Women's Health West

Integrated health promotion plan 2017 – 2021

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Women's Health West acknowledge the traditional custodians of the land on which we work, the people of the Kulin Nation, and we pay our respect to Elders and community members past and present. We express solidarity with the ongoing struggle for land rights, self-determination, sovereignty and the recognition of past injustices. We express our hope for reconciliation and justice. Women's Health West acknowledge the support of the state government.

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Contents

Women's Health West - an overview

Women's Health West (WHW) has actively contributed to the health, safety and wellbeing of women in the western region of Melbourne since 1988, through a combination of direct service delivery, research, health promotion, community development, capacity building, group work and advocacy. Our core business includes the development and implementation of strategies to prevent, intervene and respond to the homelessness, ill-health, dislocation and trauma facing women and children who experience family violence. Since 1994, WHW has delivered a wide range of effective, high quality family violence services for women and children ranging from crisis outreach and court support, to housing establishment and crisis accommodation options, to counselling and group work programs. WHW has been an active and strong supporter of family violence reform at a regional and statewide level. WHW is one of Victoria's only organisations that works across the continuum of primary prevention, intervention and response to men's violence against women and children.

WHW's strategy, advocacy and community engagement stream offers a range of health promotion and primary prevention programs and initiatives to prevent and intervene early to improve outcomes for women's health, safety and wellbeing and to increase gender equity for women and girls in Melbourne's west. We work to achieve change at a systems level by advocating, advising and working with a range of service sectors and partner organisations to promote women's health, wellbeing and safety. Our direct project work involves strong partnerships, collaboration, and the codesign of gender transformative health promotion programs and initiatives with women, young people and communities. We are also a leader in the development of regional strategies to further this work, seeing partnership within and beyond the sectors in which we work as crucial for bring about effective and sustainable outcomes for women and their children.

WHW's integrated health promotion priority areas for 2017-2021 are:

1. Preventing violence against women
2. Promoting mental health and wellbeing
3. Promoting sexual and reproductive health

Melbourne's western metropolitan region

WHW services Melbourne's west, which comprises the seven local government areas (LGAs) of Brimbank, Hobsons Bay, Maribyrnong, Melbourne, Melton, Moonee Valley and Wyndham. Our catchment can be characterised by a gentrified inner area, pockets of public housing and entrenched disadvantage in the middle area, and consistent growth in the outer western corridors.

Of the ten fastest growing municipalities in Australia for the year ending 30 June 2015, three were LGAs in our catchment - the City of Melbourne, the City of Wyndham and the City of Melton (The Population Experts, 2016). This rapid growth exerts enormous pressure on planning, infrastructure and program and service provision.

The Index of Relative Socio-economic Disadvantage indicates the high burden of ill health and disadvantage experienced by communities in Melbourne's west. The top ten most disadvantaged local government areas (LGAs) in metropolitan Melbourne include four western region municipalities - Brimbank (ranked second), Maribyrnong (ranked fourth), Melton (ranked ninth) and Hobsons Bay (ranked tenth). In fact, all seven of the western region's LGAs are named in the top 17 most disadvantaged municipalities in metropolitan Melbourne.

The west of Melbourne can also be characterised as a culturally diverse and vibrant region. Residents speak more than 100 languages and it has long been a settlement area for refugees,

including those from South-East Asia, the Horn of Africa and Southeast Europe. Census data from 2016 indicated that 46.8 per cent of women in Melbourne's west were born overseas, which is notably higher than the Victorian average of 26.8 per cent (Women's Health Victoria, 2017). Some municipalities in the west have a particularly high proportion of residents born overseas - in the City of Melbourne and the City of Brimbank, 68.9 per cent and 55.6 per cent of women who reside in these respective LGAs were born overseas (Women's Health Victoria, 2017). The region is also home to 23 per cent of Melbourne's Aboriginal and Torres Strait Islander population (ABS, 2016) and has a higher than state-average population of women living with a disability (WHW, 2013a). Many women in our region experience compounding disadvantage as a result of intersectional discrimination due to their race, ethnicity, religion, ability, sexuality and socio-economic status (United Nations, 2000).

Women's Health West's Strategic Plan 2015-2020

WHW's Strategic Plan 2015-2020 and its vision, mission and goals inform our integrated health promotion plan. The strategic plan was developed by reviewing relevant national and state government policy, funding guidelines, community health and municipal public health and wellbeing plans, and regional data sets. We also consulted with community women, partner organisations, other communities of interest, WHW staff and our Board of Directors.

WHW's vision is 'equity and justice for women in the west.' We aim to achieve this through our mission of 'working together for change – by supporting women and their children to lead safe and healthy lives, and changing the conditions that cause and maintain inequity and injustice.' Our strategic plan sets out five goals to ensure we meet current and future needs for women and children in Melbourne's west. These five goals are:

- Deliver and advocate for accessible, culturally appropriate services for women and children in the west who experience family violence
- Undertake health promotion and primary prevention actions to redress gender inequity and improve the health, safety and wellbeing of women, young people and children
- Collaborate with others to achieve shared goals
- Promote good health, safety and wellbeing in our workplace
- Enhance the long-term sustainability of WHW and our work.

Strategic policy context

Women's Health West's Integrated Health Promotion Plan 2017-2021 is strategically aligned with and leverages off federal, state and local government policies and associated reforms (Table 1). This approach ensures that our integrated health promotion activities leverage off and support the current policy agenda.

Table 1: Policies and reforms that influence WHW's Integrated Health Promotion Plan 2017-2021

Federal policy	*National Women's Health Policy 2010* *National Plan to Reduce Violence against Women and their Children 2010-2022* *The Roadmap for Mental Health Reform 2012-2022* *National Disability Insurance Scheme*
State policy	*Victorian Public Health and Wellbeing Plan 2015-2019* *Safe and Strong: A Victorian Gender Equality Strategy* *Royal Commission into Family Violence Report and Recommendations* *Ending Family Violence: Victoria's Plan for Change* *Family Violence Rolling Action Plan 2017-2020* *Free from Violence – Victoria's strategy to prevent family violence and all forms of violence against women* *Women's sexual and reproductive health: Key priorities 2017-2020*
Local policy	*Council plans that integrate municipal public health and wellbeing plans, and council community plans* *Primary care partnership strategic plans* *Integrated health promotion plans for community health services*

Federal policy context

WHW's integrated health promotion plan is guided by a suite of federal policies. The *National Women's Health Policy* (2010) outlines a dual policy approach that recognises the importance of redressing immediate and future health concerns, while challenging structural inequities that impact on women's health and wellbeing. WHW's integrated health promotion plan shares two of the national women's health priorities - sexual and reproductive health and mental health and wellbeing.

The prevention and early intervention action areas identified as priorities within the *National Plan to Reduce Violence against Women and their Children 2010-2022* further inform and align with WHW's health promotion plan. This plan, now in its *Third Action Plan* (2015-2019), is underpinned by the understanding that gender inequality is the root cause of men's violence against women, and as such takes a primary prevention approach that focuses on driving cultural change to challenge attitudes of

acceptance towards violence. Specific priorities within this plan that directly align with WHW's work include: respectful relationships education; embedding gender equality in workplace culture; increasing women's economic participation and security; improving the financial literacy and independence of women at risk of violence; and supporting local communities to take action to prevent violence against women (Council of Australian Government, 2016).

The Council of Australian Governments' (COAG) commitment to mental health reform outlined in the *Roadmap for Mental Health Reform 2012-2022* further shapes our work, particularly in relation to primary prevention and key at risk populations (COAG, 2012). The significant social policy reform of the National Disability Insurance Scheme is also a key strategic focus for WHW, specifically as it relates to our Home and Community Care (HACC) program and efforts to ensure positive health and wellbeing outcomes for women with a disability in Melbourne's west.

State policy context

WHW's integrated health promotion plan leverages off a number of state policies. Most notably, our plan is strongly influenced by and aligned with the State Government's *Victorian Public Health and Wellbeing Plan 2015-2019* as we work to improve key priorities identified in this plan, and specifically mental health, sexual and reproductive health and violence against women (Department of Health, 2015). WHW is a member of Gender Equity Victoria – the Victorian peak body for organisations who work to redress gender as a structural determinant of women's health. Gender Equity Victoria provides a strategic and coordinated statewide approach to advance gender equity, prevent men's violence against women, and promote sexual and reproductive health; by influencing policy, legislation and services, and leading best-practice primary prevention action across Victoria.

Safe and Strong: A Victorian Gender Equality Strategy is also a milestone statewide strategy that further influences our work. This strategy outlines a commitment from the state government for all Victorian women and girls to live in a safe and equal society, to have access to equal power, resources and opportunities, and be treated with dignity, respect and fairness (Victorian State Government, 2016). At the forefront of this strategy is the notion that gender equality is a human right and precondition to social justice. The strategy importantly highlights that gender inequality does not impact everyone in the same way – some women and girls experience compounding disadvantage as a result of their position on the social gradient and a particular risk of discrimination and greater inequity. The strategy articulates key domains through which the government and partners will achieve gender equality and clear priority areas and settings for action that align with WHW's priorities and settings for action (Victorian State Government, 2016).

The Victorian *Royal Commission into Family Violence Report and Recommendations* (2016) is another influential report for WHW's integrated health promotion plan. Importantly, this report highlights that primary prevention of men's violence against women has historically been overlooked, and calls for urgent action in the specialised area of primary prevention program delivery and policy development (Victorian State Government, 2016). The report recognises women's health services as ideally positioned to lead this work across the state and via regional cross-sectoral partnerships to prevent violence against women and promote gender equity. The report also articulates the need to take a public health approach to effectively prevent violence against women and refers specifically to the effectiveness of the regional primary prevention partnership led by WHW - Preventing Violence Together (Victorian State Government, 2016). *Ending Family Violence: Victoria's Plan for Change* is a ten year plan that outlines the implementation plan for all 227 recommendations of the Victorian Royal Commission into Family Violence (Victorian State Government, 2016). Two further policy documents further articulate the

concrete actions to implement these reforms, the *Family Violence Rolling Action Plan 2017-2020* (Victorian State Government, 2017) and *Free from Violence – Victoria's strategy to prevent family violence and all forms of violence against women* (Victorian State Government, 2017).

WHW's work also leverages off Victoria's first *Women's sexual and reproductive health: Key priorities 2017-2020* (2017), which encapsulates the government's commitment to redress the burden of sexual and reproductive ill-health experienced disproportionately by women and girls. Importantly, WHW's work aligns with this strategy to improve reproductive choices and sexual health for women and girls and specifically their access to safe and equitable abortion services, the provision of sexual health education and services that are free from discrimination and stigma.

Local policy context

At a local level, WHW is strategically aligned with the two primary care partnerships that service the western region catchment – Inner North West Primary Care Partnership and HealthWest – both of whom have prevention of violence against women as an integrated health promotion priority. Similarly, all seven local governments in the west have incorporated prevention of violence against women as a priority in their council plans and community plans. Three local governments have also identified sexual and reproductive health promotion actions in council plans.

WHW also works collaboratively with the North Western Melbourne Primary Health Network who focus on improving the efficiency and effectiveness of medical services and integrated care for people in Melbourne's west.

Planning context: the Victorian Women's Health Program

WHW's health promotion work is funded by the Department of Health's Victorian Women's Health Program and works at a systems level and through direct project work with women and their communities. System change involves influencing, advising and working with government, health and other sectors, as well as their community, to effectively respond to women's health needs. Our direct project work involves strong partnerships and collaboration with women and communities to codesign gender transformative health promotion programs and initiatives.

Regional partnerships

In line with the Victorian *Public Health and Wellbeing Plan 2015-2019* and the importance placed on integrated action to improve health and wellbeing across the whole community, WHW continues to lead cross-sectoral partnerships as a key mechanism for coordinated planning and program implementation across our region (Department of Health, 2015). Most notably, WHW leads two regional primary prevention partnerships and strategies in the areas of preventing violence against women and promoting sexual and reproductive health. Our regional approach strengthens collaboration across a range of sectors and settings, using a mix of health promotion interventions and capacity building strategies to optimise the health, safety and wellbeing of women in the west.

WHW is the lead agency for the *Preventing Violence Together 2030: Western Region Strategy to Prevent Violence Against Women* (PVT) regional partnership. The strategy's vision is that women and girls across Melbourne's west live free from violence and discrimination and have equal status, rights, opportunities, representation and respect (WHW, 2017). The partnership comprises nineteen partner organisations that include women's and community health, primary care partnerships, local government, Victoria University, the Western Bulldogs and a number of response sector services who are associate members. The partnership supports the implementation of policies, advocacy, program, service reforms and initiatives to promote gender equity and prevent violence against

women. The strength of this partnership was recognised in the *Royal Commission into Family Violence* report when referred to as a promising regional preventing violence against women initiative (Victorian State Government, 2016).

WHW is also the lead agency for *Action for Equity: A Sexual and Reproductive Health Plan for Melbourne's West.* The partnership is made up of fifteen organisations in the west that include women's and community health, local government, a primary health network, ethnic-specific services, an Aboriginal Community Controlled Organisation and specialist statewide services (Women's Health West, 2013b). Recognising that sexual and reproductive health is influenced by multiple interacting factors, Action for Equity incorporates a range of mutually reinforcing objectives that work at the individual, community and societal level and increases collaboration in relation to the social determinants of sexual and reproductive health.

Consultation with communities of interest

WHW undertook consultations with communities of interest to inform the development of this plan. The purpose of the consultations was to identify future directions and to reflect on the impact of current and past integrated health promotion programs. This consultation process included one partner workshop with 35 attendees, two workshops with 22 of WHW's staff as well as a participant survey.

Consultation with communities of interest confirmed the strength of WHW leading two regional partnerships and the value of our health promotion staff's specialist knowledge and expertise in gender equity. Communities of interest also identified a leadership role for WHW in translating the Royal Commission into Family Violence report and recommendations into practice over the coming years. This was proposed as a logical opportunity that relates to WHW's existing leadership role in translating policy and reform into evidence-based practice for our partners. WHW was also seen to play an important role in advocacy, research, best-practice in primary prevention, and program codesign with disadvantaged women and communities of interest.

Conceptual frameworks that inform our approach

WHW's integrated health promotion plan uses a social model of health to examine the effect of social, economic, cultural and political factors on the health and wellbeing of women and girls. This model for improving health outcomes recognises health as 'a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity' (World Health Organisation, 1986). Informed by this notion, the main conceptual frameworks WHW uses to identify our health promotion priorities, target groups and activities are health promotion, community development, gender equity and human rights approach.

Health promotion

In 1986, the Ottawa Charter was successful in challenging dominant health promotion frameworks that focused on biomedical interventions, individual risk factors and lifestyle behaviours to the exclusion of social and economic determinants of health. Health promotion includes actions directed at increasing the skills and capabilities of individuals, and most importantly action directed towards changing social, environmental and economic conditions that impact on people's health (WHO, 1986). The Charter's call for sectors outside of health to take action on the social structures and conditions that perpetuate poor health outcomes informs WHW's health promotion practice (Keleher, 2004).

In 2015, VicHealth released *Fair Foundations: the VicHealth framework for health equity*, which draws the critical distinction between the social determinants of health and the social determinants of health inequity (VicHealth, 2015). The social determinants of health are the conditions in which people are born, grow, live, work, play and age (CSDH, 2008). The underlying social structures and processes that systematically assign people to different social positions and distribute the social determinants of health unequally across society are known as the social determinants of health inequities (Solar and Irwin, 2010). Health promotion programs must target action at both, as actions focused solely on redressing the social determinants of health do not tackle the structures and processes driving the unequal distribution of power, money and resources that lead to persistent health inequities (VicHealth, 2015).

In accordance with this framework, WHW undertakes advocacy to assert the government's responsibility to redress the inequitable distribution of power, money and resources. We also deliver programs that enable and promote the participation and increased social status of all women, and particularly those known to experience compounding disadvantage.

Community development

Community development is founded on a conscious recognition and response to the ways that structural power influences all aspects of people's lives, while recognising that people still possess agency within these structures (WHW, 2010). A community development framework challenges women to identify and mobilise their agency and to find ways to contest power and its effects, in order to increase control over their lives (Nussbaum and Glover, 1995). Research shows that a community development approach that seeks to change systems, rather than people, holds the greatest potential to bring about sustained improvements for community health and wellbeing (Nussbaum and Glover, 1995).

A community development framework asserts that action in relation to women's health must be responsive to the local context and continuously engage with women's stories and lived experiences. Community development frameworks also recognise the very real barriers and challenges facing women, while at the same time encouraging sustainable actions that support communities to determine meaningful outcomes (Nussbaum and Glover, 1995). WHW works within a community development and codesign framework that assists women – collectively and individually – to identify and build their skills and experience and to take action through designing and developing their own programs and solutions that will lead to improved health and social outcomes for them and their communities.

Gender equity

Gender equity is the process of being fair to women and men with the aim of achieving equal outcomes for all. To ensure fairness, measures need to compensate for historical and social disadvantage that have prevented women from operating on a level playing field with men (WHW, 2016). Public health planning and program and service delivery that take a gender equity approach recognise that women and girls experience different and often heightened risk factors for poor health compared to men and boys. This is the result of structural and social factors that continue to marginalise women and girls, such as the unequal distribution of power and resources between women and men, and rigid gender stereotypes and norms that assign women and men different social responsibilities (Our Watch et al., 2015; WHW, 2016).

These factors intersect with the social determinants of health, such as decision-making power, income, employment, education and housing, which compound the disadvantage experienced by women and girls. Gender equity frameworks acknowledge differences among women due to race,

ethnicity, religion, sexuality, ability and socio-economic status and the complex effect this has on health and wellbeing. WHW's health promotion programs are designed to be responsive to the specific needs of women in Melbourne's west, and particularly those who experience the greatest disadvantage. They are also designed to be gender transformative, and as such, identifies, challenges and transforms the norms, structures and practices that perpetuate gender inequality and strengthens those that support gender equality (Women's Health Victoria 2012).

Refer to Table 1 entitled *Planning for Equity Framework* in the appendix that sets out a matrix of critical questions WHW uses to plan projects using the conceptual frameworks of health promotion, community development and gender equity.

Human rights

The 'right to health' was first set out in the United Nations Universal Declaration of Human Rights in 1948 and establishes fundamental freedoms and entitlements. These fundamental freedoms and entitlements include the right to control one's health and body, the right to participate in decisions about one's health, and the right to freedom from violence. Importantly, many of these rights have been systematically denied to women.

The United Nations *Convention on the Elimination of All forms of Discrimination Against Women* (CEDAW, 1979) is a foundational instrument for women's rights and affirms women's rights to non-discrimination in education, employment, and economic and social activities. CEDAW acknowledges that prejudice and restrictive gender stereotypes produce and maintain power structures within society that undermine women's health, and also provides a framework for challenging the status quo. WHW works to redress the historic and continuing gender inequities that violate women's rights to health and bodily integrity, and that limit their ability to participate in Australian society.

International, national and state human rights legislative frameworks inform WHW's health promotion projects. For example, WHW has worked for more than a decade to prevent and respond to female genital mutilation/cutting (FGM/C), which is internationally and nationally recognised as a gender-based human rights violation that affects women and girls. Our Family and Reproductive Rights Education Program works to prevent FGM/C as part of our integrated approach to sexual and reproductive health policy, program and service delivery.

Evaluation framework that informs our approach

Women's Health West's prevention efforts focus on delivering long term outcomes for women and girls in Melbourne's west. WHW is developing a series of evidence-based gender equity proxy indicators and evaluation tools to measure the collective impact of our integrated health promotion program. This process entails: testing the validity of international and national gender equity proxy indicators and their applicability; building the capacity of staff regarding collective impact evaluation, and designing a series of evaluation tools that includes a theory of change, an outcomes framework, and an evaluation framework and implementation plan. This process and the evaluation tools will allow WHW to measure change over the life of this plan. WHW is leading a shared measurement evaluation consultancy for Preventing Violence Together in order to measure the collective impact of the partnership to prevent men's violence against women.

State priority: Promoting sexual and reproductive health

Priority area: Promoting women's sexual and reproductive health

Sexual and reproductive health, like other areas of health, is influenced by a number of biological, psychological, economic and social factors (O'Rourke, 2008). Gender is one of the most significant factors that determines sexual and reproductive health outcomes, as women and girls are significantly more likely to experience sexual violence, take the main responsibility in contraceptive decision-making and pregnancy (Australian Women's Health Network, 2012a). As a result, women and girls bear the overwhelming burden of sexual and reproductive health morbidity in our community (Australian Women's Health Network, 2012a).

In Victoria, the burden of disease associated with sexual and reproductive health continues to rise, despite being preventable (Department of Health, 2015). The burden of poor sexual and reproductive health is also not equally distributed among Victorian women and girls (VicHealth, 2015). An individual's position on the social gradient combined with the social determinants of health play a critical role in shaping their sexual and reproductive health outcomes (VicHealth, 2015; CSDH, 2008). Women with a disability, Aboriginal and Torres Strait Islander women, newly arrived refugee and migrant women, young women, gender diverse women and women in incarceration are all at increased risk of poor sexual and reproductive health due to the institutions, structures and processes that work against them (VicHealth, 2015).

Definitions

WHW's sexual and reproductive health promotion program is underpinned by the following internationally recognised definitions:

The World Health Organisation defines sexual health as:

> A state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, sexual rights of all persons must be respected, protected and fulfilled (WHO, 2006: 4).

Sexuality is a key component that underlies and influences behaviours and outcomes that impact sexual health. Sexual health can therefore not be defined, understood or made operational without considering sexuality which the World Health Organisation defines as:

> A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (WHO, 2006 updated 2010).

The World Health Organisation defines reproductive health as:

> A state of complete physical, mental and social wellbeing … in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so (WHO, 2006: 4).

Reproductive rights are defined as:

> The basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health. (WHO, 2006:4).

Evidence supporting sexual and reproductive health promotion as a WHW priority

The west of Melbourne is home to many women disproportionately impacted by poor sexual and reproductive health outcomes as a result of persistent health inequities. This includes:

- High rates of teenage pregnancy - the west is home to 13 per cent of Victoria's teenage parents. Motherhood in the teenage years is associated with an increased risk of poor social, economic and health outcomes (DEECD, 2009)
- Higher than state average rates of chlamydia across all municipalities in the west - the western metropolitan average chlamydia rate per 10,000 females is 25.3 compared to the state average of 19.4 per 10,000 females (Victorian Notifiable Infectious Diseases Surveillance database, 2015)
- Low condom use - only 53 per cent of sexually active young people in the region practice safe sex by using a condom, which is lower than the reported state average of 58 per cent (DEECD, 2011)
- High numbers of women incarcerated with 82 per cent of Victoria's female prison population in the western region (Department of Justice, 2013)
- Drug dependence, injecting drug use and increased rates of men's violence against women as a result of twenty legal brothels and a street sex trade in Footscray and surrounding suburbs (Rowe, 2011).

Given that sexual and reproductive health is integral to supporting the overall health and wellbeing of women and girls, this continues to be a health priority for WHW and the western region of Melbourne.

Sexual and reproductive health promotion framework

WHW's sexual and reproductive health programs and strategies are guided by research findings from the first Australian comprehensive literature review of the social determinants of sexual and reproductive health inequities which was led by WHW on behalf of the Action for Equity partnership. WHW contracted Deakin University to undertake this literature review, which was an international first and focuses on population groups who are disproportionately impacted by poor health outcomes and supports evidence-based practice in Melbourne's western region and throughout Victoria and Australia. The literature review highlights key socio-economic, political and cultural contexts that influence sexual and reproductive health inequities that inform WHW's health promotion programs.

WHW's work is further supported by our own *Sexual and Reproductive Health Promotion Framework* (Taylor, 2011) that recognises the multiple and interacting factors that contribute to poor sexual and reproductive health. This framework provides a comprehensive approach, identifying priority target population groups, settings for action, and areas for health promotion action to redress sexual and reproductive health inequity. The framework comprises five layers of influence and recognises that opportunities to prevent sexual and reproductive health morbidity are most effective when a range of coordinated, mutually reinforcing health promotion actions occur across settings and sectors (VicHealth, 2007; Taylor, 2011).

Social determinants of women's sexual and reproductive health

To ensure effective, sustainable and equitable outcomes, WHW's programs focus on redressing the six social determinants that drive poor sexual and reproductive health outcomes as detailed below (WHO, 2010a; WHW, 2016b).

Gender norms

Gender norms are an important social determinant of sexual and reproductive health as they have a powerful influence on people's sexual identity, practices and behaviour (WHO, 2010a). They also influence the way in which people enact their sexuality and make decisions about their sexual and reproductive lives through socially constructed gender norms, roles, behaviours and attributes associated with masculinity and femininity.

Power imbalances between women and men as a result of gender norms are a common theme across the literature influencing sexual and reproductive health outcomes (Trevor and Boddy, 2013; Sen and Ostlin, 2008). When gender norms expect women to be submissive and subservient, this has a detrimental effect on a woman's ability to negotiate her own sexual and reproductive health (WHW, 2016a). For example, in some cultures relationship dynamics and gender roles inhibit women from acquiring knowledge and healthcare in relation to sexual and reproductive health needs, including vital information about contraceptives and how to negotiate safe sexual practices (Rogers and Earnest, 2015).

WHW is strongly committed to health promotion action designed to enhance respectful, gender equitable and non-violent relationships between women, men, girls and boys. Our programs take a whole-of-setting approach working with students, teachers, nurses, parents and community organisations to redress rigid gender norms and stereotypes. We provide girls and boys with comprehensive information about their sexual and reproductive health and rights, and promote shared responsibility for safe sexual practices.

Cultural and societal norms and values

Cultural norms are a key determinant of sexual and reproductive health and are the beliefs, behaviours, customs, traditions, rituals, dress, and language that govern our social engagements in society (WHW, 2010). Like other social determinants, cultural norms can promote or undermine sexual and reproductive health through the distribution of power, money and resources, which put particular individuals and population groups at greater risk of health inequities (VicHealth, 2015).

For example, cultural norms can prevent women from becoming actively involved in understanding their own sexual and reproductive health needs. A study with young Muslim women found that women maintained sexual ignorance and avoided sexual expression as a mechanism to maintain their 'purity', which was idealised in their culture (Wray et al., 2014). This led women to be misinformed about sexual health choices and to have a limited understanding of safe sexual

practices. Another ethnographic study explored the attitudes of young Aboriginal women about decisions regarding sexual relationships and pregnancy in a remote Australian Aboriginal community (Senior & Chenhall, 2008). The study found that power differentials, with women, and particularly young women, expected to be submissive and subservient to their male partners. The research further highlighted that gender-based inequities perpetuated within cultures influence women's sexual identity and the way they express their sexuality.

Cultural norms can also perpetuate practices that are inherently harmful to women's bodies. For example, female genital mutilation/cutting (FGM/C) is deeply symbolic for many women and their communities, and is known to cause long-term sexual and reproductive health complications for women, as well as having physical and psychological health implications (WHO, 2017). In most communities, FGM/C is motivated by cultural beliefs about what is deemed proper sexual behaviour, with strong links between this practice and premarital virginity and marital fidelity (WHO, 2013). The practice is also associated with cultural ideals of femininity, modesty and hygiene (WHO, 2013).

Violence, discrimination and stigma

A considerable body of research shows that violence, discrimination and stigma have significant and often long-lasting physical and psychological consequences on sexual and reproductive health (WHO, 2010b).

The prevalence of sexual violence in Australia is profound – an estimated one in five Australian women experience sexual violence over their lifetime (ABS, 2012). There is also increasing evidence that young women, Aboriginal and Torres Strait Islander women, and women with a disability are far more likely to suffer sexual violence than the general female population (Australian Law Reform Commission, 2010). Quantitative research conducted by Miller et al (2010) found that young women experiencing intimate partner violence were at an increased risk of unintended pregnancy as a result of pregnancy coercion and/or birth control sabotage. Another study showed that women experiencing intimate partner violence are more likely to experience adverse pregnancy outcomes, including miscarriage, low birth weight, preterm births or foetal death than women who live free from violence (Taft and Watson, 2007; WHO, 2010b).

Particular women are also at greater risk of discrimination and stigma leading to poor sexual and reproductive health outcomes. Victimisation, homophobia and gender-based discrimination are intensified for women living with a disability. These women are also frequently stigmatised to be asexual and their sexual behaviour can be characterised as inappropriate or immoral (Temple-Smith and Gifford, 2005). Lesbian, gay, bisexual and transgender, intersex and queer communities also experience stigma and discrimination that results in poor sexual and reproductive health outcomes. Research by Short et al (2007) explored discourses about the role and presence of fathers, biology and lesbian-parented families and found that lesbian women frequently felt 'invisible' and the object of 'scrutiny' and 'judgement' by others due to not meeting the traditional perceptions of family. This resulted in many women reporting 'distress' and 'anger' and also impacted their choice to participate and actively engage with sexual and reproductive health programs and services (Short, 2007).

Socio-economic status

The WHO states that socio-economic status, in particular poverty, is both a cause and outcome of poor sexual and reproductive health (WHO, 2010). There are in fact two levels at which socio-economic disadvantage operates as a determinant of sexual and reproductive health. At a macro level the amount of government funding allocated to health, education, housing, transport, childcare and income support impacts upon the level of socio-economic disadvantage in a community, and exacerbates the underlying drivers that compromise sexual and reproductive health (WHO, 2010). At

the micro level, socio-economic status '…limits access to material and psychosocial resources and affects individuals' ability to exercise autonomy and decision-making', both of which are essential for optimal sexual and reproductive health (VicHealth, 2005). Socio-economic disadvantage can affect women's ability to access health services, contraception, abortion and timely screening and treatment for sexually transmitted infections (WHO, 2010).

Public policy and law reform

Public policy and law reform play a central, yet often controversial role, in relation to sexual and reproductive health. This is undoubtedly further exacerbated by the lack of a national sexual and reproductive health strategy and in turn an array of ad hoc policies that have been developed independently of one another (WHW, 2013). The release of Victoria's first *Women's sexual and reproductive health: key priorities 2017–2020* is an important commitment from the State Government to this health priority and a recognition that sexual and reproductive health disproportionately affects women and girls across the state.

An example of the influence law reform has on sexual and reproductive health is demonstrated by the inconsistent abortion laws between Australian states and territories. These disparate laws can uphold or deny women's sexual and reproductive rights. Fortunately, abortion is legal in Victoria and in 2015 we saw the passing of the *Safe Access Zones Bill* that further supports good public health practice. Unfortunately, as a result of disparate policies and laws between states and territories, the number of doctors able to prescribe RU486 - also known as medication termination of pregnancy (MTOP) - across the country, and within Victoria, remains limited. MS Health data indicates that there are approximately 1,244 MTOP providers in Australia, representing a very small proportion (4 per cent) of the 30,000 registered GPs and gynaecologists in the country. This is despite the fact that MTOP has been named an acceptable termination option by community women and the medical profession (Medew, 2016; Newton et al., 2016). A key priority for WHW is to increase women's access to affordable contraceptives and abortion services to ensure they are able to exercise their sexual and reproductive rights.

Access to culturally appropriate, accessible healthcare and services

Women's ability to access culturally appropriate, accessible, affordable and responsive healthcare services is another key determinant of sexual and reproductive health (WHO, 2010a). Health services can be inaccessible to many women due to cost, location, lack of awareness of available healthcare, dominant cultural norms, institutionalised racism, language barriers or culturally inappropriate services or support.

Refugee and migrant women are 'significantly more likely to report being treated with disrespect… in the patient-provider relationship' (Blanchard and Lurie, 2004). Language barriers, limited access to interpreters, lack of continuity of care with the same practitioner, inadequate duration of appointments and service user perceptions of unhelpful or uncaring staff are all common experiences for asylum seekers when accessing health services (Murray et al., 2010; Yelland et al., 2014). Other studies have found that services are often ill-equipped to support refugee and migrant women and their families in a way that takes into account their complex experiences and current disadvantage and marginalisation (Bartolmei et al, 2014).

Aboriginal and Torres Strait women also access mainstream health services less frequently than the general population (AIHW, 2011; ABS, 2012). The main reasons known for this low attendance are long waiting times, services not being available when needed, difficulties with transport and healthcare costs, fear of discrimination and poor treatment arising from previous experiences, and the lack of culturally appropriate services (AIHW, 2011). This highlights the importance of tailoring

services and programs to the needs of an increasingly diverse western region population.

A key priority for WHW is to improve access to culturally appropriate health services and programs for women from diverse backgrounds. We are committed to delivering health promotion initiatives with strong community development, codesign, and cultural competency principles.

State priority: Promoting mental health

Priority area: Promoting women's mental health and wellbeing

Although many Victorians have a good quality of life and sense of wellbeing, almost half will experience a mental illness in their lifetime, with the first onset of symptoms most common in teenagers and young adults (VicHealth, 2016). In addition to the incredible toll that this has on an individual and those around them, mental illness costs Victoria an estimated $5.4 billion each year through lost productivity, health and social costs (The Boston Report, 2006).

It is now widely recognised that poor mental health and illness are due to a complex interplay of biological, psychological, cultural, social, environmental and economic determinants of health (VicHealth, 2008). Individual factors and experiences, social interaction, societal structures, resource distribution and cultural values affect the mental health of individuals and the community (Busfield, 1996; Read, 2004; WHO, 2004). Certain populations are also at greater risk of poor mental health and mental illness, as a result of health inequities and greater vulnerability to unfavourable social, economic and environmental circumstances (Department of Health, 2015).

Many of the negative experiences and exposures to risk factors that impact on, and maintain mental ill health disproportionately affect women (Bustow, 2003; WHO, 2004; WHO, 2008). For example, women are particularly at risk of sex and gender discrimination, poverty, social exclusion, physical ill health, violence and human rights violations (WHO, 2010b). Gender also interacts with other determinants of health including occupation, race, culture, ability, legal and political status, family composition, education, social and community support and access to health services to create compounding disadvantage, health inequity and poor mental health outcomes for women and girls (VicHealth, 2016).

Definitions

WHW's programs that promote women's mental health and wellbeing are informed by the following internationally and nationally recognised definitions. The WHO defines mental health as:

> A state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (WHO, 2010c: 1).

VicHealth's definition of mental health and wellbeing includes the:

> Embodiment of social, emotional and spiritual wellbeing. It provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just (VicHealth, 2005: 1).

Mental health promotion requires action to ensure positive environments for good health and wellbeing that:

> Influence determinants of mental health and redress inequalities through the implementation of effective multi-level interventions across a broad number of sectors, policies, programs, setting and environments (Keleher and Armstrong, 2006: 13).

Evidence supporting promoting mental health and wellbeing as a WHW priority

Poor mental health and associated disorders are common and will affect more than half of the Victorian population during their life (VicHealth, 2016). Women and men experience mental health and illness differently which is why it is important to take a gendered approach to mental health and wellbeing. For example:

- More women than men report very high, high and moderate levels of psychological distress (Department of Health, 2012)
- Women and girls comprise approximately 64 per cent of people with an eating disorder (Butterfly Foundation, 2012)
- One in six recent mothers experience a mild, moderate or severe form of peri-natal and/or postnatal depression (Australian Women's Health Network, 2012b)
- Carers experience higher rates of depression and two thirds of carers are women (Deakin University, 2007; Australian Bureau of Statistics, 2009)

Mental health and wellbeing frameworks

WHW's programs that promote women's mental health and wellbeing are informed by a number of frameworks, including the *VicHealth Action Agenda for Health Promotion* (2013) that prioritises improving mental wellbeing as a strategic imperative. The VicHealth *Mental Wellbeing Strategy 2015-2019* further provides an evidence-based conceptual framework for promoting mental wellbeing, highlighting the importance of mental health promotion action across the environments in which people live, work, learn, play and build relationships. Recognising the influences on mental health at the individual, family and friends and community levels, this strategy highlights the importance of working across various settings to build greater resilience particularly among young people.

WHW's work also leverages off the Victoria's 10-year mental health plan that promotes 'social inclusion and economic participation' as the fundamental building blocks for positive social and emotional wellbeing (Department of Health, 2015). It is well known that these social and economic determinants are key drivers of mental health outcomes and as such WHW takes an upstream health promotion approach to redress some of these health inequities.

In addition, WHW work aligns with the state government's *Safe and Strong: Victoria's Gender Equality Strategy* (2016) and VicHealth's *Action Agenda for Health Promotion: 2016 Update*, which recognises gender as an underlying determinant that drives poor mental health and wellbeing. These frameworks highlight the importance of advancing gender equality as a community-based prevention approach to prevent poor mental health (VicHealth, 2016). We also continue to use VicHealth's *Evidence-based Mental Health Promotion Resource* (2006) that is informed by a determinants approach and makes the case for three overarching social and economic determinants of mental health – social inclusion, freedom from ethnic and race-based violence and discrimination, and access to economic resources and participation (Keleher and Armstrong, 2006).

Social determinants of women's mental health and wellbeing

Social inclusion

Studies have consistently demonstrated that people who are social isolated or disconnected from others are at increased risk of poor mental health and wellbeing (Berkam and Glass, 2000). Social inclusion, and specifically being socially connected and valued, makes people feel cared for, loved, esteemed and valued and in turn supports their overall mental health and wellbeing (VicHealth,

2005).

Unfortunately, data continues to demonstrate that women are frequently excluded and underrepresented in leadership and decision-making roles in the workplace despite making up 49.7 per cent of the Australian workforce (WGEA, 2016). According to the recent Workplace Gender Equality Agency Scorecard, 16.3 per cent of CEOs and 28.5 per cent of management personnel are women (2016). Women continue to be under-represented in parliament and executive government, comprising less than one-third of all parliamentarians and one-fifth of ministers (Parliament of Australia, 2014). This is an example of the systemic social exclusion of women, which in turn impacts on the next generation of young girls who look to existing female role models to shape their career perspectives and choices (WHW, 2016).

Women from diverse ethnic, religious and cultural backgrounds experience even higher rates of exclusion from leadership and decision-making positions than other women (Australian Human Rights Commission, 2010). Women who have recently migrated to Australia are also particularly at risk of poor mental health, recognising that migration itself is a social determinant of poor mental health, and furthermore that social connection and support can be weakened through the resettlement process (Delara, 2016). WHW, via our Lead On Again program and other activities, works to increase opportunities for women, particularly young women from culturally and linguistically diverse backgrounds, to become community leaders and decision-makers.

WHW values women's right to participate and we consider this as integral to equity and justice for women in the west (WHW, 2012). Women's capacity to exercise their rights in order to influence positive social change through civic participation is a cornerstone of Australian democracy. The Victorian Human Rights and Equal Opportunity Commission (2010) maintains that Victorian women need greater access to relevant, appropriate and useful education and training about human rights. WHW's programs delivers human rights training and support to strengthen the capacity of women in the west of Melbourne to participate in civil society and to facilitate change on human rights topics of importance to their community.

Many groups of women experience social exclusion. However, women with a disability are frequently the most excluded, marginalised and discriminated of all women. Almost half of Australian women with a disability are discriminated against in employment; with only 49 per cent participating in the workforce compared with 60 per cent of their male counterparts (ABS, 2012b). High rates of gender-based violence also compound the social exclusion and poor mental health outcomes of women with a disability. As such women with a disability are a key target population for WHW's mental health and wellbeing programs via our Sunrise program.

Ethnic and race-based discrimination

VicHealth (2008) identifies ethnic and race-based discrimination as a social determinant of mental health and wellbeing. This refers to processes of 'discrimination founded upon ethnicity, perceived "racial" distinctions, culture, religion or language' (VicHealth, 2008). This form of discrimination represents a pattern of unfair treatment that is justified by social norms and beliefs designed to maintain privileges for one group at the deprivation of others (VicHealth, 2008). Research shows an established link between self-reported ethnic and race-based discrimination and depression, psychological distress, stress and anxiety (Paradies, 2006).

Aboriginal and Torres Strait Islander communities continue to experience high rates of racism and discrimination, with the recent 2016 *Australian Reconciliation Barometer Report* stating that 57 per cent of Aboriginal and Torres Strait Islander people feel Australia is a racist country, compared to 48 per cent in 2014 (Reconciliation Australia, 2016). Furthermore, 37 per cent of Aboriginal and

Torres Strait Islander people included in the study reported experiencing verbal abuse in the last 6 months in 2016, compared to 31 per cent in 2014. Aboriginal and Torres Strait Islander women's poor mental health status is impacted by a number of complex inter-related factors such as discrimination, colonisation[1], dispossession of land and culture, high rates of unemployment, sole parenting, pressure associated with multifamily households, and an overrepresentation in incarceration and the child protection system with high child removal rates (Swan and Raphael, 1995; DHS, 2006). High levels of violence also significantly impact on the mental health and wellbeing of Aboriginal and Torres Strait Islander women (Swan and Raphael, 1995; DHS, 2006).

WHW is committed to providing services and programs that are accessible and culturally welcoming to Aboriginal and Torres Strait Islander women and children, and to work to improve the overall health, safety and wellbeing of these members of our community. Our *Reconciliation Action Plan* articulates this commitment to reconciliation through a series of time bound actions and strategies that will be implemented across our organisation, services and programs.

Access to economic resources and participation

Women's economic participation encompasses the range of activities they perform to produce financial and other resources. This can include paid employment or small business, training and education, and negotiating with agencies and services about household utilities and accounts, bills, taxation, concession allowances, fines and welfare benefits. Women's economic participation is closely linked to their social participation as it fosters and benefits from community and social networks, interest group membership, volunteer and leadership opportunities, and advocacy activity. Economic participation, defined in this way, has a significant impact on women's sense of agency, health and wellbeing (WHW, 2016c).

Australian women experience disadvantage on nearly every economic indicator when compared to men (Cunningham and Zayes, 2000; Black, 2007). The persistent gender wage gap has a profound impact on women's financial security. A recent report released by the Workplace Gender Equality Agency (2015) indicated that the Australian workforce is highly gender-segregated with the healthcare, education and social service sectors being heavily female-dominated, while the more lucrative industries of construction, mining and manufacturing are heavily male-dominated. In addition, the number of women in part-time work is significantly greater than men, with three out of four part-time positions held by women (Workplace Gender Equality Agency, 2015). These figures demonstrate the concentration of women in low paying roles and industries, the concentration of men in higher paying industries and in turn, women's vulnerability to financial insecurity and in turn poor mental health outcomes (Victorian State Government, 2016).

Unfortunately, particular women are at further risk of poor economic participation and financial insecurity (WHW, 2016c). Research undertaken by WHW in partnership with Victoria University determined some of the barriers to economic participation experienced by women from refugee and migrant backgrounds. Barriers included a lack of employment support, systemic racism and rigid gender roles, inadequate English language and vocational training and rigid government systems and punitive regulations. In addition, this study found that poor access to childcare, inappropriate

[1] The historical destruction and genocide of Indigenous communities through practices, policies and laws that resulted in the forcible removal of Indigenous children from their mothers and kinship continues to have a detrimental impact on Indigenous people's mental health and wellbeing (Swan and Raphael, 1995).

class times, limited access to transport, ongoing health concerns and cultural dynamics all disproportionately impacted women and their ability to engage in language classes and opportunities that increase their chances of gaining employment or further education in Australia (WHW, 2016c).

WHW is committed to support women to gain control over their lives and their access to resources. Our Financial Literacy Program increases the capacity of women from newly arrived communities in the west to negotiate financial systems, take control of financial decision-making and access economic resources by providing financial literacy programs to target communities.

State priority: Preventing family violence

Priority area: Prevention of violence against women

Family violence is prevalent, serious and preventable (Our Watch et al., 2015). It takes many forms and occurs within all communities, irrespective of socio-economic status, ethnicity, religion, sexuality or ability. It is also a gendered phenomenon – the vast majority of violent acts are perpetrated by men against women (Our Watch et al., 2015). Men's violence against women contributes to more death, disability and illness in women aged 15 to 44 than any other preventable risk factor (Our Watch et al., 2015). One woman a week in Australia is murdered by a current or former partner and thousands more are injured or forced to live in fear (Our Watch et al., 2015).

Although there is no single cause of violence against women and their children, evidence shows that gender inequality sets the necessary social context in which violence against women occurs (Our Watch et al., 2015; Victorian State Government, 2016). Unfortunately, Australia continues to perform poorly in relation to key internationally recognised measures for gender equality. In 2016, Australia was ranked 46 out of the 144 countries included in the Global Gender Gap Index; significantly poorer than our counterparts such as New Zealand, the United Kingdom and the United States of America (World Economic Forum, 2016).

Preventing violence against women and their children before it occurs is not only important from a public health perspective and for the overall health and wellbeing of women and children, it is also economically viable. A recent report by PricewaterhouseCoopers estimated that Australia spends over $21.7 billion every year in response to the epidemic (2015). Investing in long-term primary prevention efforts is also fundamental to ensuring that women and children's right to live free from violence and discrimination are protected and upheld (Victorian Equal Opportunity and Human Rights Commission, 2006).

Definitions

WHW's violence prevention programs are informed by the United Nation's *Declaration on the Elimination of Violence against Women* and the *National Plan to Reduce Violence against Women and their children 2010-2022* definition of violence against women, which is:

> Any act of gender-based violence that causes or could cause physical, sexual or psychological harm or suffering to women, including threats of harm or coercion, in public or in private life (UN, 1993).

As articulated by the WHO, violence against women encompasses:

> Physical, sexual and psychological violence occurring in the family and in the general community, including battering, sexual abuse of children, dowry-related violence, rape, female genital mutilation[2] and other traditional practices harmful to women, non-spousal

[2] WHW recognises that female genital mutilation is a gender-based human rights violation and a form of violence against women. However, in line with best practice, WHW works to prevent the practice within a sexual and reproductive health promotion framework.

violence and violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state (WHO, 1996).

Evidence supporting prevention of violence against women as a WHW priority

International, national and Victorian research clearly demonstrates that violence against women is a human rights abuse of unparalleled proportion. Although the rates of men's violence against women are staggering, the true extent of the problem also remains unknown due to continued under-reporting of the abuse (ABS, 2011). Under-reporting is in large part due to the majority of perpetrators of violence against women being known to the victim/survivor (ABS, 2011). Despite this, available data indicates that:

- 95 per cent of all victims of violence – whether women or men – experience violence from a male perpetrator (Our Watch et al., 2015)
- Women are five times more likely to be murdered than their male counterparts (Dearden and Jones, 2008)
- One in three women has experienced physical violence since the age of 15 (ABS, 2012)
- One in five Australian women has experienced sexual violence (ABS, 2012)
- One in five women, compared to one in twenty men, experience sexual harassment in the workplace (Broderick et al., 2010)

According to crime data from Victoria Police and WHW's family violence data, women in Melbourne's west are particularly at risk of violence. During 2016-2017:

- There were 23,657 reported family violence incidents in the north-west metropolitan region of Melbourne, which accounts for 30.9 per cent of the total reported incidents of family violence in Victoria (Crimes Statistics Agency, 2017).
- Following significant increases in family violence referrals from police in previous years, WHW experienced a small decrease in referrals in 2016-17. The decrease in referrals was 5.6 per cent (9,970 referrals down from 10,565 referrals), down from a 22.7 per cent increase from the previous year and a 24 per cent increase on the year before that.

This data highlights the ongoing need for concerted action to prevent violence against women to avoid the huge cost of family violence on women and the wider community in the western region of Melbourne.

Primary prevention of violence against women frameworks

Primary prevention strategies seek to prevent violence against women before it occurs (VicHealth, 2007). These strategies are concerned with changing the underlying social determinants that enable and perpetuate violence against women, and as such require particular expertise, funding and resources that are different from family violence intervention and response efforts (Victorian State Government, 2016).

WHW's primary prevention work strongly align with the national approach to primary prevention outlined in *Change the Story*: *A shared framework for the primary prevention of violence against women and their children in Australia (2015)* and the recommendations from the *Royal Commission into Family Violence (2016)*. In particular, our approach recognises that violence against women is a complex and multifaceted social phenomenon driven by gender inequality (Our Watch et al., 2015).

Our programs focus on redressing the gendered drivers of violence against women and dismantling the underlying social practices, structures and norms that perpetuate and enable a culture of disrespect that enables violence against women to occur (Our Watch et al., 2015).

WHW's work also closely aligns with the *Third Action Plan 2016-2019 of the National Plan to Reduce Violence against Women and their Children 2010-2022* that highlights the importance of redressing the deeply held attitudes that justify and trivialise violence against women and their children through community led initiatives. WHW's work leverages off *Safe and Strong: Victoria's Gender Equality Strategy* (2016) by advocating for prevention efforts across diverse settings such as workplaces, the community and health sector, local government and educational institutions. Our programs work collaboratively with individuals, organisations, institutions and communities, as we recognise the role and responsibility we all have to play in preventing violence against women (Victorian State Government, 2016).

The gendered drivers of violence against women

A strong body of literature has identified that gender inequality sets the necessary social context in which violence against women occurs (WHO and London School of Hygiene and Tropical Medicine, 2010). Gender inequality is perpetuated and maintained in Australia through structures that reinforce the unequal distribution of economic, social and political power between women and men, limit the roles and expectations of women and men, and practices and behaviours that reinforce these gendered structures and norms on a daily basis (Our Watch et al., 2015). These forces are known as the gendered drivers of violence, and include specifically:

- Condoning of violence against women
- Men's control of decision making and limits to women's independence in public and private life
- Rigid gender roles and stereotyped constructions of masculinity and femininity
- Male peer relations that emphasise aggression and disrespect towards women

It is only through redressing these social determinants of violence against women and broader social and economic structures that perpetuate a culture of devaluing women over men, that we can prevent violence against women (Our Watch et al., 2015).

Condoning of violence against women

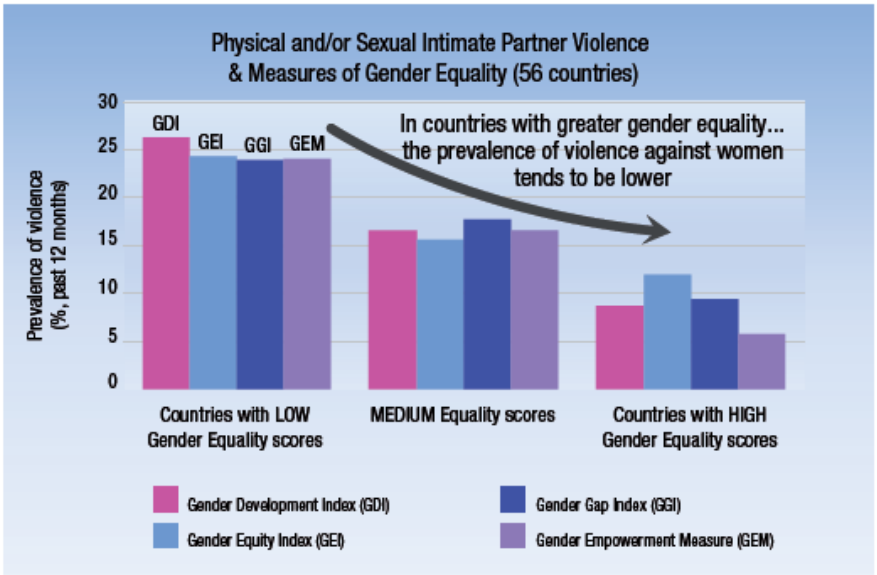
Research shows that when societies, institutions, communities or individuals condone violence against women, levels of violence are higher (VicHealth, 2010). Social norms, structures and practices that justify, excuse, trivialise and minimise violence, enable and perpetuate this abuse (VicHealth, 2013). For example, the *2013 National Community Attitudes towards Violence Against Women Survey* (NCAS) indicated that 26 per cent of young people under the age of 35 felt that partner violence can be excused if the perpetrator regrets their behaviour (VicHealth, 2013). In addition, one in five young respondents believed that there are circumstances that women bear some of the responsibility for sexual assault (VicHealth, 2013).

A culture that condones violence against women is a key driver of this abuse. However, research indicates that efforts to prevent violence cannot target this driver alone. Instead efforts must target the drivers and expressions of gender inequality (Our Watch et al., 2015).

Men's control of decision-making and limits to women's independence in public life and relationships

Evidence shows that male dominance and control of wealth and economic decision-making power is an underlying driver of men's violence against women (Our Watch., 2015). Essentially there is a higher incidence of violence against women in relationships where men control decision-making than in relationships in which women have a greater level of independence (Mouzos et al., 2004). Limiting women's independence and autonomy, whether by reducing their access to education or employment or through men's control of women's financial or social independence, increases the probability of violence against women. Furthermore, isolating women from their social networks and family is a form of controlling behaviour and psychological abuse – and an indicator of the early signs of violence (Our Watch et al., 2015).

Conversely, when power relations between women and men are more equitable, the prevalence of violence against women is lower, as demonstrated in the UNIFEM graph below (UNIFEM, 2010). When the leading global indices for gender equality are assessed, countries with greater equity between women and men tend to have lower levels of gender-based violence. These measures examine indicators such as life expectancy, sex ratio at birth, adult literacy, primary, secondary and tertiary education enrolment rates, participation in the formal labour force, estimated earned income, wage equality and numbers of seats in legislative, ministerial and senior political positions (UNIFEM, 2010).



Source: UNIFEM (2010)

Rigid gender roles and stereotyped constructions of masculinity and femininity

Levels of violence against women are consistently higher in societies where women and men adhere to rigid gender norms and stereotypes (Our Watch et al., 2015). Essentially gender roles create inequities between women and men by allocating particular attributes and behaviours to each gender. This results in men often assuming the role of primary breadwinner and women occupying a lower social status with limited formal access to power, resources and opportunities (WHO, 2009; VicHealth, 2007).

Sexist and stereotypical ideas about masculinity and femininity also perpetuate violence against women because of the assumption that men are excusably more violent and driven by uncontrollable sexual urges and women are naturally more submissive and passive (Hlavka, 2014). People who hold these traditional views about gender roles are less likely to support gender equality and are more likely to condone, justify and excuse violence against women than those who hold more egalitarian values (Flood and Pease, 2006; VicHealth, 2009). Men who hold a strong belief in male dominance are also more likely to perpetrate violence against an intimate partner than those who do not (Abrahams et al, 2006).

A critical component of WHW's primary prevention work is to deliver respectful relationships education and gender equity training and initiatives to redress entrenched social expectations and gender stereotypes that promote inequitable social norms, identities and relations between women, men, girls and boys.

Male peer relations that emphasise aggression and disrespect towards women

Male peer relations that can be characterised by aggressive forms of masculinity and that reinforce disrespect for, and objectification of, women are a recognised driver of men's violence against women. These forms of negative male peer relations and culture increase the probability and acceptance of violence against women (European Commission, 2010). International research demonstrates that the combination of devaluing women alongside the promotion of harmful forms of masculinity increases the risk of violence against women (Our Watch et al., 2015).

A gender transformative approach is needed to challenge these rigid gender roles and stereotypes, harmful and restrictive constructions of masculinity and femininity, promote healthy and diverse expressions of masculinity and femininity, and promote gender-equitable relationships between women and men (Baker, 2013). Gender transformative approaches that promote the equal distribution of power and resources between women and men are an important mechanism to progress gender equality.

WHW's work involves challenging these harmful and restrictive constructions of masculinity and, in particular, hegemonic masculinity. This is done through a number of mechanisms to promote transformative masculinity that include:

- Gender-equitable respectful relationships education with young people
- Workplace training that focuses on challenging unconscious bias and promoting men and masculinity in diverse and non-stereotyped ways
- Advocating for workplace and government policies that encourage men to undertake caring and unpaid work, and that encourage men to promote and enable women's leadership
- Awareness raising campaigns that educate the community on the harms of gender stereotypes, including harmful expressions of masculinity, and that promote diverse and alternative forms of masculinity

Gender transformative health promotion practice is fundamental to WHW's work and extends across all three health promotion priority areas: preventing violence against women; promoting women's mental health and wellbeing and promoting women's sexual and reproductive health.

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Appendix

Table 1: Planning for Equity Framework (2008)

Health promotion	Community Development	Gender Equity
What are the social determinants of health topic you are focusing on? What evidence is available to support your contention?	How do these problems affect this particular community? How do you know this?	What is the specific impact of gender (or other) inequality on this aspect of women's health? How do you know this?
Which particular population group are you working with and why did you choose this group?	How do you plan to involve the community you are working with in this project? What about this community might make it difficult to bring about change and how might you overcome this? What are the existing potentials/resources/ strengths within this community and how can they best be deployed?	What are the nuances of culture, class, ability, sexuality, ethnicity, etc that also affect the women you are targeting and what might you need to take into account to respect these differences?
Which particular setting(s) are you targeting? Why?	How will you ensure that people in communities can contribute to planning, decision-making and evaluation of health services and other settings? How will you make links between the different sites of action required to make change?	How will this work affect women's gendered experience of health, ill health and health systems? Will the activity assist those settings to consider gender in their planning, delivery and evaluation of services, policies, etc?
What types of health promotion action will you undertake and why did you choose these activities?	How will your actions help to organise the community - build the skills, processes, networks and strategies required to mobilise community action - encourage self-determination over priorities and outcomes, and sustain networks and connections? Are your planned actions realistic and do they appropriately identify the challenges to action?	Have you framed your actions and responses in ways that take women's social position into account and thus their power and capacity to be active in their communities? Will it create opportunities for women to develop new skills, ideas and approaches and validate gendered-female ways of working?
What do you hope will be the impact of your project in the short to medium term? - Individual - Organisational	Are your goals and objectives realistic for this community at this time? Explain why. How will you gauge success?	Do your goals and objectives have gendered dimensions. Will your project change attitudes or ways of working that impede women's power and capacities to be active in their communities?

What sorts of changes do you hope to see in the long term because of your project? - Individual - Organisational - Community - Society	Do the outcomes of your project help to decrease the factors that restrict this community's power to influence and participate? How will you gauge this?	Will your outcomes contribute to improving women's equality?