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Women's Health in the South East

INTEGRATED HEALTH PROMOTION PLAN 2017-2021

Southern Metropolitan Region of Melbourne

Acknowledgement

We acknowledge and than the Victorian Department of Health and Human Services for funding the Integrated Health Promotion Plan.

Women's Health in the South East 2018, Integrated Health Promotion Plan 2017-2021, WHISE, Melbourne.

Our Vision

Our vision is to build the capacity of the Southern Metropolitan Region to create norms, practices and structures which promote gender equality.

Women's Health in the South East (WHISE) is the regional women's health service for the Southern Metropolitan Region (SMR) of Melbourne. WHISE is one of 11 women's health services across the state and is funded by the Department of Health and Human Services.

The SMR covers 10 local government areas (see image 1), from South Melbourne down to the Mornington Peninsula and east to Casey and Cardinia.

The SMR covers 2,888 square kilometres, with approximately 1.3 million people, representing about one-quarter of the state's total population. Of this, 689,859 are female and 671,289 are male.

WHISE was established in 1992 and has had a consistent vision;

"To improve the health and wellbeing of women in the SMR within a Social Model of Health and a feminist perspective".

Our core focus is health promotion which is defined as;

'The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions'.[1]

WHISE works within the primary prevention space; addressing the root causes of ill health rather than the visible symptoms. The Collective Impact approach we use is premised on the belief that no single policy, government department, organisation or program can tackle or solve the increasingly complex social problems we face within our region. WHISE therefore works collaboratively with local governments, health and community agencies and other organisations to promote gender-based health promotion action and to influence policy outcomes to improve the position of women in identified priority areas.

The conditions in which people are born, grow, live, work, play and age assume a major role in shaping health outcomes, these are known as the social determinants of health (CSDH 2008). Taking a socio-ecological approach, our Integrated Health Promotion (IHP) plan considers the complex interplay between individual, relationships, community and societal factors. This allows WHISE to understand the range of factors that lead to dramatic differences in health outcomes between various populations groups.

WHISE also works from an Intersectional Feminist Framework that aims to redress inequality and discrimination that women face as a result of their gender. We recognise that women and their experiences are not homogenous, rather their various social identities such as race, gender, sexuality, and class, overlap to result in complex disadvantage which can significantly impact on health.

The political landscape has and continues to change in relation to Gender Equality, Prevention of Violence Against Women [PVAW], and Sexual and Reproductive Health [SRH].

In 2017, Australian was ranked 46th in the world in terms of gender equality (World Economic Forum 2017). In order to progress action on gender equality, in late 2016, the State Government released Safe and Strong, A Victorian Gender Equality Strategy. This strategy has created momentum in the community enabling WHISE to lead strategies to promote equal value and responsibility for all women, men, trans and gender-diverse people in the SMR.

This State strategy provides a clear outcomes framework, strengthening and guiding WHISE's action to achieve gender equality across the SMR.

[1]Our Watch 2017, 'Putting the prevention of violence against women into practice: How to Change the Story'https://www.ourwatch.org.au/getmedia/a8d9dc3d-2291-48a6-82f8-68f1a955ce24/Putting-prevention-into-practice-AA-web.pdf.aspx?ext=.pdf

The findings of the Royal Commission into Family Violence were released in 2016 and all recommendations were accepted, resulting in PVAW being seen as a whole of government priority. In addition, we saw the Victorian Government release the first Primary Prevention Strategy 'Free from violence' in 2017. This has led to an increase demand of women's health services expertise in relation to PVAW, having lead work in this space for over 25 years.

These new developments mean that WHISE has an important opportunity to continue to build the capacity of partner organisations that are new to the space, providing them support and promoting consistency of best practice primary prevention initiatives across the SMR.

After many years of advocacy in Sexual and Reproductive Health (SRH) from all women's health services, the Victorian State Government released a landmark SRH Plan 'Women's Sexual and Reproductive Health: Key priorities 2017-2020.' This plan aims to improve the sexual and reproductive health of all women across the state. This plan has enabled WHISE to secure funding to develop a Regional Strategy that brings key stakeholders together to collaboratively identify and address key SRH priorities in the SMR.

The addition of these three state strategies in the last 18 months demonstrates the urgent need to address and work collectively to prevent violence against women, improve SRH and gender equality across the SMR.

Strategic objectives

WHISE will work under the following three priority areas to acheive the following objectives:

Priority Area - Gender Equity

- Through setting based approaches, increase capacity of partners to achieve gender equality and promote implementation of system level changes.
- Collaborate on research that builds the evidence base of gender equity and disseminate best practice findings to key stakeholders across the SMR
- Improve outcomes and experiences for women within the SMR through localised and higher level collective advocacy on existing, new and emerging gender equity issues.

Priority Area - Prevention of Violence Against Women

- Increase the understanding and capacity of partner agencies to work collaboratively in the Prevention of Violence Against Women through the continued implementation of the Regional PVAW Strategy.

Priority Area - Sexual and Reproductive Health

- Build a collaborative focus towards improving women's SRH through the development, implementation and evaluation of a regional sexual and reproductive health strategy.

For a justification of the need to focus on these three priority areas in relations to improving women's health in the SMR, please see the appendices.

Primary prevention and settings-based approach:

Primary prevention initiatives aim to change the underlying causes of poor health. This is accomplished through targeting whole-of-populations, in settings where we live, work, play and recreate, in addition to targeting prevention efforts at specific at-risk population groups. These settings include:

- education and care settings for children and young people
- universities, TAFEs and other tertiary education institutions
- workplaces, corporations and employee organisations
- sports, recreation, social and leisure spaces
- the arts
- health, family and community services
- faith-based contexts
- media
- popular culture, advertising and entertainment
- public spaces, transport, infrastructure and facilities
- legal, justice and corrections contexts.

Primary prevention aims to achieve social and cultural change by targeting the norms, practices and structures which create complex, interdependent, social systems in which we live, work and play. The socio-ecological model provides the framework through which health promotion initiatives can be designed and implemented to best achieve social change.

1. Norms: rules of conduct and models of behaviour expected by a society or social group
2. Practices: the way these norms are usually or habitually performed
3. Structures: systems such as organisations or rules that arrange our norms and practices in particular ways.

WHISE will aim to transform the norms, practices and structures that result in gender inequality, violence against women and their children, and which mediate women's sexual and reproductive health outcomes.

Principles for prevention

Our Watch research suggests that there are four good practice approaches to the design, implementation and evaluation of primary prevention health promotion initiative's. These are:

Be inclusive and respond to diversity. WHISE IHP will be inclusive through the application of an intersectional feminist lens across all strategy actions.

Work in partnership. This component will be reflected through the collective impact approach.

Challenge masculinity and engage men and boys, while empowering women and girls. The strategies of the WHISE IHP will be gender transformational, actively transforming norms, practices and structures which impact women's health.

Develop and maintain reflective practice to building evidence base. This component will be achieved through following the 6 step framework for primary prevention, detailed below; understand, explore, plan, implement, evaluate and learn.

In order to create a region where women and men have equal value, power and responsibility, and therefore access to resources for good health, WHISE will embed these components our health promotion work.

Primary prevention techniques

To achieve the 2017 – 2021 strategic objectives, WHISE will provide expertise and deliver primary prevention initiatives under the following techniques:

Technique 1: Direct participation programs

Direct participation programs involve face-to-face engagement with individuals or groups. This aims to build participants' understanding of gender inequality, violence against women and sexual and reproductive health through exploring the norms, structures and practices that drive these health issues. These programs also provide participants with the skills and confidence to examine their own beliefs and behaviours and to adopt ones that are more supportive of respect, gender equality and optimal SRH.

Technique 2: Community mobilisation and strengthening

Community mobilisation and strengthening, builds on existing relationships within communities to take collective action to address particular health issues across settings.

Technique 3: Organisational development

Organisational development can include a large range of actions that aim to promote positive structures, practises and norms in the workplace. Organisational development is also an essential internal capacity building activity for organisations wishing to undertake prevention work with external stakeholders or communities.

Technique 4: Communications and social marketing

This technique uses communications to encourage behavioural and attitudinal change. It does this through a variety of media and popular entertainment channels including television, radio, print, online media and social media. Our watch (2017) explain that institutions like the media represent important 'culture creators' that can have a powerful role in establishing norms and disseminating information, and therefore influencing social change. Communications and social marketing are particularly powerful when undertaken as part of a broader multi-setting and multi-technique initiative.

Technique 5: Civil society advocacy

Advocacy is about building collective momentum for change. Civil society organisations are key players in building and supporting social movements that encourage governments, organisations, corporations and communities to take action.

Evidence shows that civil society advocacy, particularly through women's organisations, is essential to long-term and effective policy development for gender equality, PVAW and SRH.

Planning, implementation and evaluation

In line with evidence based practice, WHISE will follow the Our Watch[2] six step framework for primary prevention initiative's:

This framework was developed based on well established guidelines on prevention work from the women's health associations Victoria, Vic Health and the UN.

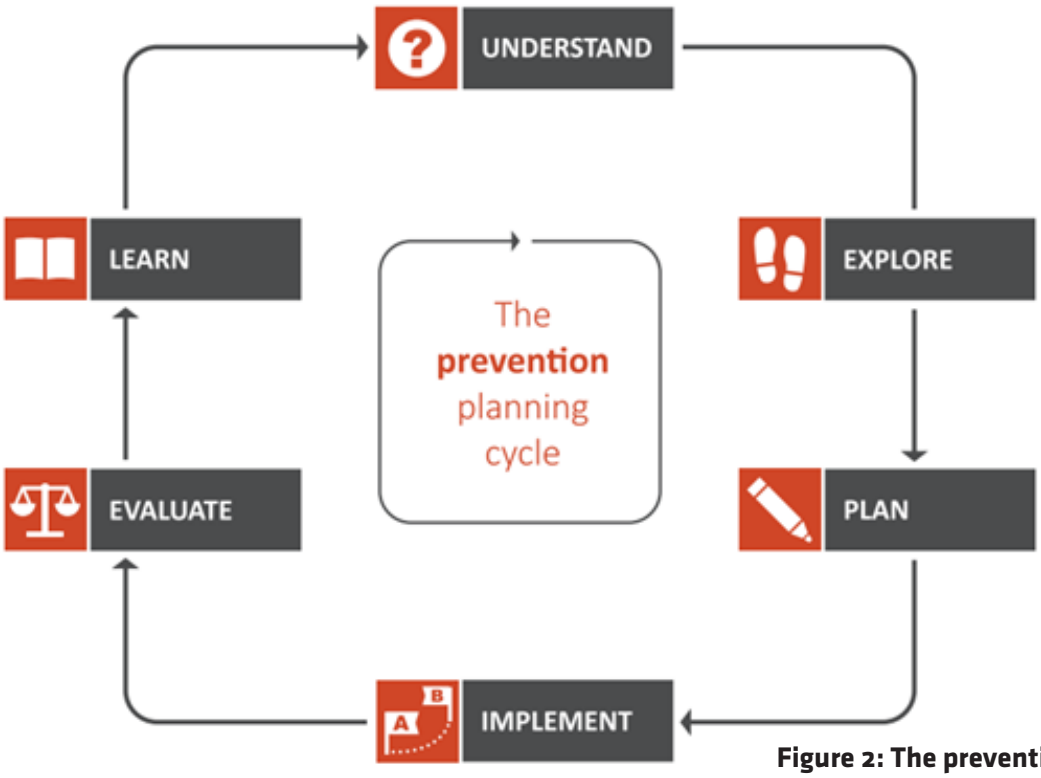

Figure 2: The prevention planning cycle

As demonstrated in figure 2 there are six key steps in the prevention planning cycle:

1. Understand: This step requires the understanding of statistics and data, applying an intersectional lens, drawing on key national and local policies and plans, as well as identifying effective and promising prevention initiatives to implement.
2. Explore: This stage is where you choose a setting, research and conduct a gender analysis of this setting (understanding gendered issues in this setting) and identify your key stakeholders.
3. Plan: Formalise partnerships and governance structures, decide what technique/s will be utilised, create a logic model, implementation plan, and evaluation.
4. Implement: this stage involves evaluation and continuous improvement. Constant referring back to your logic model and your implementation plan, and being realistic about timeframes for implementation
5. Evaluate: Evaluation is crucial for effective and sustainable prevention work, to learn about what works and what doesn't work, and to examine and prevent unintended consequences. Evaluation provides solid information to share with others and to help build a prevention sector.
6. Learn: This stage includes two key elements: reflection and sharing what you have learnt (See appendix 4. for example of logic model)

[2]Our Watch 2017, 'Putting the prevention of violence against women into practice: How to Change the Story'https://www.ourwatch.org.au/getmedia/a8d9dc3d-2291-48a6-82f8-68f1a955ce24/Putting-prevention-into-practice-AA-web.pdf.aspx?ext=.pdf

Our Priorities

Priority Area	Gender Equity
Goal	Promote gender equality across the SMR
Target population group/s	Women in the Southern Metropolitan Region

Objective 1.1	Planned impact indicators	Timeline responsibilities (include partners as relevant)
Through setting based approaches, increase capacity to identify barriers and opportunities to achieve Gender Equality and promote implementation of system level changes.	In line with the State Government Safe and Strong: A Victorian Gender Eqaulity Strategy: • Increased focus on gender equality in SMR • Increased number of organisations that demonstrate a public/communicated commitment to gender equity • An increase in the number of gender equitable policies in partner organisations. • A regional community that understands how to practice gender equality • A regional culture that values men and women equally across all settings andlife stages.	2017-2021 Local government, community health services, health services, Primary Care Partnerships [PCPs], schools, sports and recreation

Interventions/Strategies	Planned process indicators	Timelines and responsibilities (include partners as relevant)
1.1.1 Build capacity of SMR to conduct Gender Equity assessments across all settings	• Number of organisations that completed gender equity assessments • Number of meetings that supported adoption of gender equity assessment	2017-2019 Local government, Community Health services and schools
1.1.2 Build capacity of SMR to understand gender norms, practices and structures, through Gender Equity training	• Number of training sessions conducted • Number of participants who received training • Number of organisations that have received training	2017-2021 Local government, community health services PCPs, schools, sports and recreation
1.1.3 Develop communication engagement strategies that provide opportunities for communicating Gender Equity and improving the organisational profile	• Number of WHISE members • Number of newsletters distributed • Number of newsletter recipients • Number of social marketing events and campaigns	2017-2021 Local government, community health services and PCPs
1.1.4 Support the role out of primary prevention initiatives including Respectful Relationships whole of school approach	• Number of schools and regions supported • Number of induction and training sessions held • Number of participants attending	2017-2021 Local Government, Department of Education and Training, schools in SMR
1.1.5 Build capacity of key stakeholder to deliver gender equity training within their local government area, to ensure best practice in the SMR	• Number of organisations consulted on training • Number of organisations who received feedback • Number of organisations who successfully delivered gender equity training with support from WHISE	2017-2021 Local government, community health services, PCPs, schools, sports and recreation

Objective 1.2	Planned impact indicators	Timeline responsibilities (include partners as relevant)
Collaborate on research that builds the evidence base of gender equity and disseminate best practice findings to key stakeholders across the SMR	In line with the State Government Safe and strong: A Victorian Gender Equity Strategy: • Continue to champion gender equality in SMR • Increased stakeholders' awareness and understanding of literature regarding the impact of gender inequality • Partners are actively engaged in implementing best-practice initiatives in order to create a society of gender equality, across all settings	2017-2021 Universities, ANROWs, PCPS, Local Government

Interventions/Strategies	Planned process indicators	Timelines and responsibilities (include partners as relevant)
1.2.1 Collaborate with universities and peak research bodies to conduct research on gender equity in the context of the SMR.	• Number of research projects assisted with • Number of research peak bodies engaged • Number of conferences delivered • Number of collaborative projects	2017-2021 Universities, ANROWs, PCPS, Local Government
1.2.2 Create and disseminate evidence to inform policy and practice that promotes gender equality throughout SMR	• Number of factsheets • Number of tools created • Number of key resources distributed	2017-2021 Universities, ANROWs, community health services, PCPS, Local Government and schools
1.2.3 Provide expertise to partners to encourage and promote adoption of evidence based practice in primary prevention	• Number of partners listed with/provided expertise to • Number of evidence based primary prevention initiatives implemented	2017-2021 Community health services, PCPS, Local Government,schools, sports and recreation centres.

Objective 1.3	Planned impact indicators	Timeline responsibilities (include partners as relevant)
Improve outcomes and experiences for women within the SMR through localised and higher level collective advocacy on existing, new and emerging gender equity issues.	In line with the State Government Safe and strong: A Victorian Gender Equity Strategy: • Increased awareness and understanding of the extent and impact of gender inequality on health • Increased emphasis on understanding the importance of addressing gendered health issues • Increased access to gender sensitive health services • Increased capacity of individuals to make informed choices around their health • Increased positive representation of women in the media • Increased health and wellbeing of women	2017-2021 Local Government, community health services, PCPS, schools, sports and recreation centres and for-profit organisations

Interventions/Strategies	Planned process indicators	Timelines and responsibilities (include partners as relevant)
1.3.1 Collect, distribute and raise awareness of health issues impacting women in the SMR, from an equity perspective	• Number of posts about health issues in our region	2017-2021
1.3.2 Collaborate with media agencies to create positive discourse on gender equality in the SMR	• Number of partner agencies supported • Frequency and type of support • Number of media releases that promote gender equity	2017-2021
1.3.3 Work with key decision-makers in our area to increase focus on women's health and well-being from an equity perspective	• Number of decision-makers engaged • Number of issues advocated for	2017-2021

Priority Area	Prevention of Violence Against Women
Goal	To reduce the incidence of violence against women in the Southern Metropolitan Region
Target population group/s	All women in the Southern Metropolitan Region

Objective 2.1	Planned impact indicators	Timeline responsibilities (include partners as relevant)
Increase the understanding and capacity of partner agencies to work collaboratively in the prevention of violence against women, through the continued implementation of the Regional PVAW Strategy	In line with the State Government Free from Violence Strategy: • Increased awareness of what constitutes violence • Increased number of organisations with systems to support PVAW • Increased confidence in bystanders action • Increased number of organisations that model and promote gender equitable practices • Increased awareness and understanding of the extent and impact of gender inequality in relation to PVAW • Increase partners understanding and actions to challenge the four gendered drivers of violence • Increased culture in which individuals feel able, safe and supported to report experiences of violence	2017-2021 Local Government, community health services, PCPS, schools, sports and recreation centres and for-profit organisations

Interventions/Strategies	Planned process indicators	Timelines and responsibilities (include partners as relevant)
2.1.1 Continue to lead PVAW Regional Strategy Community of Practice and Steering Committee in line with State Government strategies	• Number of COP meetings • Number of steering committee meetings • Number of shared action plans • Number of signed partners • Number of settings engaged with the strategy	2017-2021 Local Government, community health services and PCPs
2.1.2 Develop, implement and lead annual PVAW Regional Strategy action plans with partners	• Number of annual action plans completed throughout the region • Number of partners involved in completed annual action plans	2017-2021 Local Government, community health services and PCPs
2.1.3 Formalise a consistent PVAW induction and orientation program with our Regional Strategy partners	• Number of partners embedding PVAW e-learning module into their induction process • Number of partners making a commitment to modify induction process to include PVAW	2017-2018 Local Government, community health services and PCPs
2.1.4 Conduct annual needs analysis to identify ongoing and/or changing needs in support of PVAW regional strategy	• Develop an annual needs analysis tool • Distribute tool to all partners • Analyse the findings of the needs analysis • Distribute a summary of the findings • Revise annual action plans to reflect needs	2017-2021

Priority Area	Promoting Sexual and Reproductive Health
Goal	To improve the sexual and reproductive health of women in the Southern Metropolitan Region
Target population group/s	The population of the Southern Metropolitan Region in particular those who experience higher rates of disadvantage

Objective 3.1	Planned impact indicators	Timeline responsibilities (include partners as relevant)
Build a collaborative focus towards improving women's SRH through the development and implementation of a regional sexual and reproductive health strategy	In line with the State Government Sexual and Reproductive Health Key Priorities: • An increase in health professionals' commitment to gender equitable SHR health services • Increased women's and health professional's knowledge and awareness of preconditions that impact women's SRH health • A culture where SRH is free of discrimination and stigma	2017-2021 Local Government, community health services, schools, Primary Health Networks (PHNs), health care providers and PCPs

Interventions/Strategies	Planned process indicators	Timelines and responsibilities (include partners as relevant)
3.1.1 Mapping of current systems preventing good SRH in the SMR (needs and gaps)	• Number of preconditions to good SRH mapped	2017-2018
3.1.2 Engage and motivate key SRH stakeholder to become signatories to a regional strategy to drive SRH action across the SMR	• Number of key stakeholders engaged in the strategy	2017-2018 Local Government, community health services, schools, PHNs, health care providers and PCPs
3.1.3 Lead and facilitate the SRH Community of Practice and Steering Committee in the SMR	• Number of Steering Committee meetings • Number of Community of Practice meetings	2018-2021
3.1.4 Develop shared annual action plans to address preconditions to good SRH in SMR	• Number of actions/action plans created to address preconditions to good SRH	2018-2021 Local Government, community health services, schools, PHNs, health care providers and PCPs

Objective 3.2	Planned impact indicators	Timeline responsibilities (include partners as relevant)
Build capacity of SMR to understand and promote Sexual and Reproductive Health (SRH)	• Improved understanding of SRH	2018-2021

Interventions/Strategies	Planned process indicators	Timelines and responsibilities (include partners as relevant)
3.2.1 Mapping of current systems preventing good SRH in the SMR (needs and gaps)	• number of preconditions to good SRH mapped	2017-2018
3.2.2 Increase agencies capacity to understand the systems that influence SRH outcomes	• Number of factsheets provided to key stakeholders on SRH • Number of workshops/information sessions provided to relevant stakeholders • Number of organisations engaged with the resources distributed	2018-2021 Local Government, community health services, schools, Primary Health Networks (PHNs), health care providers and PCPs

Objective 3.3	Planned impact indicators	Timeline responsibilities (include partners as relevant)
Research and advocate for SRH in the SMR	• Increased understanding of SRH within SMR • Interventions are evidence based and encourage best practice • Increased awareness of organisational profile in SRH across region	2018-2021

Interventions/Strategies	Planned process indicators	Timelines and responsibilities (include partners as relevant)
3.3.1 Identifying and promoting evidence based approached to increasing women's access to SRH information and services across all settings	• Continue to promote, distribute and interpret best practice evidence related to SRH.	2018-2021
3.3.2 Advocate for SRH rights of all women in the SMR	• Number of external networks attended • Number of posts shared on social media platforms relating to SRH rights in the SMR • Presence in public commitment to SRH	2018-2021

Appendices

Appendix 1

Priority Area – Gender Equity

Evidence and rationale

Gender Equity:

Gender equity is the process of giving women and men the resources that they need to succeed in life. Gender equity recognises the diversity of disadvantage experienced by women and directs resources accordingly in order to reach equality.

Gender equality is the equal outcomes achieved through the process of equity. WHISE, along with the other women's health services have been advocating for gender equality for the past 25 years. Since the Royal Commission in Family Violence we have seen a positive change in systems now acknowledging gendered issues. The Victorian Government's release of its first Gender Equality Strategy, ***Safe and Strong a Victorian Gender Equality Strategy*** demonstrates this acknowledgment to preventing violence against women through gender equality. It aims to keep gender on the agenda through attitudinal and behavioural change required to reduce violence against women and achieve gender equality. This landmark document acknowledges that gender inequality exists across the lifespan and it is intersectional. That is, it impacts individuals in different ways and can be compounded by other forms of discrimination and oppression. The strategy further acknowledges that inequality impacts men too and finally that gender equality is a human right that delivers social benefits.

Gender equality cannot be achieved alone, it is the responsibility of all of us – individuals, families, communities, work places, businesses, sporting associations, as well as media and the arts to build a culture of respect and equality for all individuals.[3]

In order to challenge harmful gender norms and restructure the boarder social conditions which create gender inequality, WHISE will drive gender transformational policy and practice in the SMR. Gender transformative practice considers the ways in which men and women's health are impacted by gender roles and stereotypes of masculinity and femininity.[4] As the name suggests, gender transformative policy and practice aims to transform unequal values, power and responsibility attached to these roles and stereotypes, in order to improve health outcomes in our community. Like all primary prevention initiatives, these take time, however have the powerful impacts on population health.

In the Southern Metropolitan Region, we have LGA's which experience significantly more privilege and those which experience significantly higher rates of oppression.

Gender inequality in the workplace:

As of May 2017, Australia's national gender pay gap stands at 15.3%, with women in full time work earning on average $251.20 less per week than men.[5] Over 20 years, the gender pay gap has ranged between 14.9 in 2004 and 18.5 in 2014. The pay gap starts from the time women enter the workforce. Contributing factors include: hiring and pay discrimination, female-dominated sectors attracting lower wages, women's disproportionate share of unpaid caring and domestic work, limited workplace flexibility to accommodate women's non-work responsibilities, and women's greater time out of the workforce impacting career progression.[6] The gender pay gap, combined with women's higher likelihood of part-time work, impacts on their lifetime economic security and

[3]Victorian State Government, 2016, 'Safe and Strong: A Victorian Gender Equality Strategy', State of Victoria, Melbourne.
[4]Women's Health Victoria, 2012, 'Gender transformative policy and practice' Women's Health Victoria, Melbourne.
[5]Workplace Gender Equality Agency, 2017, 'Australia's gender equality scorecard: Key findings from the Workplace Gender Equality Agency's 2016-17 reporting data
[6] ibid

In the SMR, we consistently see gender inequality based on employment type between women and men, with higher rates of women employed on a part-time basis, while a very small percentage of men are employed on a part-time basis. ABS census data from 2011 demonstrated that Mornington Peninsula and Bayside the highest gender inequality in the region with 50% of women in part-time work compared to only 20% of men in these LGAs.

Kingston, Glen Eira and Frankston councils scored 46-47% of women versus 17-20% of Men in these LGA's. Casey had 44% of women in part-time employment and only 15% of men in these positions. Stonnington and Greater Dandenong had 37 and 39% of women in part-time employment, while only 19% and 22% of men in this employment type.[7]

Lastly, Port Phillip had the lowest rates of inequality in employment type between the sexes, with 29% of women in part-time work and 17% of men.

When looking at 2011 census data relating to full time employment we again see gender inequality. Demonstrating the same patterns as above, this is highest in Mornington Peninsula, Bayside, Cardinia and Frankston. Followed closely by Casey, Glen Eira, Kingston and Greater Dandenong. While Port Phillip remained the only LGA in the SMR where women employed full-time ranked above the state average, demonstrating the lowest inequality in full-time employment in our region (66% females vs 79% of males). This was followed closely by Stonnington.[8]

Gender transformative practice and policy is needed to ensure equality between men and women in the workplace. In particular, to ensure that women have equal access to resources in order to participate fully and equally in life, in the same way that men do. In addition, we need to ensure men are encouraged and valued when working part-time and undertaking child-rearing.

Gender inequality in income:

ABS census data from 2016 demonstrated clear gender inequality in the proportion of women and men who earn below the minimum weekly wage (that is, $0 -$649 pw) across the SMR. In our region, the proportion of women earning below the minimum weekly wage was consistently higher than men. There were six LGAs in which the proportion of women earning below the minimum weekly wage exceeded the State average.

Greater Dandenong had the highest inequality between women and men with 53% of women earning below the minimum weekly wage compared to 39% of men. This was followed closely by Mornington Peninsula (F= 46%, M=30%), Casey and Frankston held the same percentage of inequality (F=44%, M=28%) followed by Kingston (F=42% M=29%). Glen Eira (F=39%, M=28%) matched the state average for women earning below the minimum weekly wage. While the remaining three LGAs scored below the state average, while still demonstrating gender inequality.[9]

In Bayside 36% females and 24% of males earned below the minimum weekly wage. Thirty-two per cent females and 23% males in Stonnington and lastly, 28% females and 21% of males in Port Phillip earnt below the minimum weekly wage with the smallest inequality across our region.[10]

Gender inequality and ageing:

ABS statistics demonstrate that Australia has an ageing population as a result of sustained low fertility and increasing life expectancy. This will result in proportionally fewer children in the population and a proportionally larger increase in those aged 65 and over. Census data from 2016 showed females aged under 15 years accounted for 17.3% and males 18.7% of the population in the SMR.[11] Young women are particularly affected by boarder societal issues relating to body image, to an extent not experienced by young men. [12]

Across the SMR, the largest proportion of our population is aged between 25 and 44 years with females and males across the region accounting for between 20 and 22% of the population. Applying a gendered lens, we know that in Victoria women are particularly at risk of violence aged between 15 and 50 years of age.[13] In addition, violence in intimate relationships contributes more to the disease burden for women aged 18 to 44 years than any other risk factor like smoking, alcohol use or being overweight or obese.[14] WHISE will continue to challenge the underlying causes of violence in order to ensure the best quality of life in this population group.

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[7] Australian Bureau of Statistics (ABS), 2011, 'Census of Population and Housing, Census Table: Labour Force Status by Employment type by Labour Force Status by Sex by LGA Population: Persons aged 15 years and over' ABS

[8] ibid.

[9] Australian Bureau of Statistics (ABS), 2016, 'Census of Population and Housing, Census Table: Total Personal Income (Weekly) by Sex by LGA, Population: Person aged 15 years and over' ABS.

[10] ibid.

[11] Australian Bureau of Statistics, 2016, ' Census of Population and Housing, Census Table: Persons by Age by Sex by LGA, Population: Persons'

[12] Webster et al. 2017, 'Growing up unequal: how sex and gender impact young women's health and wellbeing (Women's Health Issues Paper 12), Women's Health Victoria, Melbourne.

[13] Crime Statistics Agency, 2017 'Family incidents', Webpage: https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/family-incidents-4

[14] Australian National Research Organisation for Women's Safety (ANROWS), 2016, 'Examination of the burden of intimate partner violence against women in 2011: Final report, ANROWS, Sydney.

The SMR also has a larger proportion of females aged over 65 years (F= 16.6%, M= 14.4%) (ABS 2016). Older women are increasingly living in poverty due to the accumulative impacts of gender inequality throughout life including lack of superannuation, gender pay gap, unpaid care in the home and a lack of supportive systems.[15] In addition, in the past 12 months we have seen an increase in the rates of elder abuse being reported to police, with females being disproportionately impacted 1,894 incidents in comparison to 1,154 incidents for males.[16]

Mothers' Index Indicator:

The Mothers' Index Indicator was developed and used by Save the Children globally for 15 years and is informed by an in-depth literature review and consultation with international and local experts.[17] The indicators measure a mother's health, wellbeing of her children, her education, the family's economic status and SES. Scores for each five indicators are sorted from low to high and ranked from 1 to 79 (1 being the best place for a mother to live) to give the overall Mothers Index rank for each LGA.

In 2016, SMR ranked 39.8 above the State average of 22.1.[18] However when we look at ranking per LGA we can see varying degrees of advantage and disadvantage. Scoring better than the state average was Stonnington ranked 1, the highest in our region. Followed closely by Port Phillip (3), Bayside (4) and Glen Eira (5). Kingston ranked 16, while Mornington Peninsula scored 24, Cardinia 27 and Casey 35.

Frankston ranked higher (therefore worse) than the state average with a score of 41, while Greater Dandenong ranked worse in our region with the highest score of 65. This data demonstrates the diversity of advantage and disadvantage across the SMR.

We need to consider the social determinant of health from an intersectional lens in order to understand how the social conditions in which women live, across different LGA's, influence their health and access to health services differently.

Gender inequality in Leadership:

Gender disparities are consistently seen across Australian workplaces, such as the disparity between men and women in leadership roles. This perpetuates existing stereotypes about the role of women, both at work and in wider society, and exacerbates gender pay inequality.[19] While women in leadership does not provide a solution for gender inequality, women's increased representation contributes to gender equality which is a key determinant for women's health.

In 2016, only three of 10 mayors were female. Port Phillip was the only LGA in the SMR with a female CEO. Women were also underrepresented as Councillors across all 10 LGA's.[20]

Stonnington, Mornington Peninsula and Casey had 57% male councillors and 43% female. Cardinia had 64% males and 36% females. Kingston 67% males and females 33%, Glen Eira and Bayside had 71% males and only 28% females. Greater Dandenong 76% males and 23% females. Port Phillip had low equality by sex with only 20% of councillors being females, while 80% male. While Frankston had the lowest representation of female councillors with 14% females and 86% males.

Women are also underrepresented in executive, general management and legislator positions across the SMR. With 2011 census data demonstrating that only 20% of females represented in these positions across Casey, Mornington Peninsula, Bayside, Cardinia and Frankston city councils. Similarly, only 21% of females were represented in Kingston, 24% in Greater Dandenong, Glen Eira and Stonnington. While Port Phillip had the highest representation with 33% of females in these positions. From this data we can see that gender inequality in leadership is pervasive across the SMR.

WHISE will continue to advocate for women in leadership in order to improve the health and wellbeing of women and men in the SMR.[21]

[15] Women's Health Victoria, 2017, Victorian Women's Health Atlas, Website
[16] Crime Statistics Agency, 2017 'Family incidents', Webpage: https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/family-incidents-4
[17] Women's Health Victoria, 2017, Victorian Women's Health Atlas, Website
[18] Save the Children, 2016, 'State of Australia's Mothers Report' https://www.savethechildren.org.au/__data/assets/pdf_file/0007/143863/SOAM_report_2016.pdf
[19] Women's Health Victoria, 2017, Victorian Women's Health Atlas, Website
[20] Municipal Association of Victoria, 2016, 'Women In Local Government' http://www.mav.asn.au/about-local-government/women-in-local-government/Pages/default.aspx
[21] Australian Bureau of Statistics (ABS), 2011, Census of Population and Housing, Census Table: Labour Force Status by Occupation by Sex by LGA, Population: Persons aged 15 years or over, ABS

Appendix 2

Priority Area – PVAW:

Evidence and rationale

One in three Australian women will experience physical violence and one in five women over the age of 15 will experience sexual violence at some stage in their lifetime.[22] Violence against women includes psychological, economic, emotional, physical and sexual violence and is the leading preventable contributor to death, disability and illness in Victorian women aged 15 - 44 years.[22] It compounds existing socioeconomic disadvantage, that may result in homelessness, and has significant effects on the mental health of those affected.

Within the SMR there are pockets of disadvantage wherein we see both high and lower rates of violence in varying local government areas. However, looking at SMR as a whole, we continue to see an increase in rates of violence from 2013 to 2017 (SMR 2013 = 1,073 per 100,000 pop compared to 1,213 in 2017)[23], reflective of wider state trends. These rates demonstrate the need to work within the primary prevention space.

WHISE is committed to focusing on gender inequality in the prevention of violence against women by concentrating efforts on the gendered drivers of violence as outlined in 'Change the Story: a shared framework for the primary prevention of violence against women and their children in Australia':

- Condoning of violence against women
- Men's control of decision making and limits to women's independence
- Stereotyped constructions of masculinity and femininity
- Disrespect towards women and male peer relations that emphasise aggression

For the first time, all local governments in Victoria are legislated to have family violence as a priority in their Municipal Public Health and Wellbeing Plans. WHISE has worked with all local councils in our region, providing expertise and recommendations on the approach they can take to prevent gender-based violence. We have also seen a substantial increase in community health services choosing to include PVAW and/or Gender Equity as health priorities in their 2017 – 2021 strategic plans.

Through consultation with local governments and community organisations WHISE has established that their position within the PVAW space would be best suited to working in partnership with these councils and organisations on their health promotion interventions. In addition, we will provide expertise and support, at the organisational level, to our partners rather than working directly with the community members.

[22]Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth, 2015, 'Change the story: A shared framework for the primary prevention of violence against women and their children in Australia', https://www.ourwatch.org.au/getmedia/0aa0109b-6b03-43f2-85fe-a9f5ec92ae4e/Change-the-story-framework-prevent-violence-women-children-AA-new.pdf.aspx.
[23]Crime Statistics Agency, 2017, 'Family Incidents', Webpage: https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/family-incidents

Appendix 3

Priority Area – Sexual and Reproductive Health:

Evidence and rationale

'Sexual and Reproductive health [SRH] includes the right to healthy and respectful relationships, inclusive, safe and appropriate services, access to accurate information, and effective and affordable methods of family planning and fertility regulation.'[24]

SRH is a growing issue as indicated by the emerging health literature which emphasises the importance of the work that WHISE and many other organisations are undertaking in this space.

Access to SRH services is a fundamental right for every woman. In early 2017, Victoria released its first Sexual and Reproductive Health strategy and action plan that focuses on four priority action areas. The strategy is supported by $6.6 million to ensure that *'all Victorian women, regardless of where they live and how much money they have, are given access to the services and support they need'.*[25]

For the first time at a state level the link between PVAW and SRH has been formally made. Family and gender-based violence can create barriers to women's right to safely access appropriate SRH care services including timely access to contraception and fertility services.[26] The strategy highlights that SRH is not just about the absence of disease, it includes the right to healthy and respectful relationships and involves respect, safety and freedom from violence.

The strategy also identifies that 'sexual and reproductive health is critically influenced by sex and gender norms, roles, expectations and power dynamics'. Societal norms place responsibility for contraception on women. This means that young women are more likely to believe that they hold responsibility for condom use and managing any risks associated with sex.[27] In addition, women often face stigma attached to casual sexual practices, whereas for men this behaviour is normalised and accepted. This stigma can have implications for women accessing sexual and reproductive health services.[28]

Over the past four years, WHISE has explored a range of SRH issues across all life stages. Leading a regional strategy for action on SRH is fundamental in that it not only addresses service gaps but also the key determinants and factors impacting SRH of all women in the SMR. This strategy provides an opportunity for alignment at state level, while promoting collaboration amongst partner agencies to improve SRH from a regional perspective.

[24]Department of Health and Human Services, 2017, 'Women's Sexual and Reproductive Health: Key Priorities 2017 – 2020', State of Victoria, Melbourne.
[25]Department of Health and Human Services, 2017, 'Women's Sexual and Reproductive Health: Key Priorities 2017 – 2020', State of Victoria, Melbourne.
[26]Miller et al, 2010 'Pregnancy coercion, intimate partner violence and unintended pregnancy', Contraception, vol. 81, pp. 316-322
[27]Youth Affairs Council of Victoria (YACVic) and Victorian Rural Youth Services, 2013, 'Young people and sexual health in rural and regional Victoria, p.10
[28]Bishop EC, 2012, 'Examining the raunch culture thesis through young Australian women's interpretations of contradictory discourses', Journal of Youth Studie, vol. 15, pp. 821-840

Research and consultation for the development of this plan and the regional strategy has demonstrated a need for focus on the following areas relevant to SRH:

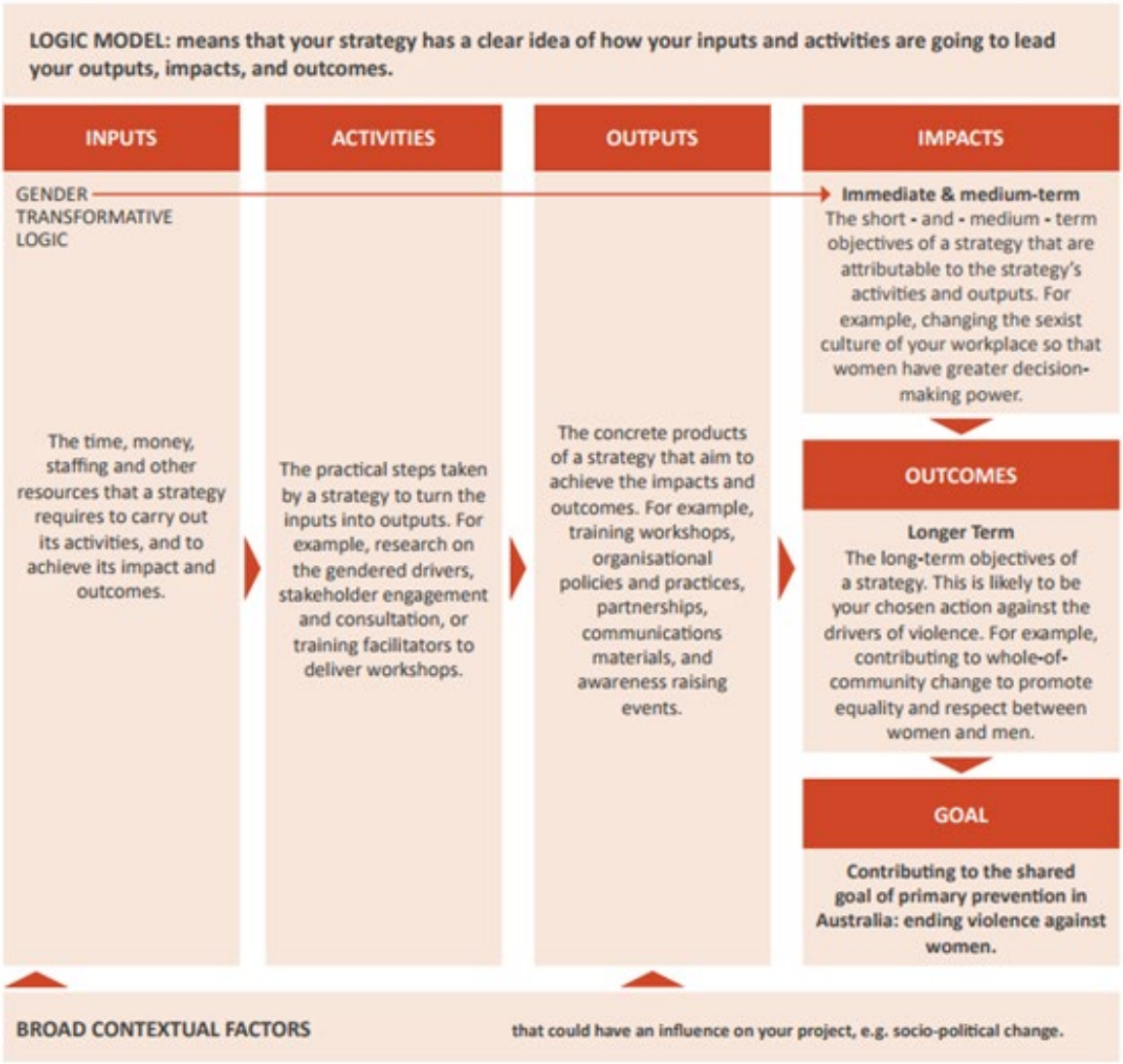
- Chlamydia remains the most common of all STIs in the SMR and rates have remained steady, albeit high, since 2011 despite a two-fold increase in testing. Young people aged 25 – 34 years are the most likely to be affected although rates remain high amongst those aged 20 – 54.[29]
- In the SMR, the proportion of women newly diagnosed with Chlamydia exceeded the state average in six of ten LGAs. Bayside reported the lowest number of new diagnosis (F=13.61, M=13.72 per 10,000), while Port Phillip held the highest rates (F=41.26, M=40.82 per 10,000).
- Data from 2015 shows the rates of newly diagnosed Hepatitis B was lowest in Bayside with only 0.4 females and 1.1 males impacted per 10,000 cases. The rates were highest in Greater Dandenong with 10 females and 10 males per 10,000 exceeding the state average of 4 cases per 10,000.
- Rates of newly diagnosed HIV, per 10,000 people, were lowest in Bayside, Casey, Cardinia, Frankston and Kingston. The highest rates were seen Port Phillip, followed by Stonnington.
- Similarly, in 2015 seven of our 10 LGAs had rates of gonorrhoea above state average. Ranking highest were Stonnington and Port Phillip. While Mornington Peninsula had the lowest rates.
- Rates of papscreening are inconsistent across the region. Rates of screening in Frankston, Greater Dandenong, Cardinia and Casey, fell below the state average . While Bayside exceeded the State average.[30]
- Between one quarter and one third of Australian women will experience an abortion in their lifetime,[31] however access to and information regarding these services are limited in the SMR.
- It is estimated that half of all pregnancies in Australia are unplanned.[32] This demonstrates the need for information and access to family planning in the SMR.

Despite Victoria having legislation that supports this strategy, many barriers and service gaps exist that affect women's access to services and information enabling them to make informed reproductive decisions across the life stages. Many SRH services in the SMR focuses strongly on early intervention and response, with limited focus on primary prevention. This supports the need for a more coordinated approach to SRH, similar to that of the current 'Preventing Violence Together: regional strategy for the SMR' led by WHISE.

[29]The Kirby Institute, 2016, 'HIV, Viral Hepatitis and Sexually Transmissible Infections in Australia Annual Surveillance Report 2016'. The Kirby Institute, Sydney.
[30]Victorian Cervical Cytology Registry, 2014, 'Statistical Report 2013', http://www.vccr.org/site/VCCR/filesystem/documents/dataandresearch/StatisticalReports/VCS_StatisticsReport_2013_Web_SinglePages_Final.pdf.
[31]Chan et al, 2009, 'Pregnancy Outcome in South Australia', Pregnancy Outcome Unit, SA Health, Government of South Australia.
[32]Rissel et al, 2003, 'Sex in Australia: attitudes towards sex in a representative sample of adults', Australian and New Zealand Journal of Public Health, 27(2), 118-123.

Appendix 4

Developing your logic model[33]



[33]Our Watch 2017, 'Putting the prevention of violence against women into practice: How to Change the Story'https://www.ourwatch.org.au/getmedia/a8d9dc3d-2291-48a6-82f8-68f1a955ce24/Putting-prevention-into-practice-AA-web.pdf.aspx?ext=.pdf

Women's Health in the South East 2018, Integrated Health Promotion Plan 2017-2021, WHISE, Melbourne.

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