health problems, resulting in higher rates of disability burden for women. This means that even though women live longer, often more of their lives are lived in ill-health and disability.⁴
- Domestic violence is the leading contributor to death, disability and illness in Victorian women aged between 15 and 44 years.⁵
- Breast cancer, depression and diabetes have the highest burden of disease (measured in Disability Adjusted Life Years or DALYs) for women aged 35 to 64 years.⁶
- Australian women are more likely to report a long-term mental or behavioural problem and higher levels of psychological distress than men.⁷
- In Victoria, the prevalence of very high levels of psychological distress is higher for women (3.4%) than for men (1.8%).⁸
- Between 2005 and 2007, life expectancy at birth for Aboriginal and Torres Strait Islander women was 9.7 years less than for non-Indigenous women (72.9 years and 82.6 years respectively).⁹

¹ Australian Bureau of Statistics. Australian Demographic Statistics, June 2013. Cat. no. 3101.0. Canberra: ABS; 2013 [cited 27 February 2014] Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Jun%202013?OpenDocument>

² Australian Bureau of Statistics. Estimates of Aboriginal and Torres Strait Islander Australians, June 2011. Cat. no. 3238.0.55.001. Canberra: ABS; 2013 [cited 11 December 2013] Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3238.0.55.001June%202011?OpenDocument>

³ Australian Bureau of Statistics. 2011 Census of Population and Housing. Cat. no. 2001.0. Canberra: ABS; 2012 [cited 27 February 2014].

⁴ Public Health Group, Department of Human Services. Victorian Burden of Disease Study: Mortality and Morbidity in 2001. Public Health Group, Rural and Regional Health and Age Care Services Division: Melbourne, Victoria; 2005.

⁵ VicHealth. The health costs of violence: measuring the burden of disease caused by domestic violence; 2004 [cited 4 September 2013]. Available from: <http://www.vichealth.vic.gov.au/en/Publications/Freedom-from-violence/The-Health-Costs-of-Violence.aspx>

⁶ Victoria. Department of Health. Victorian burden of disease study: mortality and morbidity in 2001. Melbourne: Department of Health, 2005 [cited 20 November 2013]. Available from: http://www.health.vic.gov.au/healthstatus/bodvic/bod_current.htm

⁷ Australian Bureau of Statistics. Mental Health in Australia: A Snapshot, 2004-05. Cat. no. 4824.0.55.001. Canberra: ABS; 2006 [cited 11 September 2013]. Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4824.0.55.001>

⁸ Department of Health. Victorian Population Health Survey 2010. Melbourne: State Government of Victoria Department of Health; 2012 [cited 11 September 2013]. Available from: <http://www.health.vic.gov.au/healthstatus/survey/vphs2010.htm>

⁹ Australian Bureau of Statistics. Gender Indicators, Australia, Jan 2013. Cat no. 4125.0. Canberra: ABS; 2013 [cited 14 August 2013] <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4125.0main+features3110Jan%202013>

Some factors that impact on women's health

- In 2013, 71% of women aged 15 to 64 years were participating in the labour force nationally, 12% lower than the rate for men.¹⁰
- Women's average weekly earnings are \$849.90, while men's average weekly earnings are \$1,357.10.¹¹
- On average, women reach retirement age with \$87,532 superannuation, 36% less than men². Women are two and a half times more likely to live in poverty in their old age than men, because they have contributed so much less to superannuation.¹²
- There are more women than men in unpaid caring roles and almost twice as many women primary carers as men.¹³
- 71.4% of women who are primary carers reported at least one of the reasons they took on the role was that alternatives were not available or they had no other option.¹⁴
- In 2009, 62.5% of women who were primary carers reported experiencing negative impacts on their wellbeing, compared with 48.4% of men.¹⁵

¹⁰ COAG Reform Council. Tracking equity: Comparing outcomes for women and girls across Australia Report to the Council of Australian Governments 21 October 2013. [cited 20 November 2013] Available from: <http://www.coagreformcouncil.gov.au/reports/gender-equity/tracking-equity-comparing-outcomes-women-and-girls-across-australia>

¹¹ COAG Reform Council. Tracking equity: Comparing outcomes for women and girls across Australia Report to the Council of Australian Governments 21 October 2013. [cited 20 November 2013] Available from: <http://www.coagreformcouncil.gov.au/reports/gender-equity/tracking-equity-comparing-outcomes-women-and-girls-across-australia>

¹² Cassells R, Miranti R, Nepal B & Tanton R. She works hard for the money, Income and Wealth Report, Issue 22, p. 34. Canberra: AMP with National Centre for Social and Economic Modelling: 2009 [cited 9 December 2013] Available from: <http://www.natsem.canberra.edu.au/publications/?publication=ampnatsem-income-and-wealth-report-issue-22-she-works-hard-for-the-money>

¹³ COAG Reform Council. Tracking equity: Comparing outcomes for women and girls across Australia Report to the Council of Australian Governments 21 October 2013. [cited 20 November 2013] Available from: <http://www.coagreformcouncil.gov.au/reports/gender-equity/tracking-equity-comparing-outcomes-women-and-girls-across-australia>

¹⁴ COAG Reform Council. Tracking equity: Comparing outcomes for women and girls across Australia Report to the Council of Australian Governments 21 October 2013. [cited 20 November 2013] Available from: <http://www.coagreformcouncil.gov.au/reports/gender-equity/tracking-equity-comparing-outcomes-women-and-girls-across-australia>

¹⁵ COAG Reform Council. Tracking equity: Comparing outcomes for women and girls across Australia Report to the Council of Australian Governments 21 October 2013. [cited 20 November 2013] Available from: <http://www.coagreformcouncil.gov.au/reports/gender-equity/tracking-equity-comparing-outcomes-women-and-girls-across-australia>

5. Next steps

In Victoria, evidence shows that women achieve better health outcomes where strong and well-resourced women's health services exist. It is in the interests of successive state governments to partner with Victorian women's health services in the development of strategies and actions – such as the women's health policy and action platform recommended in this document – to improve the health of Victorian women. This will, in turn, improve the health of the Victorian population and reduce the burden of ill health and disease across the state.

Victorian women's health services look forward to meeting with government and other political parties to discuss their commitment to a women's health policy and action platform as recommended in this document.

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APPENDICES

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Appendix 1: Gender equity improves health outcomes

The social determinants of health

In Victoria, as in Australia and all over the world, disparities in health outcomes exist at the population level, with different groups experiencing wellbeing and illness in unequal ways. Public health experts, such as the World Health Organization's Commission on Social Determinants of Health (CSDH), have long understood health disparities to be socially determined; that is, influenced by the socio-economic circumstances in which people are born, live, work and age.¹ There is a strong correlation, for instance, between socio-economic disadvantage, on the one hand, and shortened life expectancies and increased morbidities, on the other.²

The social gradient in health can be a matter of life and death. Importantly, it is also a matter of social justice – for governments and civil society alike. As CSDH notes, disparities in health status are based in socially-produced conditions that are unfair and inequitable – and avoidable. Removing socially-produced remediable differences in a population's health on *equity* grounds becomes the basis of sound public policy and integrated action on health. CSDH go as far as saying that governance fails its prime responsibility to ensure the fair access to life's opportunities and resources for everyone as long as inequities at the basis of differential health status are permitted to persist.³

The structural determinants of health inequities

Recent work by CSDH represents an important analytic advancement on the social determinants of health.⁴ Building on previous theories and models, CSDH now gives causal priority to the mechanisms that generate inequitable access to opportunities and resources in life in the first place. A key concept introduced by CSDH is *social positioning*. Deep underlying structural mechanisms exist that give rise to different socio-economic positions. These positions see different population groups *stratified* in relation to power, prestige and resources. Stratification (which is necessarily hierarchal) in turn engenders differential consequences for the health of more and less advantaged groups – the social gradient and disparities in health status described above.

¹ CSDH 2008, Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. World Health Organization, Geneva. Available http://www.who.int/social_determinants/thecommission/finalreport/en/, accessed 15 February 2014

² Marmot M, Wilkinson R 2003, *Social determinants of health: the solid facts*. 2nd edition. World Health Organization, Copenhagen. Available <http://www.euro.who.int/en/what-we-publish/abstracts/social-determinants-of-health-the-solid-facts>, accessed 15 February 2013

³ Solar O, Irwin A 2010, *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization, Geneva. Available http://www.who.int/social_determinants/corner/en/, accessed 15 February 2013, p. 12.

⁴ Solar O, Irwin A 2010, *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization, Geneva. Available http://www.who.int/social_determinants/corner/en/, accessed 15 February 2013.

The causal priority given to the mechanisms that stratify society, as well as their relationship to the socio-economic conditions of daily life and resulting population health disparities, is conceptualised as a coherent framework for policy and action by CSDH.⁵ The importance of the framework is that it moves thinking on the social determinants further upstream, beyond socio-economic conditions to the *structural determinants of health inequities*.

CSDH also makes it clear that the target of policy and action must include the mechanisms that stratify society as the root causes of health inequities. Interventions can no longer afford to limit themselves only to the socio-economic circumstances of people's lives. People's lived experiences, their material living and working conditions, are seen as playing a more intermediary (and downstream) role in determining health. In the words of CSDH:

Arguably the single most significant lesson of the CSDH conceptual framework is that interventions and policies to reduce health inequities must not limit themselves to intermediary determinants. In conventional usage, the term 'social determinants of health' has often encompassed only intermediary determinants. However, interventions addressing intermediary determinants can improve average health indicators while leaving health inequities unchanged. For this reason, *policy action on structural determinants is necessary* (emphasis added).⁶

The social construction of gender as structural stratifier

In the context of the CSDH framework, *the social construction of gender is one of the most serious of society's stratifying mechanisms, the effects of which are plainly detrimental to the health outcomes of women around the world*. According to the Australian Women's Health Network (AWHN), the social construction of gender – or how we live our biological sex as women and men in accordance with prevailing norms, institutions, expectations and behaviours – positions women and men in particular ways in society. This differential social positioning gives rise to the unequal distribution of power, prestige and resources between the genders, which in turn influences women's health status.⁷ Thus, gender-based stratification – at once systemic, hierarchical, unfair and inequitable – dictates the social positioning of women, shapes the material conditions of their lives, and leads to consequences for health and illness in ways that are unique to them as women.

⁵ Solar O, Irwin A 2010, *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization, Geneva. Available http://www.who.int/social_determinants/corner/en/, accessed 15 February 2013, p. 48.

⁶ Solar O, Irwin A 2010, *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization, Geneva. Available http://www.who.int/social_determinants/corner/en/, accessed 15 February 2013, pp. 64-65.

⁷ AWHN 2013, *Women's health: Meaningful measures for population health planning*, Australian Women's Health Network, Drysdale, Victoria, p. 11.

The following example on women and work is offered by AWHN and CSDH and shows how women's health status and population health disparities (the outcome the end of the chain) are fuelled by gender-based stratification (the uppermost determinant).

- Prevailing gender norms define different employment expectations of women and men and what counts as women's work (social positioning/hierarchy).
- Women are systematically disadvantaged in relation to opportunities for secure and continuous paid work and the burdens of unpaid work in the home (unequal distribution of power, prestige and resources).
- Women are more likely than men to work in lower paid roles, occupations or sectors of employment, and to endure poor working conditions (material conditions or lived experience).
- Women are more likely than men to have fragmented and economically uncertain work trajectories, reduced lifetime earning capacity and lesser accumulated savings (material conditions or lived experience).
- Women's socio-economic disadvantage relative to men exposes them to risks and vulnerabilities for poor health outcomes, with financial insecurity, housing insecurity, low social capital and poverty being among the most significant of predictors for ill health (social gradient in health, disparities in health status).

What this tells us is that *the social construction of gender is a cause of population health inequities of the highest order*, and that *tackling gender-based stratification is one of the most important policy steps for health equity in our time*. Indeed, given the numbers of women who stand to benefit, action to mitigate the effects of gender-based stratification and alter the social construction of gender as a structural determinant of health inequities is surely an efficient and effective use of health resources for jurisdictions around the world – including Victoria.

The intersectionality of structural stratifiers

AWHN offers further rigour to the thinking on the structural determinants of health inequities through the concept of *intersectionality*. Mechanisms of social stratification never work in isolation but in unison to compound social positioning and hierarchies. Gender-based stratification intersects with other deep and underlying structural mechanisms, such as racial privileging or hetero-normativity. Thus, the distribution of power, prestige and resources is not only unequal between women and men but *within* women as a group, 'with some women experiencing the effects of compounded inequities because of their positioning through multiple axes of social stratification and systemic hierarchies'.⁸

⁸ AWHN 2013, *Women's health: Meaningful measures for population health planning*, Australian Women's Health Network, Drysdale, Victoria, p. 12.

It is therefore important for any action on the disparities in a population's health status to consider *all* the mechanisms of social stratification that are the basis of the health outcomes of that population's specific groups, in our case Victorian women.

Implications for government action

The analytic advancement in social determinants thinking described above provides strong evidence for action that tackles gender-based stratification as a structural determinant of health inequities. As stated, interventions can no longer afford to limit themselves to the socio-economic circumstances of people's lives but must look further upstream to the structural determinants of health inequities. Indeed, CSDH notes that *addressing social stratification is the most critical area today in terms of diminishing disparities in health.*⁹

Government today must play its part, *specifically through the development of policy that advances gender equity.* Such policy would go a long way to improving the health outcomes of the Victorian population, precisely by addressing the root causes of disparities in the population's current health status. Such action would work by mitigating the effects of gender-based stratification, chiefly the unequal and inequitable distribution of (and access to) opportunities and resources that systematically disadvantage Victorian women. It would also, importantly, stand to alter the very mechanism of gender-based stratification – the social construction of gender – as a significant structural determinant of Victorian health inequities.

⁹ Solar O, Irwin A 2010, *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization, Geneva. Available http://www.who.int/social_determinants/corner/en/, accessed 15 February 2013, p. 52

Appendix 2: Women's sexual and reproductive health

A strong body of evidence indicates that sexual and reproductive health morbidity is to a large extent preventable.¹ Victoria women and girls continue to experience the overwhelmingly burden of sexual and reproductive ill health when compared with their male counterparts.² In the absence of a comprehensive sexual and reproductive health strategy, unacceptably high levels of sexual and reproductive ill health will continue to rise.

- Chlamydia is the most commonly reported infection in Australia.³ In 2013, reported rates of chlamydia were higher among women than men (390.5 compared to 288.0 per 100,000) and since 2003 the number of women diagnosed with chlamydia has doubled.⁴
- In 2011, of the 357,500 Australian women who were employed while pregnant, 17 per cent reported experiencing pregnancy related discrimination.⁵
- Only 58.1 per cent of sexually active Victorian adolescents report that they practice safe sex by using a condom, which puts them at significant risk of sexually transmissible infections (STIs) and unwanted pregnancy.⁶
- Women comprise just seven per cent of Australia's prison population, yet the rate of women in incarceration is growing at a faster rate than men.⁷ Women in prison experience high rates of STIs, blood born viruses, gender-based violence and one in five have been paid for sex.⁸
- In the most recent national school survey, 37.8 per cent of young women in years 10 and 12 had experienced unwanted sex.⁹
- Same-sex attracted young women are more likely to be sexually active earlier, less likely to use a condom and are at higher risk of STIs than their heterosexual peers.¹⁰

¹ World Health Organisation (2010) *Social Determinants of Sexual and Reproductive Health: Informing future research and programme implementation*, WHO Press: Geneva.

² Department of Health (2011) *Victorian Public Health and Wellbeing Plan 2011–2015*, Department of Health: Melbourne.

³ Australian Government Department of Health (2012) *National Notifiable Disease Surveillance System: Disease notification rates by State and Territory*, Australian Government Department of Health: Canberra.

⁴ Australian Government Department of Health (2012) *Notification rate of Chlamydial infection, Australia 2003 and 2013*, Australian Government Department of Health: Canberra.

⁵ Australian Bureau of Statistics (2011) *Pregnancy and Employment Transitions, Australia*, Catalogue No 4913.0, Australian Bureau of Statistics: Canberra.

⁶ Department of Education and Early Childhood Development (2011) *Adolescent Community Profile Services*, Victorian Government Department of Education and Early Childhood Development: Melbourne.

⁷ Australian Bureau of Statistics (2012) *Women prisons increasing at a faster rate than men*, Catalogue No 4517.0, Australian Bureau of Statistics: Canberra.

⁸ Indig, D., Topp, L., Ross, B., Mamoon, H., Border, B., Kuman, S. and McNamara, M. (2010) *2009 NSW Inmate Health Survey: Key findings report*, Justice Health: New South Wales.

⁹ Smith, A., Agius, P., Barrett, C., Mitchell, A. and Pitts, M. (2009) *Fourth National Survey of Australian Secondary Students and Sexual Health*, Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.

¹⁰ Hillier, L. Jones, T., Monagle, M. Overton, N., Gahan, L., Blackman, G and Mitchell, A. (2010) *Writing Themselves In 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people*, Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.

- National research that found that 61 per cent of same-sex attracted young people reported experiencing verbal homophobia abuse and 18 per cent physical abuse.¹¹
- Infertility is a growing concern with approximately one in six Australian couples taking longer than one year to conceive a planned pregnancy during their reproductive life¹² and approximately 4 per cent of Australian children are now born via some form of assisted reproductive technology.¹³
- Births to women aged under 30 years contributed three-quarters (76 per cent) of the total fertility rate for Aboriginal and Torres Strait Islander women in 2012, compared with less than half of the total fertility rate for all women (45 per cent).¹⁴
- A 2013 Australian study on contraceptive use and unintended pregnancy among 18–23 year old women found that of those who had been pregnant 69 per cent were reported using a range of contraceptive methods.¹⁵
- Women with a disability continue to have their sexual and reproductive rights denied through forced sterilisation, denial of appropriate sexual and reproductive healthcare, access to assisted reproductive technologies and poorly managed pregnancy, birth and post natal care.¹⁶
- A large national representative survey found that 22.6 percent of women aged 16–59 years in Australia report ever having had an abortion.¹⁷
- International and Australian research consistently shows an emphatic association between intimate partner violence and abortion.¹⁸ Results from the World Health Organisation 2013 multi-country study found that primary prevention efforts that reduce rates of intimate partner violence by 50 per cent could potentially reduce unintended pregnancy by 2–18 per cent and abortion by 4.5–40 per cent.¹⁹

¹¹ Ibid.

¹² Labett T (2006) Fertility study attitudes, experiences and behaviours of Australian general public. A report commissioned by the Fertility Society of Australia (FSA). Cited in Wang YA, Chambers GM, Dieng M & Sullivan EA 2009. Assisted reproductive technology in Australia and New Zealand 2007. Assisted reproduction technology series no. 13. Cat. no. PER 47. Canberra: AIHW. Available at: <http://www.aihw.gov.au/publications/per/per-47-10753/per-47-10753.pdf>.

¹³ Infertility Treatment Authority (2013) *Victorian Assisted Reproductive Treatment Authority: Annual Report 2013*, Victorian Assisted Reproductive Treatment Authority: Melbourne

¹⁴ Australian Bureau of Statistics (2012) *Aboriginal and Torres Strait Islander Births and Fertility*, Catalogue No 3301.0, Australian Bureau of Statistics: Canberra.

¹⁵ Herbert, D., Harris, M., Loxton, D. and Lucke, J. (2013) 'Contraceptive use and unintended pregnancy among 18-23 year olds women in Australia: the first findings of the CUPID study', *The European Journal of Contraception and Reproductive Health Care*, vol. 18, pp. 78–93.

¹⁶ Frohmader, C. (2010) *Women With disabilities and the Human Right to Health: A Policy Paper*, Women With Disabilities Australia: Australia.

¹⁷ Smith, Rissel, Richters, Grulich, and de Visser (2003) 'Sex in Australia: sexual identity, sexual attraction and sexual experience among a representative sample of adults', *Australia and New Zealand Journal of Public Health*, vol. 2, no. 2.

¹⁸ Taft, A. J., Watson, L. F. (2007) 'Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women', *Australian and New Zealand Journal of Public Health*, 31(2), 135–42.

¹⁹ World Health Organisation (2013) Intimate partner violence, abortion and unintended pregnancy: Results from the WHO multi-country study on women's health and domestic violence, *International Journal of Gynaecology and Obstetrics*, vol. 120, pp. 3–9.

Implications for government action

Based on the evidence above, there is a need for government to develop and implement a sexual and reproductive health strategy that addresses the social determinants of sexual and reproductive health and focuses on primary prevention, and includes (but is not limited to) the following components.

- Fund Victorian women’s health services to lead the development, implementation and evaluation of regional sexual and reproductive health plans in partnership with others.
- Establish a comprehensive, uniform Victorian sexual and reproductive health data collection system, including aggregated data for priority populations, to ensure that prevention and intervention strategies are evidence based.
- Fund translation of research into practice in relation to women’s sexual and reproductive health and disseminate findings on topics including the link between violence against women and rates of sexually transmitted infections, abortion, cervical cancer and pregnancy.
- Support women’s right to health through the provision of safe, legal and accessible abortion service provision by way of:
 - continued compliance with the *Abortion Law Reform Act 2008*;
 - funding and implementing a statewide professional pregnancy support helpline to enable the provision of accurate and timely information, counselling and referral to services that provide abortion;
 - making it unlawful to protest, intimidate and harass women who access abortion services;
 - mandating publicly funded sexual and reproductive health services, including those that provide termination of pregnancy and contraception, to meet catchment need; and
 - funding education, training and professional development initiatives for health practitioners to support the provision of accessible surgical and early medication abortion.
- Fund and implement comprehensive primary prevention whole-of-school sexuality and respectful relationships education programs that include:
 - standardised curriculum, policy development and teacher training;
 - strong partnerships that promote shared responsibility between schools, young people, parents and local community organisations; and
 - accountability mechanisms to ensure compliance with best-practice.
- Develop and fund strategies to combat the sexualisation of young women and girls in the media, advertising and product marketing.

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Appendix 3: Violence against women

Research and available data on violence against women in Australia and Victoria, demonstrates that, despite many years of government attention, significant additional effort and action is required to redress the enormous social, economic and health impacts of such violence. Violence against women is an entrenched problem and a major public health crisis; it requires long-term, resourced and evidence-based primary prevention strategies in order to redress the root causes of the problem.¹

Prevalence rates

While violence against women is an under-reported crime and thus statistics are likely to be an underestimate, research highlights that it is the major cause of illness, death and disability in Victorian women aged between 15–44 years.²

Findings from the latest *Australian Personal Safety Survey (2012)* reveal the following figures.

- One in three Australian women has experienced physical violence and one in five has experienced sexual violence, in their lifetime. These statistics have not changed since 2005.
- Women are four times more likely than men to have experienced sexual violence since the age of 15 years.
- Women are more than three times more likely than men to have experienced violence by an intimate partner, since the age of 15 years.
- In the 12 months prior to the survey, 102,400 women reported they had experienced sexual violence and 132,500 women reported they had experienced intimate partner violence.
- An estimated 67% of women have *not* been in contact with the police after their most recent incident of physical assault by a male.³

¹ In addition to primary prevention, it is essential that significant resources are allocated to early intervention and tertiary response services to support women and children affected by violence. It is crucial that primary prevention efforts are supported by commensurate increases to intervention and response services.

² VicHealth, 2004, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence*, VicHealth, Melbourne.

³ Australian Bureau of Statistics, 2012, *The Personal Safety Survey, 2012*, Cat. No. 4906.0, Australian Bureau of Statistics, Canberra.

Health, social, cultural and economic impacts

Violence against women (in particular, intimate partner violence) is the leading cause of premature death, disability and illness for women aged 15–44 years in Victoria.⁴ Violence against women is associated with a range of physical, mental and sexual and reproductive health problems, including:

- brain injuries, disabilities, chronic diseases and physical injuries;⁵
- depression, anxiety, traumatic and post-traumatic stress disorder, substance dependency (including tobacco and alcohol use, illicit and prescribed drug use), sleeping problems, self-harm tendencies and suicidal ideation;⁶ and
- unplanned pregnancies, sexually transmitted infections (including HIV), gynaecological problems and pregnancy complications.⁷

Women who have experienced violence can face a range of social, cultural and economic concerns including social isolation, financial debt, economic insecurity, insecure housing, unemployment and employment difficulties, and limited access to cultural/spiritual supports.⁸

Homelessness is a profound impact of violence against women; one in five Australian women seeking supported accommodation does so in response to family violence⁹. In Victoria, one in every two women with children seeking homelessness services is escaping family violence¹⁰

Populations groups particularly exposed to the risk of violence and its impacts

Women with disabilities are twice as likely to experience violence as other women, but less likely to receive an adequate service response.¹¹

Aboriginal and Torres Strait Islander women are more likely than non-Aboriginal women to be a victim/survivor of violence. Around 22 percent of Aboriginal and Torres Strait Islander women over the age of 18 years reported that they had been a victim of physical or threatened violence in the twelve months prior to being surveyed.¹²

⁴ VicHealth, 2007, *Preventing violence before it occurs: a framework and background paper to guide the primary prevention of violence against women in Victoria*, VicHealth, Melbourne.

⁵ Kramer, A, Lorenzon, D & Mueller, G, 2004, Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics, *Women's Health Issues*, 14, pp.19-29.

⁶ The Royal Women's Hospital, 2012, *Family Violence – Information for Women*, The Royal Women's Hospital, Melbourne.

⁷ The Royal Women's Hospital, 2012, *Family Violence – Information for Women*, The Royal Women's Hospital, Melbourne.

⁸ The Royal Women's Hospital, 2013, *Health issues faced by women experiencing violence across the lifespan*, unpublished.

⁹ Australian Institute of Health and Welfare, 2008, *Homeless people in SAAP: SAAP National Data Collection Annual Report 2006-07*, SAAP NDCA Report Series 12, Canberra.

¹⁰ Council to Homeless Persons, 2012, *Homelessness in Victoria – Key Statistics*, Council to Homeless Persons. Available at: http://chp.org.au/wp-content/uploads/2012/12/10122012_Homelessness-in-Victoria-with-2011-ABS-stats.pdf.

¹¹ Healey, L. (2008) *Building the Evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria*, VWDN, Melbourne.

¹² Australian Bureau of Statistics (2007) *The health and wellbeing of Aboriginal and Torres Strait Islander women: A snapshot, 2004-05*. Australian Bureau of Statistics. Cat. No. 4722.0.55.001. Available at: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4722.0.55.001Main+Features12004-05?OpenDocument>.

Intersectional experiences of marginalisation, low socio-economic status and disadvantage mean that some women from migrant and refugee background communities are at heightened vulnerability to ongoing intimate partner violence and the impacts of such violence.¹³

Implications for government action

Based on the evidence above, there is a need for government to undertake a number of actions, including (but not limited) to the following.

- Fully fund the implementation of actions outlined in *Victoria's Action Plan to Address Violence against Women and their Children 2012–2015*, including all primary prevention initiatives.
- Commit to the prevention of violence against women as a priority in Victorian health planning.
- Commission Women's Health Victoria to lead and coordinate Victorian investment and efforts in the primary prevention of violence against women.
- Continue to resource Victorian women's health services to lead, implement and expand regional partnerships to prevent violence against women.
- Continue to fund Victorian women's health services to deliver gender equity training with local government.
- Fund Victorian women's health services to develop and deliver targeted primary prevention of violence against women training to key sectors including business, police, government, public health, housing, education, sports, media and the arts.
- Fund women's health services to develop state-wide communications and social marketing campaigns that achieve consistent messaging on promoting gender equity and the primary prevention of violence against women.
- Partner with Victorian women's health services to implement primary prevention of violence against women initiatives to support mental health promotion action as part of the *Victorian Public Health and Wellbeing Plan 2011–2015*.
- Collaborate with the National Centre for Excellence and other key research institutions to fund research that investigates the determinants of violence against women and that builds the evidence-base for effective primary prevention practice.
- Fund Victorian women's health services to develop strategies to prevent the use of Information and Communication Technologies (ICTs) in the perpetration of violence against women (for example, non-consensual sexting), through education and awareness raising initiatives with young people embedded in a gendered, primary prevention and whole-of-school approach.

¹³ VicHealth, 2007, *Preventing violence before it occurs: a framework and background paper to guide the primary prevention of violence against women in Victoria*, VicHealth, Melbourne.

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Appendix 4: Women in a changing society

The financial crisis of 2008 and ongoing global economic uncertainty create an opportunity to argue for reforms that provide a safety net for disadvantaged groups.^{1,2,3,4,5} Women are clearly and evidently at a disadvantage in terms of both economic participation and environmental justice. Taking up this window of opportunity to forge change means firstly educating women and society about the ways gender equality can be achieved.

Fair Work Australia found that gender discrimination was influential in the 17% pay gap between male and female wages.⁶ From the first job for new graduates where women were paid \$5,000 per annum less than men in 2011–12⁷ through to the gender difference in superannuation balances (\$112,000 for women and \$198,000 for men), women hit the ‘glass ceiling’ while men step on to a ‘glass escalator’.^{8,9} Almost two-thirds (63%) of superannuation in Australia belongs to men as a result of the pay differential and cultural expectation that women take on caring responsibilities: three quarters of primary carers are women, 70% of carers of parents are women, and almost all those caring for children with disability are women (92%).^{10,11,12,13} Until a true division of labour in the domestic and caring roles is achieved, the earnings gap is not predicted to close significantly for young women, with estimates of lifetime-earnings differentials of over a million dollars.^{14,15}

The link between discrimination against women and disadvantage – moderated by intersections with other aspects of marginalisation such as age, ethnicity, disability and sexuality – clearly stems from the

¹ Wade, R. (2009) From global imbalances to global reorganisations. *Cambridge Journal of Economics*, 33, 539-62.

² Birkmann, J, Buckle, P, Jaeger, J, Pelling, M, Setiadi, N, Garschagen, M, et al. (2010) Extreme events and disasters: a window of opportunity for change? Analysis of organizational, institutional and political changes, formal and informal responses after mega-disasters. *Natural Hazards*, 55(3), 637-55.

³ Seib, G.F. (2008) In Crisis, Opportunity for Obama. *The Wall Street Journal*. Retrieved 19/1/2014, from <http://online.wsj.com/news/articles/SB122721278056345271>.

⁴ Stiglitz, J.E. (2012) *The Price of Inequality: How Today's Divided Society Endangers Our Future*. New York: W.W. Norton.

⁵ Reich, R.B. (2013) *Beyond Outrage: What has gone wrong with our economy and our democracy, and how to fix it*. New York: Vintage Books.

⁶ Gender pay gap short-changes women \$250.50 a week [database on the Internet]. Australian Government. 2012. Retrieved from <http://www.wgea.gov.au/find/2/11/2014>.

⁷ Australian Government. (2013) Graduate pay gap blowout: Females earn \$5K less. Retrieved 29/6/2013 from <http://www.wgea.gov.au/content/graduate-pay-gap-blowout-females-earn-5k-less>.

⁸ Keene, N. (2013) Not so super future. Retrieved 30/11/2013 from <http://www.news.com.au/national-news/nsw-act/not-so-super-future/story-fndo4bst-1226548556717>.

⁹ Noble, C, & Pease, B. (2011) Interrogating male privilege in the human services and social work education. *Women in Welfare Education*, 10:29+.

¹⁰ Gender pay gap short-changes women \$250.50 a week [database on the Internet]. Australian Government. 2012. Retrieved 30/11/2013 from <http://www.wgea.gov.au/find>.

¹¹ Australian Human Rights Commission. (2013) *Investing in care: Recognising and valuing those who care Volume 1: Research Report*. Sydney: Australian Human Rights Commission.

¹² Potts, D. (2013) Women treated as second-class citizens. Melbourne: The Age. Retrieved 28/3/2014 from <http://www.smh.com.au/money/super-and-funds/women-treated-as-secondclass-citizens-20130702-2p8vw.html>

¹³ Hodgson, H. & Medd, R. (2013) Do major parties address women's super disadvantage? Retrieved 30/11/2013 from <http://www.abc.net.au/unleashed/4767118.html>.

¹⁴ Cerise S. (2009) Accumulating poverty? Women's experiences of inequality over the lifecycle. Australian Human Rights Commission.

¹⁵ Summers A. (2013) *The Misogyny Factor*. Sydney: NewSouth Publishing.

social construction of gender with men holding greater privilege than women.^{16,17} The result for an increasing number of women is risk of homelessness as they age, particularly when reliant on private rental.¹⁸ This is borne out by 2011 Census statistics which show that in Victoria, more females than males aged 55-64 were homeless (51 per cent).¹⁹

Climate change is likely to further exacerbate inequality between men and women, as gendered roles can mean the effects of climate change are felt more immediately and more acutely by women. Women are vulnerable through caring roles and poverty, and are more restricted in working and living options resulting in environmental crises hitting women hardest and affecting health and wellbeing.^{20,21,22,23,24}

During disasters, too, women and children are more vulnerable, often alone without the skills to increase their chances of surviving or escaping, or perhaps subject to the direction of a male partner in decisions on evacuation and relocation.^{25,26,27} After disasters, women are at increased risk of male violence as men's coping strategies in the aftermath include hyper-masculinity, violence and alcohol abuse.^{28,29,30,31} Women's post-disaster risk extends to disproportionate economic insecurity; increased workload; increased conflict in the community and the workplace and fewer supports for workforce participation.^{32,33,34,35}

¹⁶ Connell, R.W. (2005) *Masculinities* (Second Edition). Berkeley and Los Angeles, California: University of California Press.

¹⁷ Pease, B. (2010) *Undoing privilege: Unearned advantage in a divided world*. London: Zed books.

¹⁸ Security4Women. (2008) *Women and Housing*. Retrieved 30/11/2013 from <http://www.security4women.org.au/wp-content/uploads/WomenHousing202008.pdf>.

¹⁹ ABS (2011) 2049.0 Census of Population and Housing: Estimating homelessness_2011 State and territory of usual residence_Persons 15 years and over. Table 1 [database on the Internet]. 2011 [cited 6/3/2013]. Retrieved 28/3/2014 from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2049.02011?OpenDocument>

²⁰ Duncan, K. (2007) Global Climate Change and Women's Health. *Women & Environments International Magazine* [Internet]. 23/07/2010 Retrieved 18/3/2014 from http://www.redorbit.com/news/health/890479/global_climate_change_and_womens_health/index.html.

²¹ Nellemann, C, Verma, R, Hislop, L, editors. (2011) *Women at the frontline of climate change: gender risks and hopes*. GRID-Arendal: United Nations Environment Programme.

²² Neumayer, E. & Plumper, T. (2007) The gendered nature of natural disasters: the impact of catastrophic events on the gender gap in life expectancy, 1981–2002. *Annals of the Association of American Geographers*, 97(3):551–66.

²³ Enarson, E. (1998) Through women's eyes: a gendered research agenda for disaster social science. *Disasters*, 22(2), pp. 157-73.

²⁴ Enarson E. (2012) *Women confronting natural disaster: From vulnerability to resilience*. Boulder, Colorado: Lynne Rienner Publishers, Inc.

²⁵ Enarson, E. & Phillips, B. (2008) Invitation to a new feminist disaster sociology: Integrating feminist theory and methods. In: Phillips, B. & Morrow, B.H. editors. *Women and Disasters: From Theory to Practice* (pp. 41-74). USA: International Research Committee on Disasters.

²⁶ Henrici, J.M., Helmuth, A.S., Braun, J. (2010) Women, Disasters, and Hurricane Katrina. *Institute for Women's Policy Research Fact Sheet*. Washington: Institute for Women's Policy Research.

²⁷ Haynes, K, Tibbits, A, Coates, L, Ganewatta, G, Handmer, J, McAnerney, J. (2008) 100 years of Australian civilian bushfire fatalities: Exploring the trends in relation to the 'stay or go policy': Report for the Bushfire CRC.

²⁸ Houghton, R. (2009) 'Everything became a struggle, absolute struggle': Post-flood increases in domestic violence in New Zealand. In: Enarson, E, Chakrabarti, P, editors. (2009) *Women, gender and disaster: global issues and initiatives* (pp. 99-111). New Dehli: Sage.

²⁹ Wilson, J, Phillips, B.D., Neal, D.M. (1998) Domestic Violence after Disaster In: Enarson, E, Morrow, B.H., editors. *The Gendered Terrain of Disaster: Through Women's Eyes*. Westport, CT: Praeger Publishers.

³⁰ Enarson, E. (1999) Violence Against Women in Disasters: A Study of Domestic Violence Programs in the United States and Canada. *Violence Against Women*, 5(7):742-68.

³¹ Sety, M. (2012) Domestic violence and natural disasters. *Australian Domestic and Family Violence Clearinghouse Thematic Review*, 3 (February):1-10.

³² Shaw, C, van Unen, J, Lang, V. (2012) *Women's Voices from the Floodplain*. North Sydney: economic Security4women.

³³ Scanlon, J. (1998) The Perspective of Gender: A Missing Element in Disaster Response In: Enarson, E, & Morrow, B.H. editors. (1998) *The Gendered Terrain of Disaster: Through Women's Eyes*. Westport, CT: Praeger Publishers.

³⁴ Enarson, E. (2000) *Gender and Natural Disasters*. Geneva: International Labour Organisation.

³⁵ Dasgupta, S, Siriner, I, Partha, S.D., editors. (2010) *Women's Encounter with Disaster*. London: Frontpage Publications.

Within emergency management organisations, women are predominant as volunteers and in the lower professional ranks but are not in positions of power, both in the US and in Australia.^{36,37,38} The proliferation of men in leading roles in emergency management is evident and could be addressed by increasing the number of women in paid and volunteer roles, leading to equal decision-making, reduction of harmful masculine behaviour, and more women in power.^{39, 40} (46, 47).

Implications for government action

Based on the evidence above, there is a need for government to undertake a number of actions, including (but not limited) to the following.

- Fund a comprehensive analysis of women in a changing society (including sex-disaggregated data) with specific attention to the impacts of climate change (and related natural disasters) on Victorian women's health.
- Amend the *Victorian Equal Opportunity Act 2010* to include a requirement that all private and public sector agencies report against a gender equity framework.
- Through Victoria's role on the Council of Australian Governments (COAG) incorporate a gender analysis and awareness of increased family violence into the *National Strategy for Disaster Resilience*.
- Use the influence of the Victorian government's role on COAG to improve fairness of superannuation schemes for women and to revise the Aged Pension age for women back to 60 until financial analyses indicate women's superannuation balances have achieved parity with men.
- Devise and subsidise co-operative, non-traditional housing options for older Victorian women, including culturally specific facilities, particularly for Aboriginal and Torres Strait Islander women and women with disabilities.
- Fund further research relating to women in a changing society and disseminate findings on specific topics including:
 - ongoing barriers to women's equal participation in the workforce

³⁶ Phillips, B.D., Morrow, B.H., editors. (2008) *Women and Disasters: From Theory to Practice*. USA: International Research Committee on Disasters.

³⁷ Eriksen, C. (2013) Gendered Risk Engagement: Challenging the Embedded Vulnerability, Social Norms and Power Relations in Conventional Australian Bushfire Education. *Geographical Research*.

³⁸ Ainsworth, S, Batty, A, Burchielli, R. (2014) Women Constructing Masculinity in Voluntary Firefighting. *Gender, Work & Organisation* 21 (1), 37-56. Retrieved 11/03/13 from: onlinelibrary.wiley.com/doi/10.1111/gwao.12010/abstract;jsessionid=A3833ECD803BE09E2C668B66294844B.d04t01?deniedAccessCustomisedMessage=&userIsAuthenticated=false.

³⁹ Owen, C. (2013) Gendered communication and public safety: Women, men and incident management. *Australian Journal of Emergency Management*, 28(2).

⁴⁰ Enarson, E. & Morrow, B.H. editors. (1998) *The Gendered Terrain of Disaster: Through Women's Eyes*. Miami, Florida: Laboratory for social and behavioural research, Florida International University.

- exploitation of vulnerable women in employment
(for example, those on low-incomes, in casual employment, those with uncertain citizenship status, international students and single mothers)
- the impact of the global financial crisis on women
- the impact on women of homelessness arising from increased housing prices, poverty, discrimination and family violence.

Appendix 5: Women’s mental health and wellbeing

Mental health is a state of complete physical, mental, spiritual and social wellbeing in which each person is able to realise one’s abilities, can cope with the normal stresses of life, and make a unique contribution to one’s community.¹ The Melbourne Charter (2008) clearly defines a range of society-level protective factors for mental health and wellbeing, many of which can be achieved by government intervention.²

Women’s mental health and wellbeing is adversely affected by gendered divisions of labour in the economy, the home and the community, and gender based expectations about roles, responsibilities and power relations. While women reported a higher level of satisfaction with work/life balance and similar levels of subjective wellbeing, a recent VicHealth survey found that, significantly greater numbers of women (44.5 per cent) indicated that they always felt rushed or pressed for time, compared with 37.9 per cent of men.³

The World Health Organisation (WHO) recognises that gender differences are evident in the onset, prevalence, diagnosis, trajectory, co-morbidity, treatment, prognosis and outcomes of mental health and depression. Despite this evidence, sex and gender differences are not routinely considered in mental health research or service provision in Victoria.

Some key statistics for Victoria and Australia include:

- Australian women are more likely to report a long-term mental or behavioural problem and higher levels of psychological distress than men.⁴
- Women in prisons were more likely to have a high level of psychological distress, history of mental illness or self harm than men in prisons.⁵
- In Victoria, the prevalence of very high levels of psychological distress is higher for women (3.4%) than for men (1.8%).⁶
- Up to 9% of women will experience depression during pregnancy and this increases to 16% in the year following birth.⁷

¹ VicHealth, The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders: VicHealth, 2008, available from: http://www.vichealth.vic.gov.au/~media/ProgramsandProjects/Publications/Attachments/Melbourne_%20Charter_final.ashx

² Ibid

³ VicHealth 2012, VicHealth Indicators Survey 2011, Victorian Health Promotion Foundation, Melbourne, Australia, available from: http://www.vichealth.vic.gov.au/~media/Indicators/Report/VicHealth_IndicatorsSurvey_SelectedFindings.ashx

⁴ Australian Bureau of Statistics. Mental Health in Australia: A Snapshot, 2004-05. Cat. no. 4824.0.55.001. Canberra: ABS; 2006 [cited 11 September 2013]. Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4824.0.55.001>

⁵ Australian Institute of Health and Welfare 2013. The health of Australia’s prisoners 2012. Cat. no. PHE 170. Canberra: AIHW, available from: <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543945>

⁶ Department of Health. Victorian Population Health Survey 2010. Melbourne: State Government of Victoria Department of Health; 2012 [cited 11 September 2013]. Available from: <http://www.health.vic.gov.au/healthstatus/survey/vphs2010.htm>

⁷ Beyond Blue. Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period: A guide for primary health care professionals. Melbourne; 2011 [cited 5 November 2013] Available from: <http://www.beyondblue.org.au/resources/health-professionals/clinical-practice-guidelines/perinatal-clinical-practice-guidelines>

- Women are more likely to have attempted suicide than men (57.5% and 44.2% respectively).⁸
- 66% of Aboriginal and Torres Strait Islander women report low or moderate levels of psychological distress and 32% report high or very high levels of psychological distress.⁹
- Women from CALD backgrounds are particularly vulnerable to developing emotional distress or mental health disorders in the perinatal period and they often do not receive the care they need.¹⁰
- Almost 60% of women with disabilities report experiencing at least one stressor in the past 12 months.¹¹
- Lesbian women experience lower levels of sense of belonging than heterosexual women. This can be largely attributed to sexual prejudice and homophobia.¹²
- Decreased sense of belonging is linked with depression, lower levels of self-esteem, self-worth and self-sufficiency¹³.

Implications for government action

Based on the evidence above, there is a need for government to undertake a number of actions, including (but not limited) to the following.

- Act to eliminate discrimination, stigma and inequities, and key risk factors for women's poor mental health and wellbeing.
- Lead – in partnership with peak bodies – the implementation and evaluation of gendered approaches to mental health and wellbeing, focused on reducing the wide-ranging impact of long-term mental health conditions such as depression and anxiety.
- Fund services to implement best practice programs with young women and girls to promote mental health and wellbeing, recognising that primary prevention and early intervention is key to lifelong mental health.

Provide recurrent funding for implementation and evaluation of gender sensitivity and safety programs in adult acute inpatient units and detention environments.

8 Australian Institute of Health and Welfare. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW; 2012 [cited 5 October 2013] Available from: <http://www.aihw.gov.au/publication-detail/?id=10737422172>

9 Australian Bureau of Statistics. The health and wellbeing of Aboriginal and Torres Strait Islander women: A snapshot, 2004-05. Cat. No. 4722.0.55.001. Canberra: ABS; 2007 [cited 4 September 2013] Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4722.0.55.001Main+Features12004-05?OpenDocument>

10 Australian Bureau of Statistics. Reflecting a Nation: Stories from the 2011 Census, 2012–2013. Cat. No. 2071.0. Canberra: ABS; 2013 [cited 5 November 2013] Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/EB2F8382979D8F12CA257842000EC9DA?opendocument>

11 Australian Bureau of Statistics. General Social Survey, Victoria, 2006. Table 4 Personal characteristics, By Age – Females. Canberra: ABS; 2007 [cited 11 December 2013] Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4159.2.55.0012006?OpenDocument>

12 McLaren S. The interrelations between sexual orientation, sense of belonging and dysphoria among Australian women. *Women and Health*. 2006; 43(3): 123-137.

13 Hillier L, Jones T, Monagle M, Overton N, Gahan L, Blackman J & Mitchell A. Writing themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people. Australian Research Centre in Sex, Health and Society: La Trobe University; 2010 [cited 11 September 2013]. Available from: <http://www.glhv.org.au/node/657>

Appendix 6: Partnerships for improved outcomes for women’s health

Victorian women’s health services partner with a range of stakeholders including local government, family violence services, community health services, hospitals and community women to ensure that mainstream services are responding to the needs of women in their services. Partners and stakeholders include individual women and children in the community as well as organisations, agencies and peak bodies, a number of which are listed in the table below. Women’s health services’ ability to engage with, support and lead this multiplicity of partnerships at regional and statewide levels reduces costs to government by decreasing duplication, building regional and statewide strategies or programs that leverage off the capacity in each organisation, and forging links between agencies to create seamless service integration.

Key sectors engaged with	Examples and/or context (not exhaustive)
Legal and justice sectors	Victoria Police; DOJ networks; Legal Aid and other community support mechanisms; Private security companies
Family violence and sexual assault response services	Includes family violence services, sexual assault services, courts, legal services, children’s services; DHS; Integrated Family Violence Committees; consortiums, forums, planning and policy
Acute and allied health sector	Rural, regional and statewide hospitals; Primary Care Partnerships. Advocacy for sexual and reproductive health services; professional development
Community and primary health services sector	Community health centres; maternal and child health; lactation nurses; refugee health nurses; clinical health nurses/nurse practitioners; PCP; Medicare Locals; Divisions of GP; men’s health. Provision of clinical prevention services and preceptorship for new nurses (meeting the need for female Pap providers in rural areas)
Emergency services and emergency management	CFA, SES; VicPol, Vic Fire Services Commission
Local government	Each WHS works with each local council in their catchment – staff and councillors – to varying degrees; support for Municipal Public Health Planning, workplace education to prevent violence, gender equity planning
MAV	WHS work with MAV to support systemic change in local government.
Financial sector	Microfinance; Banks; financial counsellors; Financial literacy programs
Aged sector	PVAW and responses for women experiencing violence, development of educational resources for professionals, forums/conferences
State government	Consultations, input into public policy development, providing services on their behalf
Federal government	Consultations, input into public policy development, providing services on their behalf
Private philanthropic agencies and registered charities	Funding and collaborative purposes
Housing and Homelessness sector	Community/Rural Housing

Key sectors engaged with	Examples and/or context (not exhaustive)
Education	Schools, schools networks; neighbourhood houses, adult/community learning centres; universities, TAFE; adolescent school nurses; welfare coordinators; employment and training; community colleges; Catholic Education and Independent Schools; government P-12; English-language schools. Provision of sexual health education, promoting respectful relationships, whole schools projects, capacity building for staff
Disability	Carer support; PVAW and responses for women experiencing violence, development of educational resources for professionals, forums/conferences; peak bodies
Youth, family and community services	PVAW and responses for women experiencing violence, development of educational resources for professionals, forums/conferences
Aboriginal and Torres Strait Islanders	Aboriginal health cooperatives; Aboriginal controlled organisations; communities
Universities and research foundations	Research centres; Centres for Excellence; supporting student placements
Divisions of General Practice	Capacity building re primary prevention
Community-based women's groups	CWA; Zonta; sporting clubs, etc
Faith Communities	PVAW
Primary Care Partnerships	Each service engages with multiple PCPs in their catchment, with focus including mental health, sexual and reproductive health, violence prevention/gendered approach to service planning
Peak bodies	DVVic; Council to Homeless Persons; CASA forum; Australian Women's Health Network; VCOSS
Migrant and refugee services	Migrant Information Centres, settlement services, MRCs, etc
Medicare Locals	Each service engages with multiple MLs in their catchment
Sporting bodies and local clubs	Regional sporting assemblies; Women's Football Foundation; Victorian Women's Football League; Sporting, craft, fundraising, etc
Environment sector	Focus on gendered impacts of climate change
Women	WHS have extensive links with women in geographically and culturally diverse communities through projects, programs, membership and consultation
Children	Large numbers of girls and boys engage with our programs, particularly through school-based programs
Family Planning services/S&RH services	Regarding unplanned pregnancy, STIs, engaging with social determinants of S&RH
Mental health sector	Violence against women (VAW) is a significant contributor to mental health services for women.
Media	Local and statewide media – advocacy, information provision, engagement

Appendix 7: Setting the agenda since 2006

The Victorian women's health sector has a notable history of collaborating with Victorian women to put women's health on the agenda, influence policy and improve women's health outcomes.

In 2006, Victorian women's health services developed a comprehensive document, *Women's Health Matters: From Policy to Practice – Setting an Agenda for Victorian Women's Health 2006–2010*. The widely-endorsed document was influential in driving priority setting for women's health within government and developing a common set of agreed priorities across the Victorian women's health sector. The document argued for a coordinated and integrated approach to women's health policy, embedding gender in a social determinants approach to health policy and action.

In 2010, a second iteration of this document, *10-point Plan for Victorian Women's Health 2010-2014*, identified that a cross-government approach, coordinated through the Department of Premier and Cabinet, was vital to achieving desired outcomes and improvements for women's health. The action plan, endorsed by over 100 organisations, was cognisant of existing state policies and service systems, as well as emerging state and national policies. It highlighted the importance of initiatives being developed in close collaboration with the Victorian women's health sector with a strong emphasis on measurable, transparent outcomes.