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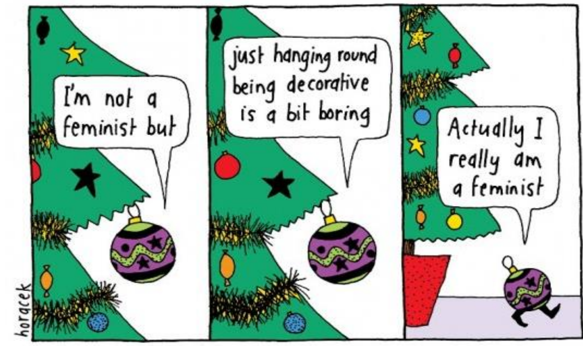
Women's Community Health Network WA

Update



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Gender transformative practice to achieve gender transformative change

Gender transformative *practice* is the work undertaken – using a gender transformative *approach*– towards achieving gender transformative *change*. A gender transformative approach seeks to challenge the causes of gender inequality and strengthen actions that support gender equality within a given context.

A gender transformative approach is not a prescriptive set of actions, but rather a way of conceptualising how the problem of gender inequality in our society is identified and addressed. A gender transformative approach is possible in every situation, though its application will vary depending on the context.

Key elements of gender transformative practice include:

- A focus on both individual and structural forms of inequality
- The understanding that gender transformative practice is a process and that it is relative and context-specific
- Seeking to challenge binary ways of thinking
- Practitioners taking the time to recognise 'the practitioner in the practice'

Effective gender transformative practice at practitioner or program level is more likely in organisations and workplaces that foster and embed gender transformative practice at an

organisational level. This Knowledge Paper explores the key elements of 'gender transformative practice' and how these can be applied by specialist practitioners and organisations working to create gender transformative change to prevent violence against women and family violence.

The paper aims to support practitioners to develop and enhance the critical thinking and reflection skills needed to apply a gender transformative lens to their current and future work.

Download the Final Print version: Towards gender transformative change: a guide for practitioners

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Spotlight on trauma-informed practice and women

This Spotlight features a list of up-to-date and freely available research and resources on the topic of trauma informed practice and women.

Traumatic experiences result 'from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening, such as intimate partner violence or childhood sexual abuse. Trauma can also be experienced as a result of structural violence, that is, the multiple ways that political, economic and social structures result in injustice, inequality and marginalisation.

A trauma-informed approach requires an awareness of a person's history of trauma and understanding the impact that violence and victimisation has in their lives. The aim is to move away from a victim-blaming deficit focus towards a strengths-based approach, asking 'what has happened to you?' rather than 'what is wrong with you?

A framework that is grounded in understanding and responding to trauma is important in any service that supports women, due to the links between poor mental health and experiences of gendered violence, including domestic and family violence and sexual abuse. A trauma-informed approach should recognise how socio-cultural factors such as gender inequality, power, colonisation and disenfranchisement give rise to victimisation and are barriers to seeking support. Using this intersectional lens, behaviours that may be considered 'difficult' are understood as appropriate responses or adaptations to trauma.

Download the Final Print version: Spotlight on trauma-informed practice and women

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Women's health conference highlights the toll of violence and reproductive coercion

Intimate partner violence and reproductive coercion are common, significantly increase the odds of adverse maternal and perinatal outcomes, and ought to be screened for by all women's health specialists, a recent summit of Australian and New Zealand obstetricians and gynaecologists was told.

Dr Vijay Roach, president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), has identified domestic and family violence, and mental health as two key issues for the College as it steps up its advocacy on the social determinants of women's wellbeing.

As well as laying out the scope of domestic and family violence, and demonstrating its links to a host of adverse outcomes including sexually transmitted infections, unwanted pregnancy, preterm delivery, low birthweight and foetal or neonatal death, speakers made the case for

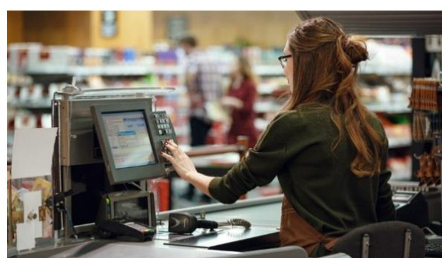
obstetric and gynaecological doctors to walk with their patients as 'safety allies', and having strategies for women experiencing and at risk of violence and abuse.

For obstetric doctors, the imperative was clear, with demonstrated links to outcomes including preterm birth, low birth weight, admission to NICU, growth restriction, pre-eclampsia, labour and obstetric complications including caesarean section, and foetal and neonatal death.

Professor Kelsey Hegarty, director of the Centre of Research Excellence to Promote Safer Families, who – in keeping with the meeting's theme (Stop. Start. Continue) – urged colleagues to stop ignoring the issue, start asking women about it and continue responding to their needs. Hegarty said what women wanted was simple: someone to listen, and a team to support them.

Contrary to the received wisdom that people experiencing violence and abuse in their relationship were reluctant to talk about it, Hegarty said it was overwhelmingly the case that women were relieved to be asked about it, to have their story heard, and to be validated.
See a Twitter summary of her talk.

Professor Hegarty had some important advice for health care workers, including the WHO's LIVES framework for responding to intimate partner violence (Listen, Inquire about needs and concerns, Validate, Enhance safety, Support).



Everyone's Business: Sexual harassment of SDA members

In 2018 the Australian Human Rights Commission (the Commission) published its fourth national report on the prevalence, nature and reporting of workplace sexual harassment in Australia (2018 National Survey). In early 2020 the Commission will publish the findings of its National Inquiry into Sexual Harassment in Australian Workplaces (the National Inquiry).

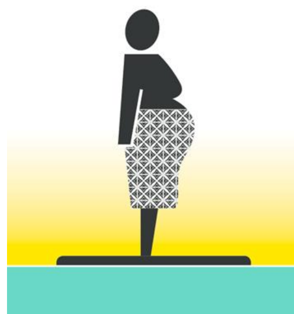
The 2018 National Survey report identified that one in three (33%) working Australians had experienced sexual harassment at work in the last five years. A number of industries reported workplace sexual harassment prevalence rates higher than the national rate (33%) including: retail trade (42%) and accommodation and food services (39%).

In response to these concerning results the Shop, Distributive and Allied Employees' Association (the SDA), approached the Commission to conduct a comprehensive survey of its members, who are employed in these industries. The survey (2019 Member Survey) conducted earlier this year was based on the instrument and methodology adopted in the 2018 National Survey.
SDA members are primarily employed in the retail, fast food, and warehouse sectors and often work in environments with direct and daily contact with customers. The results of their survey provides valuable information about the specific challenges and opportunities for change.

The results of the 2019 Member Survey reflect those of the 2018 National Survey, in terms of the prevalence of workplace sexual harassment, the gendered nature of these experiences and the low reporting rates. The 2019 Member Survey has allowed the Commission to provide the SDA with a comprehensive picture of the workplace sexual harassment experienced by its members, including valuable new information about the role of customers in workplace sexual harassment, both as harassers and bystanders.

This report is an important step in addressing both the systemic drivers which underpin workplace sexual harassment in the working population, as well as factors which are unique to the workplaces of SDA members.

Everyone's Business: Sexual harassment of SDA members



Pregnancy and homelessness: service responses

This research by Launch House in Victoria, originated from concerns that pregnant homeless women are not receiving the level of support warranted, given their circumstances and that of their unborn child. While individual homelessness services work with pregnant homeless women, there is currently no systemic response to this group, nor is there reliable information on how many women among the homeless population are pregnant. These gaps in the service system, and in the collection of data, contribute to lost opportunities for intervention to provide the best possible support to women and infants.

The lack of data about the incidence of pregnancy and homelessness in Australia is a significant gap in knowledge that could be used to inform social and health policy and service delivery. While homelessness can have dire consequences for both mothers and infants, pregnancy can be a turning point for homeless women, which supports the need for strong system responses to this group.

The research found that, like all homeless people, pregnant homeless women experience difficulty in accessing housing support due to the overwhelming demand for these services. Moreover, even when accessing housing support services, pregnant homeless women may not receive responses to their additional support needs, in part because some homelessness services do not take pregnancy into account as a risk factor for determining access to support until late in the pregnancy. In a housing crisis, women may be referred to rooming houses or to stay with family or friends, which is likely to be unsustainable or become unsuitable once the baby is born.

Many pregnant homeless women have experienced domestic and family violence but, due to an overburdened service system, they may not receive a family violence specialist response. Women aged 25 years and over are the least likely to receive a specialist response. Critical shortages in safe, stable and affordable housing constrain the capacity of homelessness services to support pregnant homeless women.

It was also evident that housing and homelessness service workers may not have the skills to work with pregnant homeless women. Training is needed in sensitively collecting information about pregnancy status and improving practice with this client group to produce the best possible outcomes for the woman and her child.

Service providers reported the need for specialist health support for homeless pregnant women, as well as for mainstream health services, to be well-informed of the needs and circumstances of this group of women. Service providers identified the key elements of these programs as wraparound provision of services, continuity of care and outreach. Peer support was identified as particularly important for young women and there is the potential to further develop such initiatives for pregnant homeless women of all ages. Long-term support, while often needed, was limited.

Ongoing collaboration and further integration among and between specialist health and homelessness services were seen as a means of improving responses to pregnant homeless women.

Pregnancy and homelessness: service responses

Community responses to gender portrayals in advertising: a research paper

This study explores community responses to gender portrayals in advertising.
The study suggests that community members perceive that stereotyped gender portrayals and sexualised images of women are common in advertising, and that these portrayals pressure women and men to conform to limiting stereotypes, have negative impacts on health and wellbeing, and may support attitudes that cause violence against women.

In contrast to the Australian code, Britain's Advertising Standards Authority is now obliged to consider the cumulative health impacts of stereo-typed gender portrayals and sexualised images. This recognises the pervasiveness of these types of portrayals perpetuate problematic gender norms. This research highlights that people want more responsible advertising. The advertising industry has acknowledged a need to review its code of ethics. Something else to learn from Britain to address sexist advertising is the value of a co-regulatory system that doesn't leave the industry to set its own rules.

This study is part of Women's Health Victoria's *Advertising (In)equality project*, funded by the Victorian Government.

Download the Final Print version: Community responses to gender portrayals in advertising: a research paper

Related Resources:

- Reporting sexist advertising: a toolkit for consumers

For women's sake, let's screen for depression as part of the new heart health checks

The latest government statistics, released last week, show that from 2001-2016, the rate of cardiac events (heart attacks or unstable angina) fell by more than half among Australian women. That's largely because of greater education about risk factors for heart disease (smoking rates continue to fall), and medical advances in prevention and treatment. One thing that might reduce rates of heart disease even further is to make sure women, in particular, are asked about their current mental health. This can be a pointer to a hidden risk of developing heart disease in the future.

Mental illness can directly affect heart health by placing extra pressure on the cardiovascular system. Depression has been linked to inflammation, which can clog a person's arteries. Depression also increases the presence of stress hormones in the body, which dull the response of the heart and arteries to demands for increased blood flow. Less direct effects on heart health include the impact of depression on a person's health behaviours, such as diet and exercise, and their connections with other people.

Australian middle-aged women with depression have double the risk of having a heart attack or stroke in the following 18 years compared to women without depression. While we're seeing significant reductions in the number of people getting heart disease overall, the latest report shows the opposite is true in young women. The rate of cardiovascular events like stroke is increasing in women aged 35 to 54.

Drinking alcohol, smoking, high cholesterol, type 2 diabetes, overweight/obesity, and a family history of heart disease are some of the important predictors of a person developing heart disease over the next five years. So if someone is considered to have high risk of a cardiovascular event, this risk can be managed with the help of a medical professional.

April 1 saw the introduction of two new Medicare item numbers allowing eligible patients (those aged 45 and over, or 35 and over for Aboriginal and Torres Strait Islander peoples) to be assessed for their risk of developing cardiovascular disease. This is known as a heart health check. If a person is identified as being sufficiently at risk, they will be targeted with preventative measures such as assistance with lifestyle modifications, and/or interventions like blood pressure or cholesterol medications.

While many of the common risk factors for heart disease are shared between women and men, young and middle aged women have some that men don't. Polycystic ovary syndrome and complications during and after pregnancy (such as gestational diabetes and pre-eclampsia) are all important considerations. We're only beginning to understand how these factors affect a woman's risk, but they are likely to be as important as traditional risk factors in the context of heart health checks.

Another common issue in young women that influences heart disease risk is poor mental health. Common mental disorders like depression are more common in women than men until age 75. Both heart disease and depression are largely socially determined, especially for women and girls. Early life trauma, poverty, and gendered violence and discrimination can accumulate across a woman's lifespan to shape her risk of heart disease and stroke.

Screening for mental health

While more research is needed, asking about a woman's mental health may help GPs better identify risk of heart disease in younger women.

Large population-based studies show reducing the prevalence of depression could have major implications for the prevention of heart disease and stroke. One study found having a poor psychosocial profile (depression, stress, isolation and anxiety) contributes 32% of the risk for heart attacks across the population. In other words, if these psychosocial issues were eliminated, the incidence of heart attacks would be reduced by one-third.
Given the burden of these psychosocial issues is greater for women than men, women may have even more to gain if depression was targeted as part of preventing heart disease.

Read more For women's sake, let's screen for depression as part of the new heart health checks

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We are a force for good, and the Australian public should know about it

It was 25 November, the International Day for the Elimination of Violence against Women. The Morrison government decided the best way to honour that important day on the international calendar was to cut funding to the National Family Violence Prevention and Legal Services Forum, our national voice for Aboriginal and Torres Strait Islander women who are survivors of family violence. It represents 13 services across this country. It provides a shield, a force, for those who have neither.

It's important to let the Australian public know exactly what our force for good does. It's true, we speak up and we speak out. But we do more, much more, than that.

Our forum builds a national community to strengthen family violence prevention. We work together to build our community's capacity to confront – and then deal with - all the challenges we face. Our biggest challenge is the limited funding we receive; our services must find new and innovative ways to fund our work. The national forum develops strategies and then templates to apply for that funding. It's a waste of time for each service to have to start from the ground up. Together we build the ground and raise us all up.

Read more here

A Theory of Change in sexual and reproductive health

Understanding that we cannot create change alone, the Victorian Women's Health Program is seeking to initiate collaborative action with a range of partners to develop programs, policies and practice to improve the sexual and reproductive health and autonomy of women and girls. All levels of government, health services and health professionals, research organisations, schools and the community must play a role if optimal sexual and reproductive rights, health and wellbeing are to be achieved for women and girls. To be effective, this work must be supported by policies and regulatory change.

This Theory of Change takes an intersectional approach to sexual and reproductive health (SRH), advocates for a gender transformative approach and is based on a socio-ecological model of health. An intersectional approach involves considering the intersecting factors that impact on SRH of women from diverse backgrounds. Using an intersectional approach encourages social change leaders and policy advocates and decision makers to make connections between various forms, and diverse experiences of, discrimination and disadvantage, to ensure we achieve optimal health for all groups of women.

This means balancing population level universal strategies with specialist, tailored approaches for women who experience intersectional disadvantage, including Aboriginal women, culturally and linguistically diverse women, women with disabilities, sexuality diverse women, gender diverse people, and women living in rural areas.

The Theory of Change is also based on the socio-ecological model of health, which demonstrates how different levels interact to influence and impact the health of an individual. This means that in order for a vision to be achieved, change must be affected on an individual level (knowledge and attitudes), interpersonal (relationships, friends, family, social networks), organisational (workplaces, schools, social institutions), community (physical and social environment) and societal (social policy, economic and legal context) level.

In relation to changing social norms and stereotypes, a gender-transformative approach is favoured to proactively and intentionally transform and alter the underlying gender structures, norms and relations that perpetuate gender inequality. A gender transformative approach, though ambitious, ultimately benefits men, gender diverse people and women. This approach breaks down rigid and limiting gender stereotypes, structures and norms, and the systems of privilege and discrimination that accompany them.

This Community of Practice was comprised of women's health services across the state. A key priority area of their work is to identify and change systems and structures that place women at risk of poor sexual and reproductive health and wellbeing.

This document outlines a Theory of Change (ToC) that was primarily developed to guide the collective and individual work of the women's health services to track progress towards the vision for the rights of all women to optimal sexual and reproductive health and wellbeing to be fully realised.

Read the Report

Does gynaecological cancer care meet the needs of Indigenous Australian women?

Cancer is a leading driver in the health gap between Aboriginal and Torres Strait Islander people. There is a disparity in the burden of gynaecological cancer for Indigenous women compared with non-Indigenous women in Australia. Understanding how Indigenous women currently experience gynaecological cancer care services and factors that impact on their engagement with care is critical. This study explored Indigenous Australian women's experience of gynaecological cancer care at a major metropolitan hospital in Queensland.

There is a pressing need for culturally-appropriate, person-centred cancer care and resources to be made available for Indigenous women diagnosed with a gynaecological cancer. The experiences of the Indigenous women in this study highlight some critical areas for change to meet their needs and improve the cancer outcomes of this currently underserved patient population. The Indigenous women in the study faced substantial challenges associated with late referral, misdiagnosis, miscommunication, lack of information, logistical challenges in accessing treatment and services, background life crises, and cultural insensitivities in the system.

While some of these issues are not in themselves particular to this population, it is the accumulation of these challenges that negatively impact on Indigenous women's experiences of and engagement with cancer care. The overarching picture that emerges through this analysis is of a group of women at breaking point, often with limited access to resources and support. Cancer care services need to account for the commonality of these issues facing Indigenous women with gynaecological cancer and adapt their services and models of care to better support them through their cancer journey.

Read the Report

Empowering bystanders to act on sexist and sexually harassing behaviours

This guide has been developed to help organisations introduce bystander initiatives as part of their work to reduce sexist and sexually harassing behaviours. It explains what bystander action is and outlines four key steps for implementing effective bystander initiatives. This is an innovative program of work that uses behavioural insights theory and approaches to encourage bystander action against sexism and sexual harassment in various settings.

Understandably, people on the receiving end of inappropriate behaviour can find it difficult to confront the perpetrators. However, research shows that when a third party steps in and

becomes an active bystander, it helps to discourage the perpetrator and emotionally support the victim. By speaking up, individuals can contribute to a culture that condemns sexist behaviours.

In workplaces, sexist behaviour could take the form of a crude joke, making unwanted approaches, or treating men and women differently for doing the same job. Whatever its form, sexist and sexually harassing behaviour hurts both individuals and organisations. It's not always easy to call out these behaviours. This bystander action guide was developed to help organisations reduce sexist and sexually harassing behaviour.

There are different ways to be an active bystander. Sometimes it's reporting inappropriate behaviour, other times it's responding to an offensive remark to show the perpetrator that their comments are not okay. You can read a range of responses to sexist behaviour in this guide, as well as learn how to implement active bystander initiatives in your organisation.

The reports and tools below distill the findings and practice insights from the 'Active Bystander' trials:

- Take action: Empowering bystanders to act on sexist and sexually harassing behaviours in universities - Summary Report from the Phase Two bystander trials, 2018 – 2019
- Take action: Empowering bystanders to act on sexist and sexually harassing behaviours in universities - The final report from the Phase Two bystander trials, 2018 – 2019 MB)
- Guide to implementing a university-wide bystander email campaign
- Bystander behavioural survey tool for universities

Another stolen generation looms unless Indigenous women fleeing violence can find safe housing

In Western Australia more than half the children placed in state care are Aboriginal. The state government has committed to reducing this over-representation, in a move that parallels the Closing the Gap Refresh draft target nationally. Despite concerns about another stolen generation, Australia has yet to act on a root cause – the difficulty Indigenous women escaping family violence face in finding safe housing.

Research by Kyllie Cripps and Daphne Habibis shows domestic violence and housing are linked as a cause of child removal. Indigenous children are admitted to out-of-home care at 11 times the rate for non-Indigenous children. Emotional abuse, which includes the child's exposure to family violence, accounts for most notifications.

The second-most-common type is neglect. This occurs at more than double the non-Indigenous rate and includes inadequate, insecure or unsafe housing. Many Aboriginal woman face an impossible situation when trying to protect their children. If they stay with the perpetrator they risk notification for emotional abuse. If they leave but cannot find suitable housing, they risk allegations of neglect.

This dilemma applies to all low-income women, but it is most acute for Aboriginal women. The combination of discrimination and low income means few find private rental housing. Crisis services are often full. The bottlenecks in the homelessness system result in long waits for transitional accommodation. Waiting times for scarce public housing are long. Many also face delays in being added to priority wait lists due to housing debt – even though this is often a result of their partner's financial abuse.

These women are often trapped in a revolving door between crisis centres, homelessness and returning to an unsafe home. This is a factor in their high rates of injury and early death.

Delays in being appropriately housed can prevent children from ever being returned to their parents. Child protection timelines generally allow only 12 months before removal can become permanent.

Housing's critical role at the intersection of child protection and domestic violence has yet to be recognised in public policy. The national Fourth Action Plan to reduce violence against women and their children refers to "inadequate housing and overcrowding" as a factor in Aboriginal family violence. Despite this, it offers no specific guidelines or strategies to overcome these problems.

The Closing the Gap policy focus on housing is limited to reducing overcrowding. While critical, this misses the relationship between housing shortages and family violence and its impact on mums being separated from their children. And the Refresh targets are uncertain and underdeveloped.

Read more here

Endometriosis in Australia: Prevalence and hospitalisations

Almost 11% (one in nine) of women aged 40–44 and 7% of women aged 25–29 have endometriosis, according to the latest Australian Institute of Health and Welfare (AIHW) report, Endometriosis in Australia: Prevalence and hospitalisations.

The report provides new insights into the historically under-recognised condition and includes the most recent estimates of endometriosis prevalence in Australia. Based on national data from health services and the large Australian longitudinal study on women's health, researchers at the University of Queensland estimated the prevalence of endometriosis in women born in:

- 1973–78, with data available up until age 40–44
- 1989–95, with data available up until age 25–29.

Prevalence of the condition was found to be 1.7 times higher for women born in 1989–95, who were diagnosed with endometriosis by age 25–29 (6.6%), compared with women born in 1973–78 at the same age (4%).

This recent increase may indicate a greater awareness of endometriosis among the general public and health professionals, leading to increased diagnosis and reporting of diagnosis among women born more recently.

According to the report, endometriosis cost an estimated $7.4 billion in Australia in 2017–18, mostly through reduced quality of life and productivity losses. However, the AIHW states that this may be an underestimate due to under-diagnosis and difficulties in diagnosing the condition.

Read the Report

3D mammography screening

It is unlikely BreastScreen will introduce routine 3D mammography screening in the short term based on the current evidence. However, a 3D mammogram may be recommended in cases where women have dense breast tissue or a family history of breast cancer.

For older women, there may not be additional benefits of 3D mammography over 2D. All women should consider the balance of potential benefits (early detection) and potential harms

(overdiagnosis, overtreatment and anxiety) before deciding on a 3D versus a 2D screening mammogram.

For further information please see:
For routine breast screening, you may not need a 3D mammogram

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She's price(d)less: the economics of the gender pay gap

She's Price(d)less is the third in a series of reports that uses econometric modelling applied to data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey to unpack the factors that contribute to the gender pay gap.

The report shows that deeply entrenched gender stereotypes about the roles men and women play in paid work and caring continue to be the driving force behind the gender pay gap. The report found that:

- **Gender discrimination** continues to be the biggest contributing factor to the pay gap, accounting for almost two-fifths (39%) of the gender pay gap,
- The combined impact of **years not working** due to interruptions, **part-time employment** and **unpaid work** contributed to 39% of the gender pay gap.
- **Occupational and industrial segregation** continue to be significant contributors to the gender pay gap at 17%.

Understanding the drivers of the gender pay gap is critical to designing interventions to close the gap.

The study, conducted for the Diversity Council of Australia (DCA) and the Workplace Gender Equality Agency found that halving the gender pay gap and entrenched discrimination against women would increase economic growth by $60 billion by 2038.

Solutions outlined in the report included:

- Addressing discrimination in hiring, promotion and training
- Increased pay transparency and reporting on gender pay gaps
- Increasing the availability of childcare; and reducing disincentives through personal tax, family payment and child support systems
- Increasing the share of women in leadership positions through targets, quotas and diversity policies

She's Price(d)less – Summary report

She's Price(d)less – Detailed report

Spotlight on alcohol and women's health

This Spotlight features a list of up-to-date and freely available research and resources on the topic of alcohol and women's health.

Alcohol is the most commonly used drug in Australia. Alcohol consumption increases the risk of health problems including cancers, brain damage, liver disease and heart disease. While men are more likely to drink at 'risky' levels than women, women's rates of alcohol use and related harms are catching up with men. Women start to experience alcohol-related health problems sooner and at lower drinking levels than men.

Overall, increases in women's alcohol consumption have also been attributed to changes in gender roles and women's increasing workforce participation and wage earning. While the literature tends to focus on the harms of women's drinking, there is a lack of research on their motivations for consuming alcohol.

Different expectations apply to men and women in relation to alcohol consumption. While men's behaviour is more likely to be excused, women are judged more harshly on behaviour and appearance if they have consumed alcohol.

Barriers women face in accessing treatment include social stigma, childcare concerns, fear of losing their children and the lack of gender-sensitive treatment programs.

Download the Final Print version: Spotlight on alcohol and women's health

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The First Response project: Trauma and culturally informed approaches to primary health care for women who experience violence

Research has shown that trauma informed services are effective in reducing the burden of violence against women. This is reflected in Australian policy landscape, including the National Plan to Reduce Violence against Women and their Children 2010–22, which calls upon services to deliver trauma informed care. However, much of the research that guides policy is based upon Western concepts of trauma, which may not consider First Nations peoples experiences and perspectives on trauma. To address this, the First Response project explored how the workforce within Aboriginal Community Controlled Health Organisations (ACCHOs) conceptualise trauma and culturally informed care and how this informs approaches to primary health care for women who are experiencing violence.

Fear, shame and stigma prevents women from disclosing experiences of family violence or intimate partner violence (IPV) and accessing support. This can be compounded for First Nations women due to systemic racism and traumatising experiences with police, legal and health services. In response to these barriers, recommendations include the provision of trauma informed care, in which the multiple, complex nature of women's lives is properly understood and responded to without judgement or shame.

The partnership for First Response was developed between the researcher team and four New South Wales ACCHOs with the shared vision of centring Aboriginal and Torres Strait Islander peoples' worldviews throughout the research activities. This paper shares the results of the research, including on:

- What trauma and culturally informed care means to ACCHO staff
- Supporting holistic client trajectories
- Finding the right people
- Training and resources

Read more here: **The First Response project: Trauma and culturally informed approaches to primary health care for women who experience violence**

Interventions addressing men, masculinities and gender equality in sexual and reproductive health and rights: An evidence and gap map and systematic review of reviews

Working with men/boys, in addition to women/girls, through gender-transformative programming that challenges gender inequalities is recognised as important for improving sexual and reproductive health and rights (SRHR) for all. The aim of this paper was to

generate an interactive evidence and gap map (EGM) of the total review evidence on interventions engaging men/boys across the full range of WHO SRHR outcomes and report a systematic review of the quantity, quality and effect of gender-transformative interventions with men/boys to improve SRHR for all.

An important finding of this review is that research and programming must be strengthened in engagement of men/boys; it should be intentional in promoting a gender-transformative approach, explicit in the intervention logic models, with more robust experimental designs and measures, and supported with qualitative evaluations.

The case for addressing gender equality as part of a human rights-based approach to improving health, including sexual and reproductive health (SRH), has been a longstanding guiding principle in the feminist literature on gender and development and significantly foregrounded in global public health since before the 1994 International Conference on Population and Development (ICPD) in Cairo.

The conference marked a paradigm shift in global health away from an overarching concern with population control in low-resource countries to a human rights-based approach aimed at empowering women to control their fertility and their access to safe childbearing, while making explicit too the need to engage men to make this a reality. Since then, too, the focus on addressing gender inequality in health programming has become more clearly conceptualised as a gender-transformative approach.

The concept of gender-transformative approaches was first coined by Dr Geeta Rao Gupta in the context of the HIV/AIDS epidemic and has since gained traction in international health and development policy. The WHO defines a gender-transformative approach as one 'that address the causes of gender-based health inequities through approaches that challenge and redress harmful and unequal gender norms, roles, and power relations that privilege men over women'. Men are also implicated in the harmful consequences of gender inequality, harming their own and other men's health and the health of their female partners as a result of narrow and constraining definitions of what it means to be a man, therefore gender-transformative approaches also benefit men in broadening the interpretation of masculinity and the socially acceptable ways in which masculinity can be expressed.

Just as in the original definition offered by Rao Gupta, the WHO definition of a gender-transformative approach is derived from considering a continuum of approaches to addressing gender equality in health programming. In the WHO definition, these are:

- a gender unequal approach that perpetuates gender inequality by reinforcing unbalanced norms, roles and relations;
- a genderblind approach that ignores gender norms, roles and relations and thereby often reinforces gender-based discrimination;
- a gender-sensitive approach that considers gender norms, roles and relations but does not address inequality generated by unequal norms, roles or relations;
- a gender-specific approach that considers women's and men's specific needs or roles but does not seek to change these roles; and
- a gender-transformative approach that considers gender norms, roles and relations for women and men, as does gender-specific and gender-sensitive, but is distinguished by the imperative to challenge gender inequality.

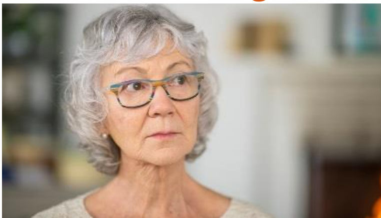
A gender-transformative approach seeks to challenge gender inequality by transforming harmful gender norms, roles and relations through inclusion in programming of strategies to foster progressive changes in power relationships between women and men. The underpinning

rationale of addressing gender inequality is because it is a key determinant of the health of men and women of all gender identities and sexualities yet generally disproportionately disadvantages the opportunities and outcomes for women and girls, including in the particular field of sexual and reproductive health. However, a gender-transformative approach also prompts an explicit focus on the roles of men/boys in transforming gender inequality to improve men's health and especially SRHR.

There is increasing recognition that men and boys can play a role as either supporting and championing or damaging and denying the health and rights of women and girls. Hence, focusing on boys/men through a gender-transformative approach goes beyond a men's health focus or the inclusion of men as partners of women with respect to SRH decision making.

Read more:
Interventions addressing men, masculinities and gender equality in sexual and reproductive health and rights: An evidence and gap map and systematic review of reviews.

Elder abuse national research – strengthening the evidence base: research definition background paper



This background paper by the Australian Institute of Family Studies sets out the approach to the development of a working definition of abuse of older people. The working definition is intended to be applied in the Elder Abuse National Research Program and, in particular, to inform the development of data collection instruments for an Australian Prevalence Study. The proposed working definition set out in this paper will be applied and tested as part of the Prevalence Study. At the conclusion of the study, it is expected a final research-based definition will have been developed that is appropriate to the Australian context and can be used to support any future research conducted in Australia. In the interim, it is expected that the Australian Government will continue to refer to the World Health Organization's (WHO) definition of elder abuse.

At present, there is no legislative or purpose-built Australian definition of elder abuse or the abuse of older people. According to this research, there is a significant distance between the broad formulations in the accepted definitions, such as the WHO definition, and the level of precision that is required to develop measures for the purpose of assessing prevalence. Theoretical approaches, including those based on human rights, socio-ecological perspectives, life-course and feminist perspectives, can support consideration of the circumstances in which abuse of older people occurs, and inform this examination of the elements of the definition.

The proposed working definition is:

a single or repeated act or failure to act, including threats, that results in harm or distress to an older person. These occur where there is an expectation of trust and/or where there is a power imbalance between the party responsible and the older person.

Although not specifically articulated in the working definition, the acts or omissions to be captured by this definition for the purposes of the Australian Prevalence Study include:

- physical abuse (including pushing/shoving, hitting/slapping, punching and kicking)

- emotional/psychological abuse (including verbal abuse such as yelling insults and name calling; intimidation/bullying and harassment; damaging or destroying property; threatening to harm the older person or their family members/friends or pets; threatening to withdraw care and preventing or attempting to prevent access to funds, telecommunication or transport)
- financial/economic abuse (including misuse or theft of finances or other assets and abuse or misuse of powers of attorney)
- sexual abuse (including unwanted sexual contact and rape)
- social abuse (including preventing or attempting to prevent the older person from having contact with family, friends or community - social isolation)
- neglect (including the failure to provide access to essentials such as food and hydration, clean and appropriate shelter, adequate hygiene or medical care).

Find the report here

The health of Australia's females

In 2018, just over half of Australia's population—51% or 12.6 million people—were female. On average, Australian females experience different health outcomes than Australian males. Compared with males, females have a higher life expectancy and experienced more of their total disease burden due to living with disease rather than from dying early from disease and injury. They are more likely than males to experience sexual violence and to have multiple chronic conditions.

https://www.aihw.gov.au/reports/men-women/female-health/contents/who-are

background paper by the Australian Institute of Family Studies sets out the approach to the development of a working definition of abuse of older people. The working definition is intended

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Women's Community Health Network 2019 presentations

- The intersections between domestic and family violence, sexual assault, and childhood sexual abuse in the context of violence against women
- The intersections between gender and disability, power and marginalisation
- Domestic violence, pregnancy and community-based women's health services
- Women's Health in Context