

# VicHealth Indicators Survey 2015

## Supplementary report: Gender

The VicHealth Indicators Survey is a Victorian population-level survey conducted every four years. Selected findings from the VicHealth Indicators Survey 2015 were published in 2016. This report provides a closer look at the health and wellbeing of surveyed respondents based on their gender.

### Introduction

The important influence of gender equality on population health and wellbeing has gained increasing prominence in Australia in recent times. VicHealth's vision for gender equality is a Victoria where everyone can realise their full potential for health and wellbeing, regardless of gender (VicHealth 2017a). Our work is about finding and delivering solutions that build the social, economic, political and cultural foundations that enable all Victorians to participate fully and equally in all aspects of their lives. As part of this, we are committed to addressing health inequities between women and men – the differences in health outcomes and their risk factors between social groups that are socially produced, systematic in their distribution, avoidable, unfair and unjust (Whitehead 1992).

Australian women and men self-assess their overall health similarly, with the majority rating their health as either excellent or very good (ABS 2016b). However, evidence documenting gender inequalities in health and wellbeing is

abundant with research findings consistently showing that gendered health inequities stem from social norms reflecting an unequal distribution of power and resources between women and men (Department of Premier and Cabinet 2016). For example, women disproportionately experience sexual and intimate partner violence and are more likely to be denied opportunities associated with better health, such as well-paid employment (OurWatch et al. 2015; ABS 2016a; VicHealth 2017a). At the same time, adherence to rigid gender norms and stereotypes and harmful constructions of masculinity (e.g. entitled, aggressive, dominant) may make men less likely to seek help and more likely to exhibit certain risky health behaviours that cause injury, disease, and premature death, such as excessive alcohol consumption (Mahalik et al. 2007; ABS 2016a; Wong et al. 2017).

The following sections provide context on health inequities between women and men in Australia across a selection of VicHealth's areas of interest.

### A note about diverse gender identities

*Safe and strong: Victoria's Gender Equality Strategy* defines gender as the "socially-constructed differences between men and women, as distinct from 'sex', which refers to their biological differences" (Victorian Government 2016). VicHealth recognises that some people's gender identities or physical characteristics do not fit into binary categories of male or female, or do not reflect the biological sex they were assigned at birth. In contrast, cisgender people's gender identities are in line with the social expectations of their sex assigned at birth. VicHealth recognises that trans, gender-diverse, non-binary and intersex people encounter greater barriers to equality and are more likely than cisgender people to report poor mental health and to have experienced harassment or violence (Leonard et al. 2015).

This report focuses on Victorians that identified as a woman or a man when responding to the survey. While the 2015 survey design allowed people to identify as neither male nor

female, there were limited respondents who did so, meaning that the sample size was too small to allow for analysis. VicHealth is committed to exploring ways to improve survey design and data collection methods for future research, so that respondents' needs are recognised, data integrity is improved and findings better reflect the diversity of Victorians' gender identities and sexes (VicHealth 2017a). VicHealth also recognises that the impacts of gender inequality can be exacerbated by the intersection of multiple factors or identity attributes, such as education level, income, occupation type, ethnicity, ability, sexuality, religion, Aboriginality, age and place of residence (VicHealth 2015). This report looks in detail at the intersection between gender and social disadvantage. However, there is value in further analysis of other intersections, and VicHealth is committed to exploring this in future research.

## Summary of key findings



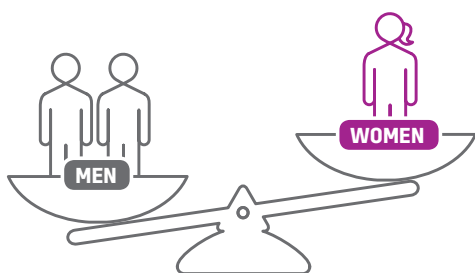
### WELLBEING

Women and men have equal levels of satisfaction with their overall health. Women have higher levels of wellbeing and life satisfaction.



### SAFETY

Women feel 60–80 per cent less safe than men to walk alone in their neighbourhood.



### GENDER EQUALITY

Men are twice as likely as women to hold low levels of support for gender equality.

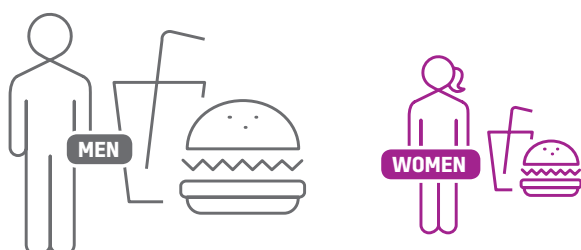


### ALCOHOL

Men are almost four times more likely than women to drink at levels that put them at very high risk of short-term harm.

### PHYSICAL ACTIVITY

Women are about 20 per cent less likely than men to be considered active.



### HEALTHY EATING

Men are about two and a half times more likely than women to report consuming takeaway food three or more times per week.

## Wellbeing

**Wellbeing is defined as the balance point between an individual's physical, psychological and social resources and the physical, psychological and social challenges they face (Dodge et al. 2012). When individuals have more challenges than resources, the balance dips, along with their wellbeing, and vice-versa. Wellbeing can be measured objectively (e.g. household income, education, leisure time or life expectancy) or subjectively (e.g. life satisfaction and quality of life surveys).**

The Personal Wellbeing Index (PWI) is a tool used to assess subjective wellbeing, that is, the self-perception of one's own wellbeing. The PWI is the principal indicator of the Australian Unity Wellbeing Index, which has been collecting subjective wellbeing data since 2001 as a barometer of Australians' satisfaction with their lives (Cummins et al. 2003). The PWI assesses satisfaction with life across seven domains, and scores can be aggregated to provide a single index of subjective wellbeing. In the 2016 survey, women scored higher both overall and across the majority of domains, except for the domains of Health and Personal Safety, where men scored slightly higher than women (Capic et al. 2016). This trend has been relatively consistent across the years, with Australian women generally reporting higher subjective wellbeing than men (Cummins et al. 2011).

Recent research among Australian women using a different measure of subjective wellbeing suggests that women report higher subjective wellbeing even when they are objectively disadvantaged (Western & Tomaszewski 2016), mirroring initial findings from the PWI development study (Cummins et al. 2003). It has been argued that women are more likely to report higher satisfaction even when experiencing circumstances that are objectively worse than that of men, due to a phenomenon called 'adaptive preference formation', whereby women have lower expectations and are more likely to make the best of a bad situation (Western & Tomaszewski 2016). This may help to explain why Australian women report higher subjective wellbeing (Capic et al. 2016) despite experiencing higher rates of anxiety, depression and psychological distress than men (ABS 2016b).

There is evidence that some of the difference in mental health and wellbeing between women and men can be attributed to differences in social and economic status. An Australian study found that when women and men had equal social opportunities (such as work, social support, and education), some of the gender differences in rates of mental ill health were diminished (Wilhelm et al. 2008).

## Safety

**Neighbourhood safety and security are important determinants of people's health and wellbeing. Feeling safe while walking alone in your local area is a basic indicator of security and is correlated with trust and social connection (Baum et al. 2009).**

Women's perceptions of safety in Australia are the lowest of any developed country in the world, with over half of Australian women feeling unsafe when walking alone at night (GIWPS and PRIO 2017). The 2016 Australian Bureau of Statistics (ABS) Personal Safety Survey found that Australian women are more likely to feel unsafe when alone in their community (either at home, walking or on public transport) compared to men. Over a quarter of women reported that they had not walked alone in their local area after dark over the previous 12 months because they felt unsafe (ABS 2017).

All Victorians should feel safe, and all violence is wrong, regardless of the victim or perpetrator's gender. At a population level, there are several characteristics of women's experiences of violence that are different from men's. Men are most likely to be physically assaulted in public by a male stranger, whereas the majority of violence against women occurs in the woman's own home and is perpetrated by a man they know (ABS 2017).

The ABS (2017) reports that a higher proportion of Australian men than women have experienced violence since the age of 15 (defined as any incident involving the occurrence, attempt or threat of either physical or sexual assault). However, almost 90 per cent of Australian women have experienced at least one form of verbal or physical street harassment, with the majority having experienced this harassment while alone in the community. Over half were younger than 18 years when they first experienced street harassment (Johnson & Bennett 2015). These forms of harassment that take place on the streets are a contributing factor to the disproportionate number of women who feel unsafe alone within their community.

## Alcohol

**Harm associated with alcohol use, including short-term harm and long-term health consequences, is well documented (Rehm et al. 2010). The risk of injury increases as more alcohol is consumed during a single session, with risks predominantly associated with self-injury or injuries to others affected by the drinker's behaviour (e.g. families, friends and strangers).**

National data show that men are more than twice as likely as women to drink alcohol at levels associated with risk of short-term harm (ABS 2016a). A gender difference also exists in relation to harms from the alcohol consumption of others, with men more likely to be affected by harms related to the alcohol consumption of strangers, friends and co-workers, and women more likely to be affected by the alcohol consumption of family members (Laslett et al. 2011).

The relationship between disadvantage, alcohol consumption and alcohol harms is complex. Those with greater advantage are more likely to be drinkers and to drink more often, particularly more light-to-moderate drinking occasions, than their more disadvantaged counterparts (Schmidt et al. 2010). However, drinking occasions that involve very high risk consumption are typically more common for those with greatest disadvantage. It has been suggested that for the same level of alcohol consumed by both advantaged and disadvantaged individuals, the more disadvantaged groups may experience higher levels of alcohol-related harm (Schmidt et al. 2010).

## Physical activity and healthy eating

**Being overweight or obese is associated with an increased risk of developing chronic disease (NHMRC 2013). Overweight and obesity rates are high in Australia, with data from 2014–15 indicating that two in three adults (63.4%) were overweight or obese (ABS 2016b). Unhealthy diet and physical inactivity are significant contributors to these high rates. There are significant gender differences in the rates of overweight/obesity, with Australian men more likely to be overweight and obese than Australian women (ABS 2016b).**

Across Victoria, high-income groups and people living in more advantaged neighbourhoods are more likely to eat a healthy, balanced diet, be physically active, be a healthy weight and have better health outcomes (ABS 2016b; Ghosh et al. 2016). While there are differences in both diet and physical activity levels between women and men, they are in opposite directions: Australian women are more likely than men to meet the healthy eating guidelines, and Australian men are more likely than women to meet the physical activity guidelines (ABS 2016b).

## Focus of this supplementary report

Although *VicHealth Indicators Survey 2015: Selected Findings* reports differences in response proportions by gender, the survey data provided an opportunity to examine differences between women and men across several domains in more detail, including wellbeing and safety, attitudes towards gender equality in relationships, physical activity, healthy eating, and alcohol consumption. In this report, we also explore how the socioeconomic disadvantage of an area is associated with these health domains.

## VicHealth Indicators Survey 2015

**The VicHealth Indicators Survey is a population-level survey focused on behaviours and attitudes associated with chronic disease risk. It has been conducted every four years since 2007. In 2015, data were collected from more than 22,000 Victorian adults (18 years and over) via telephone interviews using a dual-frame survey design utilising randomly generated mobile and landline phone numbers. Full details of the data collection method and measures used in the VicHealth Indicators survey are provided in *VicHealth Indicators Survey 2015: Selected Findings (VicHealth 2016b)*.**

Respondents were asked to classify their gender as: male, female, or other. People could also choose not to respond. Of the 22,819 Victorian adults who were interviewed, 9351 identified as male, 13,422 identified as female, six identified as other, and 40 preferred not to identify their gender. Socioeconomic disadvantage of an area was defined using the ABS Socio-Economic Index for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage (IRSD). The IRSD is derived from Census variables related to disadvantage, such as low income, low educational attainment, unemployment, and dwellings without motor vehicles. This means that, unlike the other indexes, a high score reflects a relative lack of disadvantage rather than relative advantage. For the purposes of this report, SEIFA has been divided into five quintiles (sections), where Quintile 1 is the most disadvantaged and Quintile 5 is the least disadvantaged. The IRSD is the preferred index for these survey results as it highlights the relationship between broad disadvantage and health behaviours. A range of validated scales and survey items were used to collect data on all health and wellbeing indicators. Respondents were also asked to provide sociodemographic data.

## Statistical analysis

In order to determine the relationships between gender and the indicator of interest, a statistical technique called regression analysis was performed. This approach allows estimation of the influence of predictor variables on each of the outcome variables of interest to be gauged after controlling for the influence of other relevant variables. For example, it was previously reported in *VicHealth Indicators Survey 2015: Selected Findings* (VicHealth 2016b) that life satisfaction scores improved with age and declined with increasing relative socioeconomic disadvantage. Therefore, in order to determine the impact of being a woman (the comparison group) on life satisfaction compared to being a man (the reference group), we adjusted for the influence of age and SEIFA by including them in the model as predictors.

Continuous variables were analysed using linear regression analysis, with results presented in Figures 2 and 3 as adjusted beta coefficients with 95 per cent confidence intervals, whereby negative values indicate lower scores compared to the reference group, and positive values indicate higher scores compared to the reference group. Binary variables were analysed using logistic regression analysis, with results presented in Figures 4 to 9 as odds ratios with 95 per cent confidence intervals, whereby values under 1 indicate reduced odds compared to the reference group, and values over 1 indicate increased odds compared to the reference group. **Figure 1** shows an example.

The reporting of differences between categories is noted only when such differences are statistically significant, based on a P value less than 0.05.

## How to interpret the figures

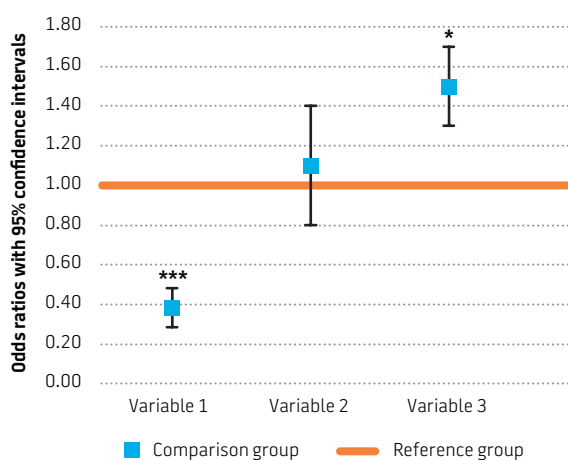
Estimated odds ratios or coefficients for the comparison group (for example, women) are shown in blue, with error bars indicating the 95 per cent confidence intervals. The reference group against which these are estimated (for example, men), is shown in orange.

Odds ratios that are above the orange line indicate higher likelihood in the comparison group than the reference group; ratios below the orange line indicate a lower likelihood in the comparison group than the reference group.

Coefficients above the orange line indicate association with higher scores in the comparison group than the reference group; coefficients below the orange line indicate association with lower scores than the reference group.

Stars indicate a statistically significant difference compared to the reference group, with increasing numbers of stars indicating a stronger significance. If there are no stars, there is no statistically significant difference between the comparison group and the reference group. One star indicates a statistically significant difference with a P value less than 0.05; two stars indicate a P value less than 0.01; three stars indicate a P value less than 0.001.

**Figure 1 Example figure**



# Findings

## Wellbeing and safety

**Life satisfaction, subjective wellbeing and feelings of safety are important determinants of people’s health and wellbeing. Victorian women report higher levels of satisfaction with life as a whole and subjective wellbeing than men, but report poorer scores in relation to feelings of safety.**

### Life satisfaction

General life satisfaction was measured by asking participants to rate their satisfaction with life as a whole on a scale from 0 to 10, where 0 indicates ‘completely dissatisfied’ and 10 indicates ‘completely satisfied’.

Overall, life satisfaction scores improved with age and declined with increasing relative socioeconomic disadvantage. When adjusted for age and relative disadvantage, life satisfaction was slightly higher for women than men (approximately 0.1 points higher: see Figure 2a).

### Subjective wellbeing

This survey assessed subjective wellbeing using the Personal Wellbeing Index (Cummins et al. 2003). The index asks respondents to rate their satisfaction with life across seven domains: standard of living; health; current achievements in life; personal relationships; feelings of safety; feeling part of the community; and future security. Satisfaction is rated on a scale of 0 to 10, where 0 indicates ‘completely dissatisfied’ and 10 indicates ‘completely satisfied’.

Similar to overall life satisfaction, scores for overall subjective wellbeing and the seven domains improved with age and declined with increasing relative socioeconomic disadvantage (with the exceptions of levels of satisfaction with health and feelings of safety, that both declined with age).

When adjusted for the effects of age and relative disadvantage, women generally scored slightly higher than men (approximately 0.2 points higher out of 10 on each scale); this was seen for levels of satisfaction with standard of living, current achievements in life, personal relationships, feeling part of the community, and future security (see Figure 2b).

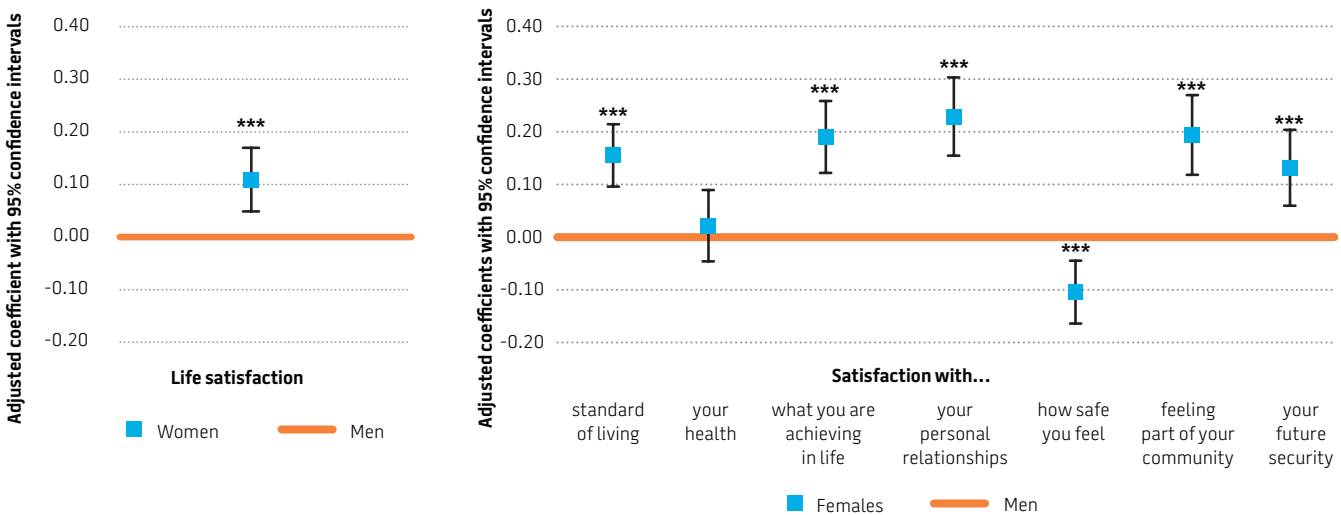
There were two exceptions: levels of satisfaction with health were not different between women and men; and notably, in the domain of satisfaction with feelings of safety, women scored approximately 0.1 point (out of 10) lower than men.

We also examined the impact of relative disadvantage on scores for the seven domains for women and men, adjusting for the impact of age. The patterns across SEIFA quintiles were similar between women and men (see Figure 3), with those in areas of greatest disadvantage (Quintile 1) displaying poorer wellbeing scores than those in areas of least disadvantage (Quintile 5) across five of the seven wellbeing domains.

The relationship between SEIFA quintiles and satisfaction with one’s standard of living indicates a stronger impact of relative disadvantage on women than men, with living in Quintile 1 associated with a reduction in score of 0.63 and 0.49 respectively. Conversely, the relationship between SEIFA quintiles and satisfaction with how safe someone feels indicates a stronger impact of relative disadvantage on men than women, with living in Quintile 1 associated with a reduction in score of 0.42 and 0.27 respectively.

It is important to highlight that relative disadvantage of residential area was not significantly associated with satisfaction with personal relationships, and there was no clear pattern of association with satisfaction with feeling part of your community for either men or women for areas of either higher or lower relative disadvantage.

**Figure 2 Associations between gender and: a) satisfaction with life as a whole scores; b) subjective wellbeing domain scores**



Positive coefficients (data points above the orange line) indicate association with higher scores in the comparison group (blue, indicated in legend) than the reference group (orange, indicated in legend); negative coefficients (data points below the orange line) indicate association with lower scores than the reference group. Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance. \*p<0.05; \*\*p<0.01; \*\*\*p<0.001. Note that the seven subjective wellbeing domains were analysed as separate regression models but are shown in one figure for visual clarity; all models are adjusted for age and SEIFA.

Figure 3a Associations between subjective wellbeing domains and relative disadvantage, by gender: satisfaction with standard of living

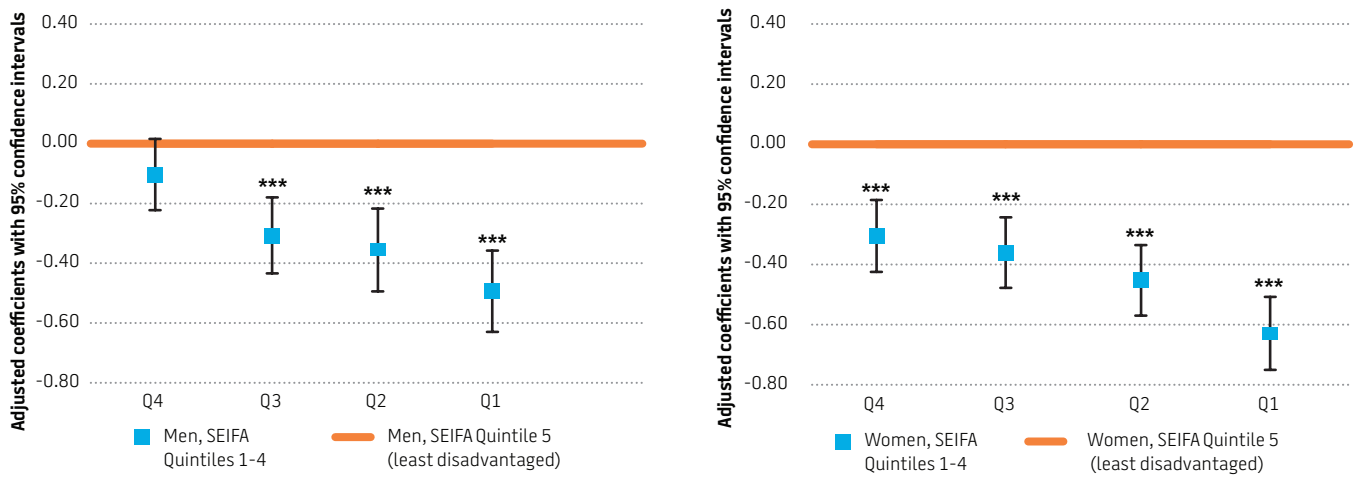


Figure 3b: Associations between subjective wellbeing domains and relative disadvantage, by gender: satisfaction with your health

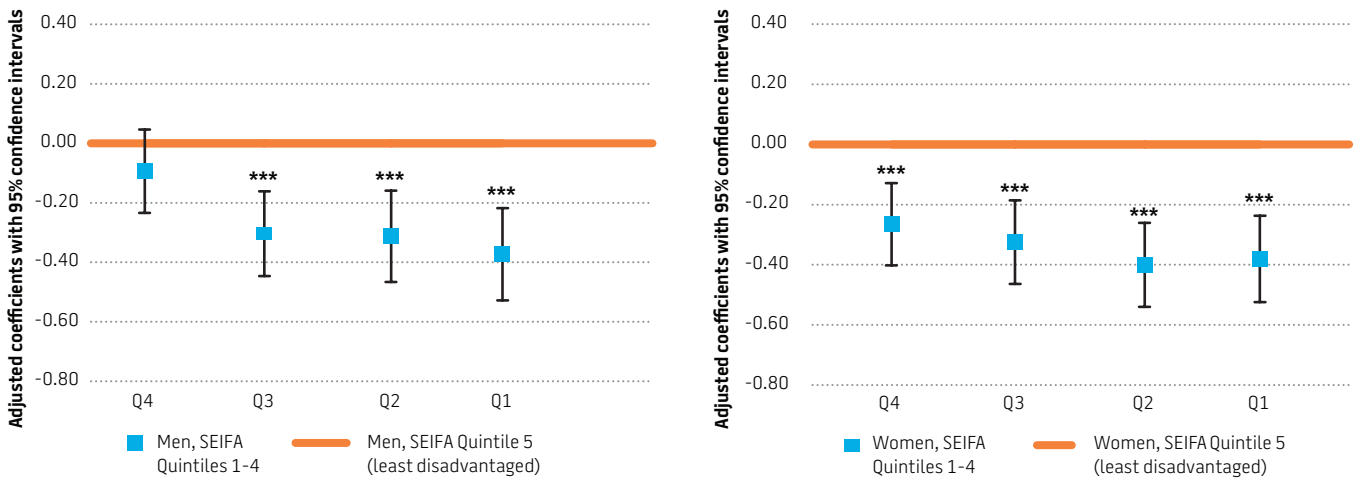
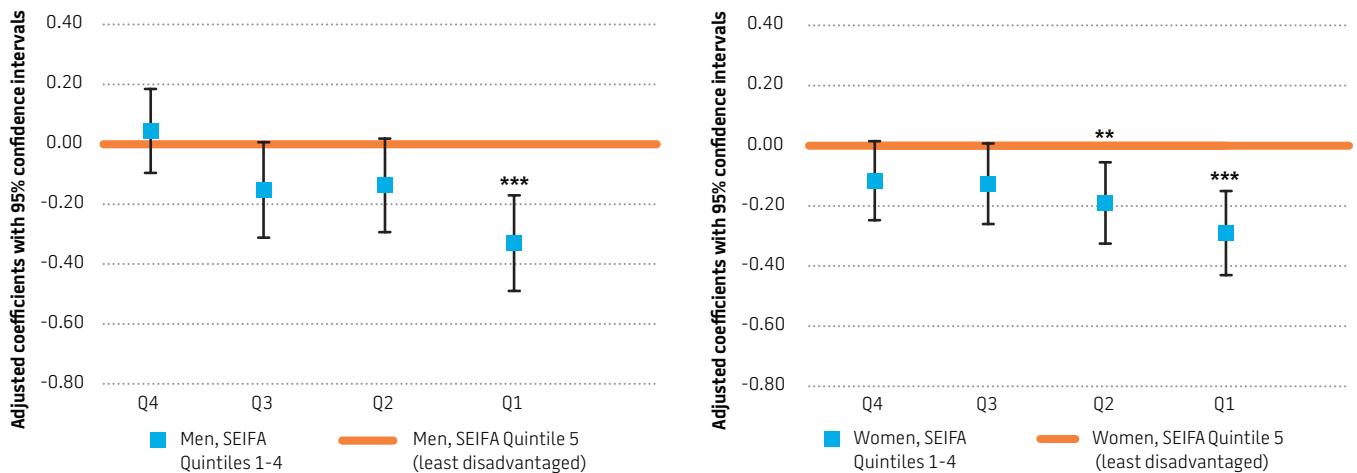
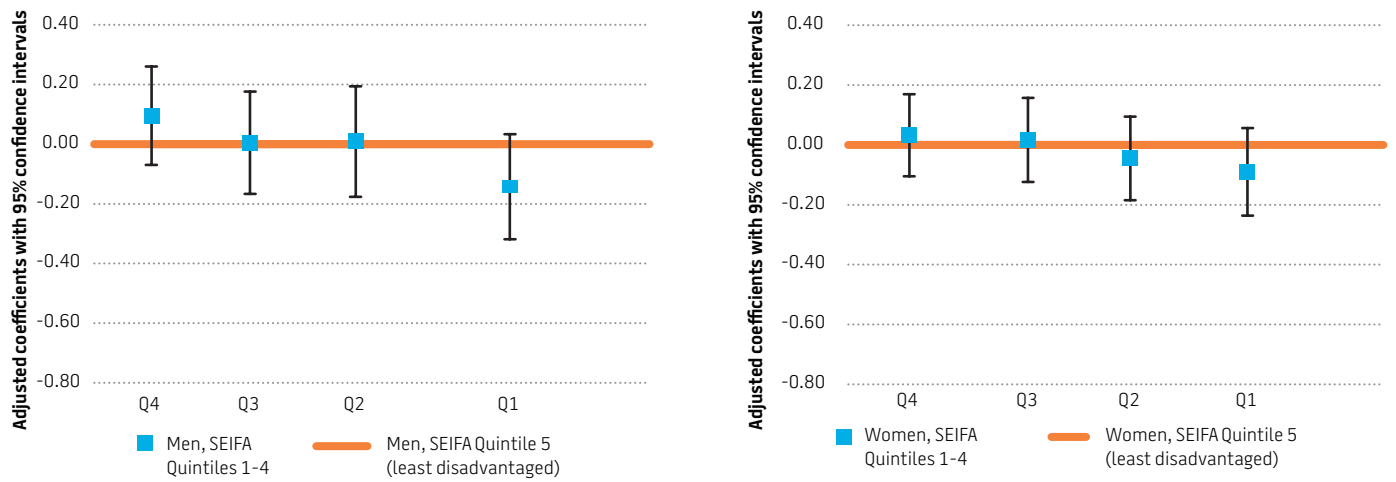


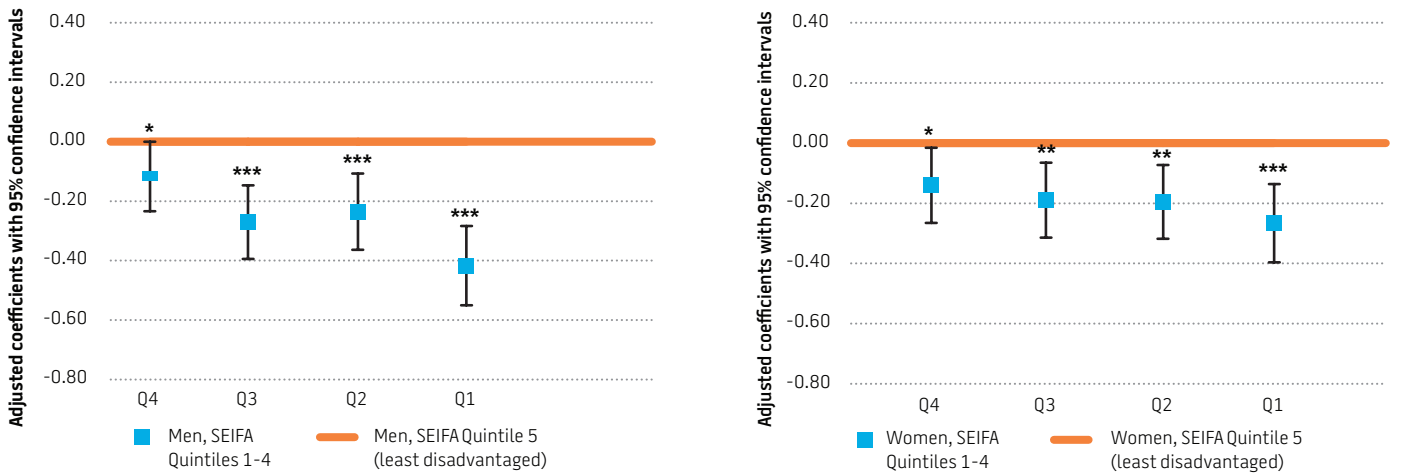
Figure 3c: Associations between subjective wellbeing domains and relative disadvantage, by gender: what you are currently achieving in life



**Figure 3d: Associations between subjective wellbeing domains and relative disadvantage, by gender: your personal relationships**

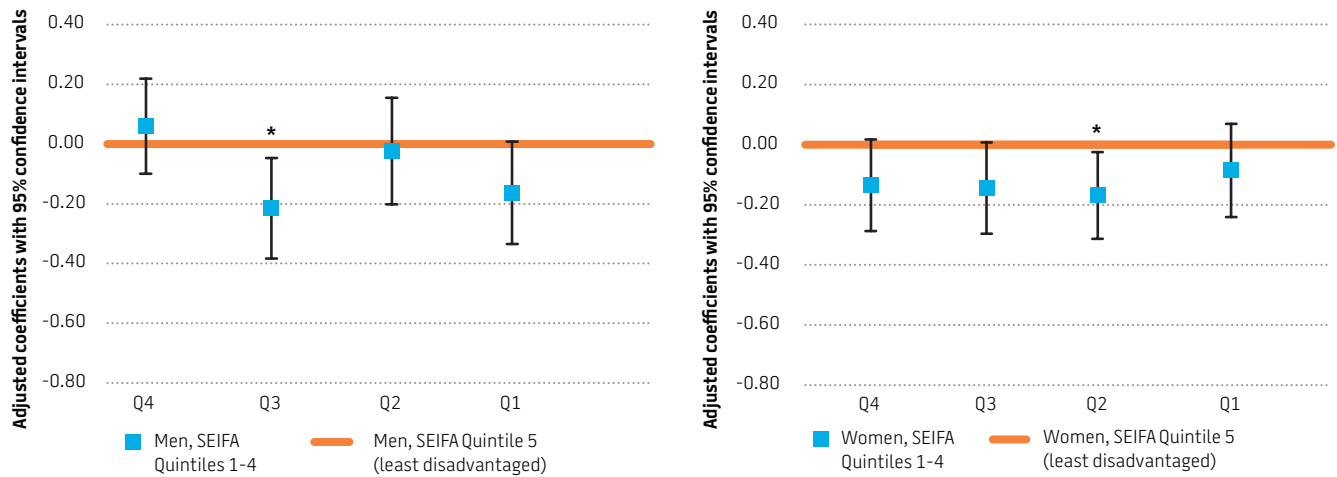


**Figure 3e: Associations between subjective wellbeing domains and relative disadvantage, by gender: how safe you feel**

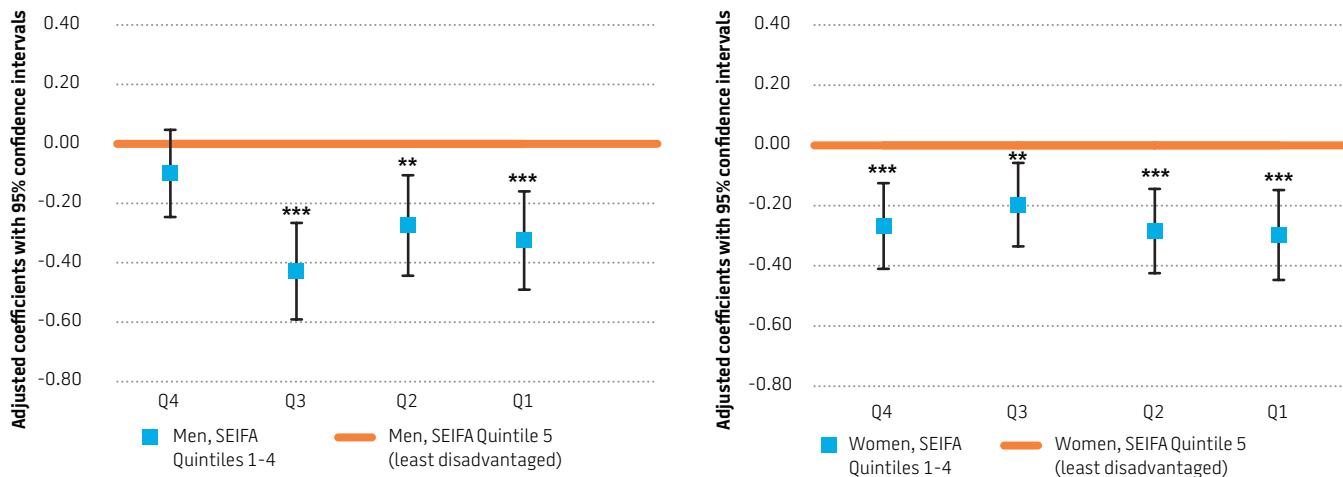




**Figure 3f: Associations between subjective wellbeing domains and relative disadvantage, by gender: feeling part of your community**



**Figure 3g: Associations between subjective wellbeing domains and relative disadvantage, by gender: your future security**



Positive coefficients (data points above the orange line) indicate association with higher scores in the comparison group (blue, indicated in legend) than the reference group (orange, indicated in legend); negative coefficients (data points below the orange line) indicate association with lower scores than the reference group.

Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance. \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

### Perception of safety

Perception of safety while walking alone during the day and perception of safety while walking alone after dark were measured on a 5-point Likert scale where 1 indicates 'very safe' and 5 indicates 'very unsafe'.

When adjusted for the effects of age and SEIFA, women were less likely than men to feel safe walking alone (Figure 4a). Women were almost 60 per cent less likely than men to feel safe walking alone during the day and nearly 80 per cent less likely to feel safe walking alone at night. There was a clear socioeconomic gradient for both women and men; with those in SEIFA quintiles 1 to 3 less likely to report feeling safe walking alone at any time of day

compared to those in the least disadvantaged quintile (Quintile 5) (Figure 4b & c). These patterns reflect the findings described above in relation to satisfaction with how safe someone feels.

The impact of socioeconomic disadvantage on feeling safe walking alone is more pronounced among men than women, particularly in relation to walking alone during the day. Men living in the most disadvantaged areas (Quintile 1) were approximately 80 per cent less likely to feel safe walking alone during the day than men living in the least disadvantaged areas (Quintile 5), whereas women living in Quintile 1 were approximately 60 per cent less likely to feel safe walking alone during the day than those in Quintile 5.

Figure 4a Odds of feeling safe walking alone during the day and after dark: for females compared to males

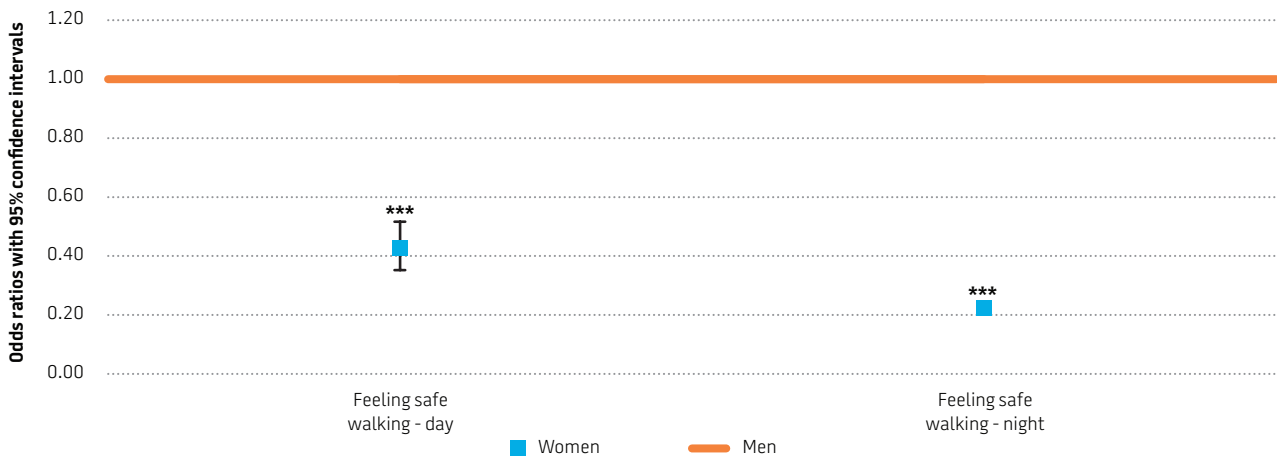


Figure 4b Odds of feeling safe walking alone during the day and after dark: among males, by level of disadvantage

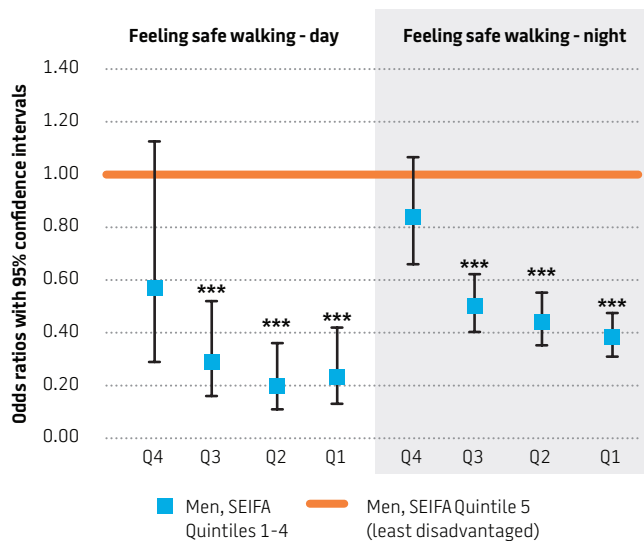
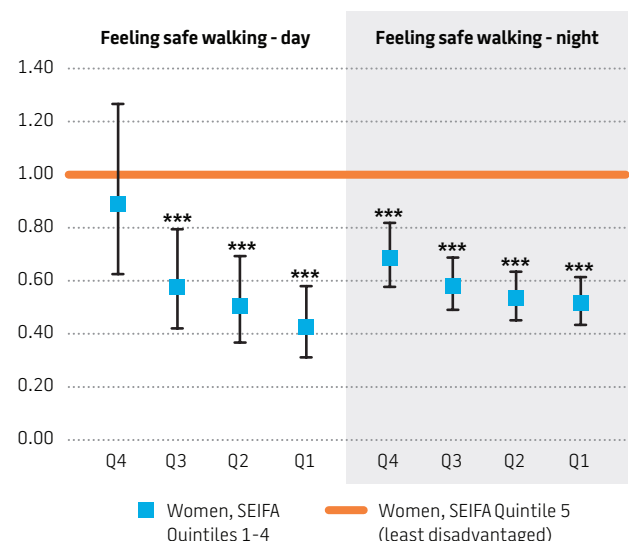


Figure 4c Odds of feeling safe walking alone during the day and after dark: among females, by level of disadvantage



Odds ratios above one (data points above the orange line) indicate a higher likelihood in the comparison group (blue, indicated in the legend) than the reference group (orange, indicated in the legend); odds ratios below one (data points below the orange line) indicate a lower likelihood than the reference group.

Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance: \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$ . All models are adjusted for the effects of age. Model a) is also adjusted for SEIFA.

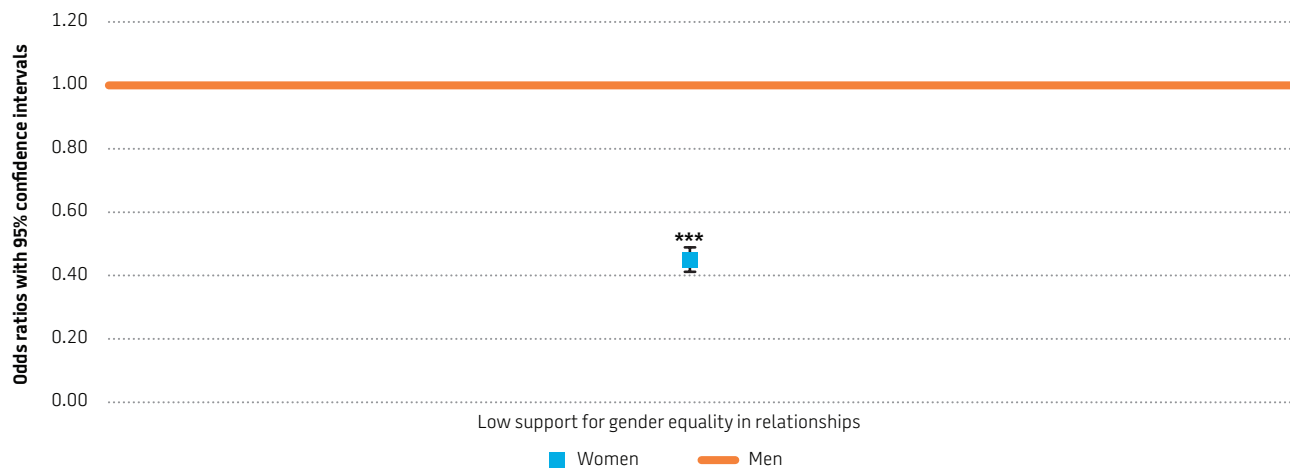
### Gender equality within relationships

Gender norms, roles and relations are important contributing factors to mental, physical and social health and wellbeing (WHO 2015). Attitudes towards gender equality within relationships are an important measure of community support for respectful and equal relationships.

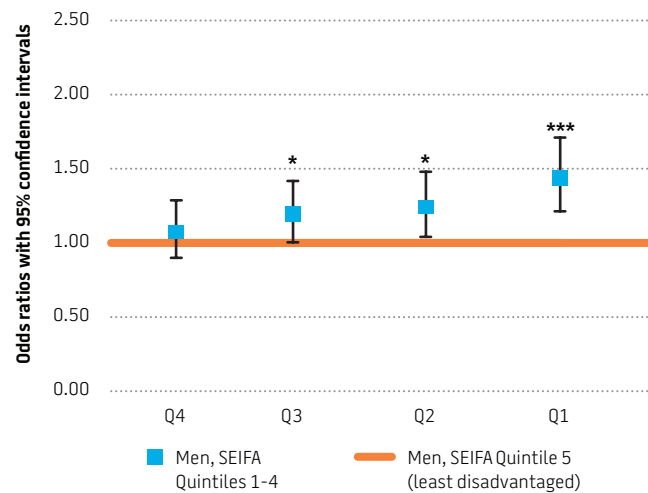
Attitudes were measured using an indicator based on the Gender Inequality in Relationships Scale (Harris et al. 2015), which asks respondents about their level of agreement with two statements: “Men should take control in relationships and be the head of the household” and “Women prefer a man to be in charge of the relationship”. Agreement with each statement was measured on a 5-point Likert Scale, where 1 indicates ‘strongly agree’ and 5 indicates ‘strongly disagree’. The score for each item is multiplied by 10 then summed together to produce a total score out of 100. Low support for gender equality is defined as a total score equal to or less than 70.

Men were twice as likely as women to hold low levels of support for gender equality across each SEIFA quintile (Figure 5a). Increasing socioeconomic disadvantage was associated with increased likelihood of reporting low support for gender equality within relationships for both women and men (Figure 5b & c). The impact of disadvantage on attitudes to gender equality was more pronounced in women than men; women in the most disadvantaged areas (Quintile 1) were almost twice as likely to report low support for gender equality in relationships as women living in the least disadvantaged areas (Quintile 5).

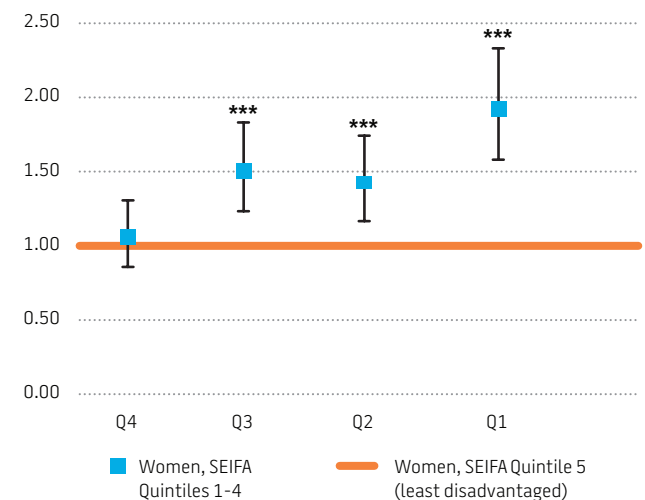
**Figure 5a Odds of reporting low support for gender equality in relationships: for females compared to males**



**Figure 5b Odds of reporting low support for gender equality in relationships: among males, by level of disadvantage**



**Figure 5c Odds of reporting low support for gender equality in relationships: among females, by level of disadvantage**



Odds ratios above one (data points above the orange line) indicate a higher likelihood in the comparison group (blue, indicated in the legend) than the reference group (orange, indicated in the legend); odds ratios below one (data points below the orange line) indicate a lower likelihood than the reference group.

Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance: \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

All models are adjusted for the effects of age. Model a) is also adjusted for SEIFA.

## Physical activity and healthy eating

**Being physically active and eating a healthy diet are vital for physical, mental and social health and wellbeing. Victorian women are less physically active than men. Participation in physical activity by women is more likely to be through walking or organised physical activity at a fitness centre, but less likely to be through participation in sport than men. Victorian men are more likely to regularly consume takeaway food than women.**

In Australia, unhealthy diet and physical inactivity are responsible for a significant proportion of the chronic disease burden (AIHW 2016b). Gender differences for selected indicators of physical activity and healthy eating are described below.

### Physical activity

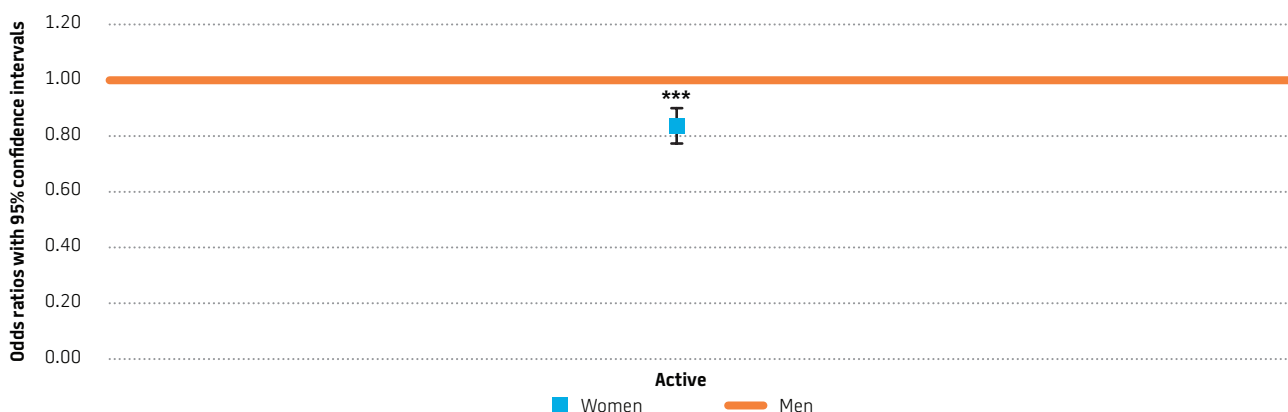
Respondents were asked how many days in a usual week they participate in physical activity for at least 30 minutes, using a validated single item measure (Milton et al. 2013). Respondents who were physically active for at least 30 minutes on four or more days per week were considered active. Respondents were also asked about the three main types of physical activity that they usually do with their responses grouped into three common

types of physical activity: physical activity organised by a fitness, leisure or indoor sports centre; physical activity organised by a sports club or association; and walking.

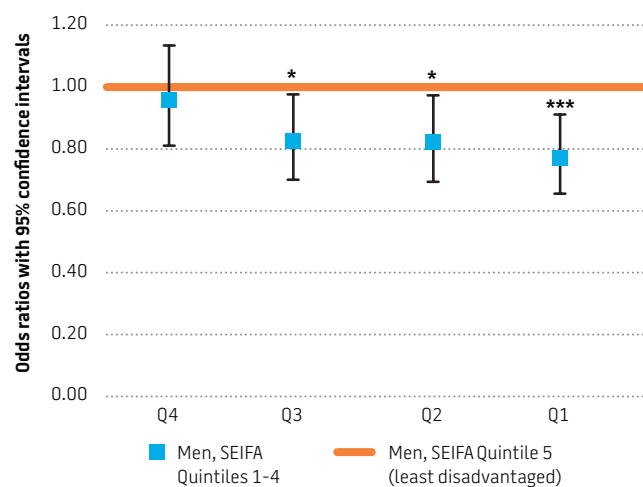
There are clear gender differences in the frequency and types of physical activity that women and men usually participate in. When adjusted for the effects of age and area-level disadvantage, women were about 20 per cent less likely than men to be considered active (Figure 6a). They were about 40 per cent more likely than men to report participating in organised physical activity at a fitness centre or walking, however they were about 40 per cent less likely to participate in physical activity organised by a sports club (Figure 7a).

The level of disadvantage where someone lives appears to play a role in frequency of activity, with both women and men in areas of greatest disadvantage (SEIFA Quintile 1) least likely to complete 4 or more days of physical activity (Figure 6b & c respectively). For women, there is no clear impact on sports participation based on area-level disadvantage; however, living in areas of greatest relative disadvantage is associated with reduced likelihood of participating in organised physical activity at a fitness club or walking (Figure 7c).

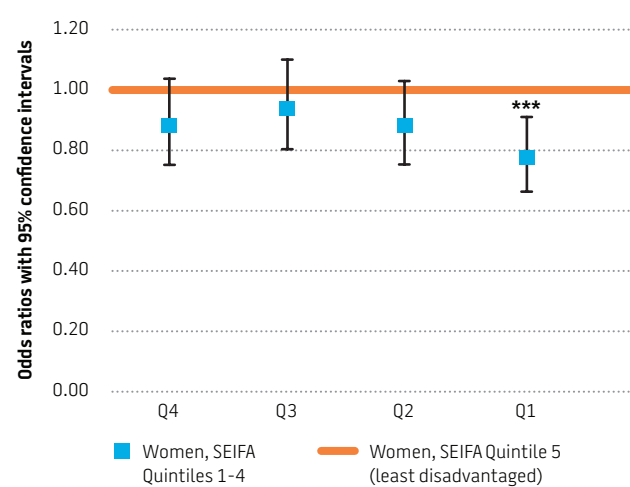
**Figure 6a Odds of being physically active: for females compared to males**



**Figure 6b Odds of being physically active: among males, by level of disadvantage**



**Figure 6c Odds of being physically active: among females, by level of disadvantage**

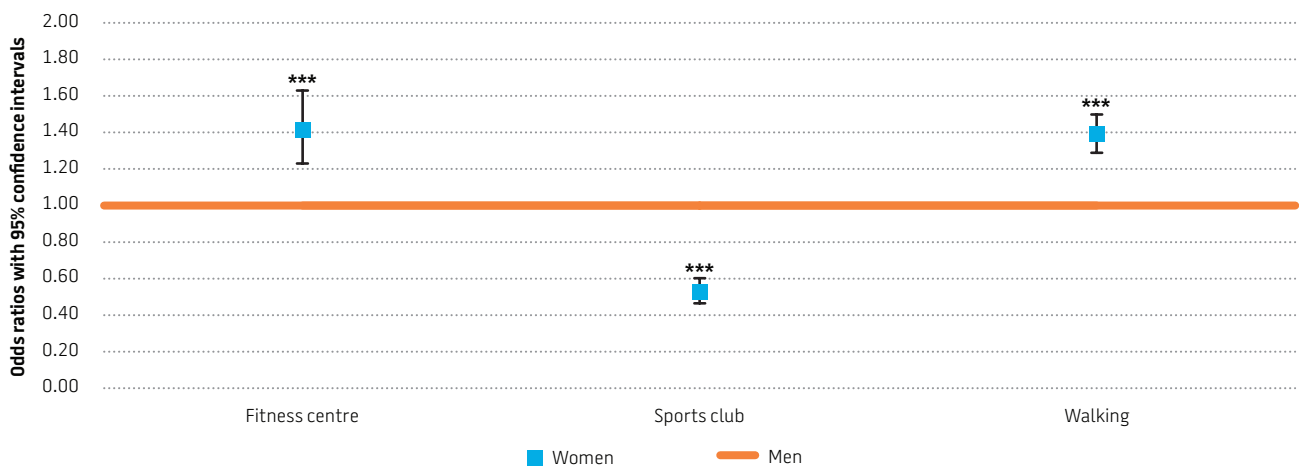


Odds ratios above one (data points above the orange line) indicate a higher likelihood in the comparison group (blue, indicated in the legend) than the reference group (orange, indicated in the legend); odds ratios below one (data points below the orange line) indicate a lower likelihood than the reference group.

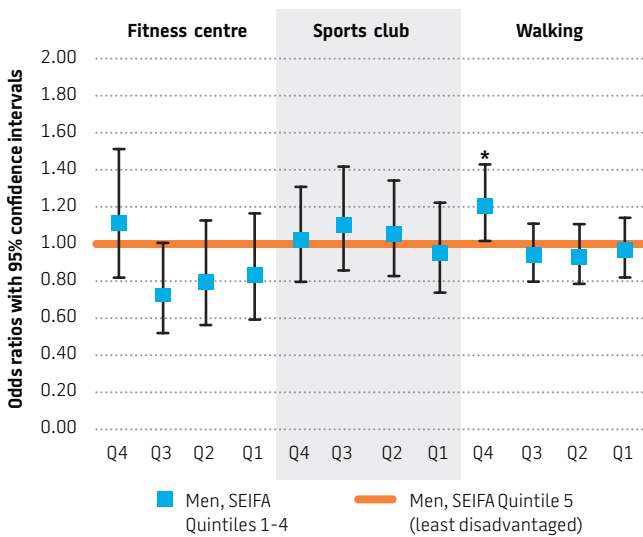
Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance: \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

All models are adjusted for the effects of age. Model a) is also adjusted for SEIFA.

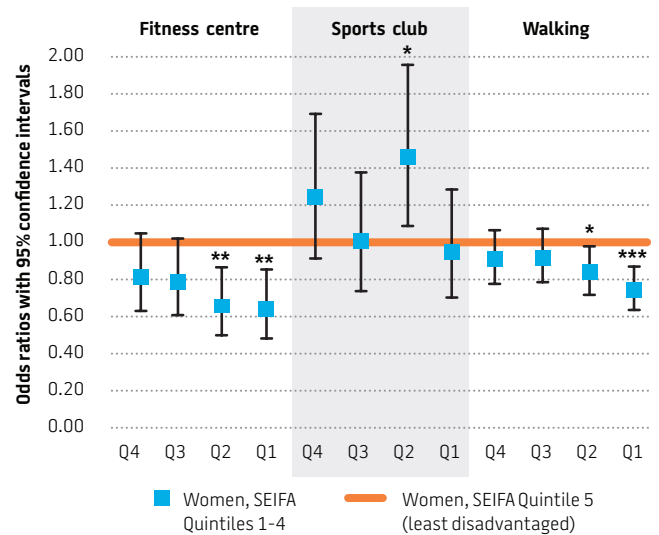
**Figure 7a Odds of participating in selected types of physical activity: for females compared to males**



**Figure 7b Odds of participating in selected types of physical activity: among males, by level of disadvantage**



**Figure 7c Odds of participating in selected types of physical activity: among females, by level of disadvantage**



Odds ratios above one (data points above the orange line) indicate a higher likelihood in the comparison group (blue, indicated in the legend) than the reference group (orange, indicated in the legend); odds ratios below one (data points below the orange line) indicate a lower likelihood than the reference group.

Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance: \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

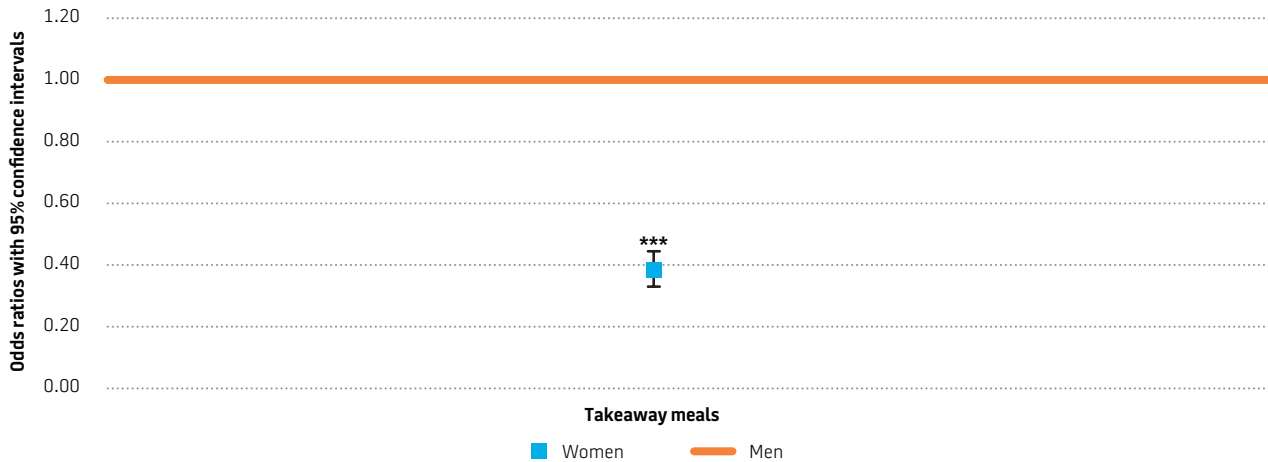
All models are adjusted for the effects of age. Model a) is also adjusted for SEIFA.

## Takeaway food consumption

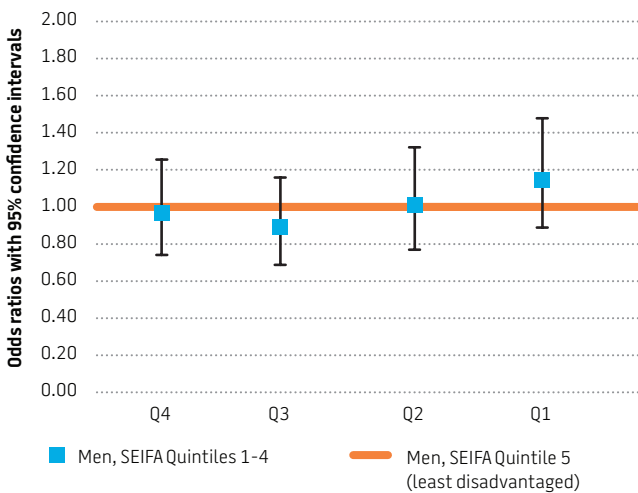
Takeaway food consumption was measured as a proxy indicator for unhealthy, discretionary food intake. The indicator reports on consumption of takeaway meals and snacks at a frequency greater than three times per week, derived from a single graduated frequency item.

Men were about two and a half times more likely than women to report consuming takeaway food three or more times per week (**Figure 8a**). There were no significant associations between area-level disadvantage and regular takeaway consumption for either men or women (**Figure 8b & c**).

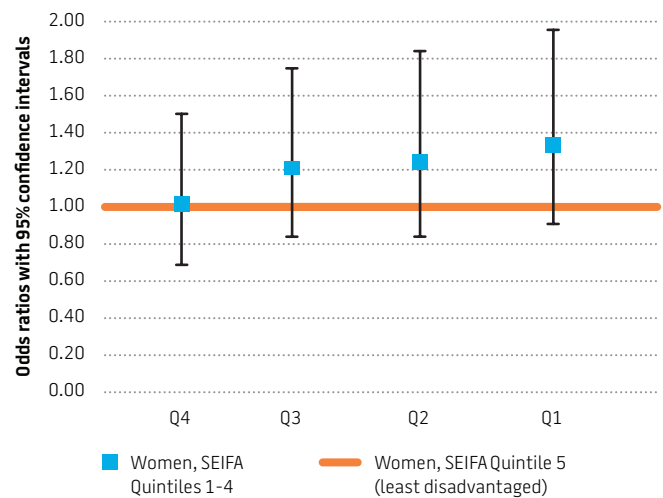
**Figure 8a Odds of regular takeaway food consumption: for females compared to males**



**Figure 8b Odds of regular takeaway food consumption: among males, by level of disadvantage**



**Figure 8c Odds of regular takeaway food consumption: among females, by level of disadvantage**



Odds ratios above one (data points above the orange line) indicate a higher likelihood in the comparison group (blue, indicated in the legend) than the reference group (orange, indicated in the legend); odds ratios below one (data points below the orange line) indicate a lower likelihood than the reference group.

Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance: \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$ . All models are adjusted for the effects of age. Model a) is also adjusted for SEIFA.

# Alcohol

**Alcohol plays a complex role in Australian society. Most Victorian adults who drink alcohol do so for enjoyment, relaxation and socialisation at levels that cause few adverse effects. Men are more likely than women to drink alcohol at levels that put them at risk of short-term harm.**

Harms associated with alcohol use may include the development of chronic health conditions such as cancer or substance use disorder, or short-term harms including injury from accidents, violence or abuse (AIHW 2016a). In the VicHealth Indicators Survey 2015 (VicHealth 2016b), alcohol consumption was measured using a standard assessment of how often (at least once per month) respondents consumed levels of alcohol that put them at risk (five or more standard drinks in a single sitting) or at very high risk (11 or more standard drinks in a single sitting) of short-term alcohol-related harm each month.

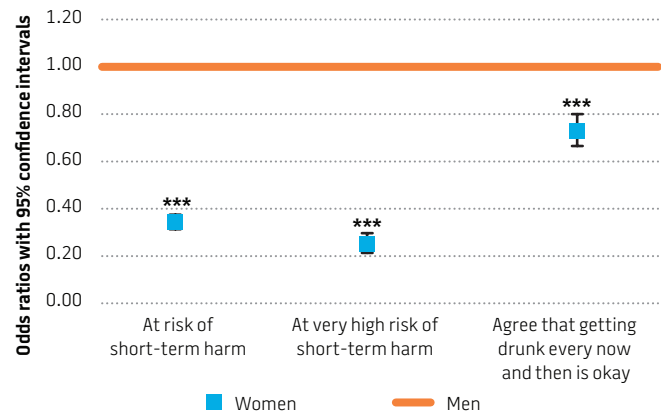
Respondents were also asked a question related to alcohol culture: whether they agree that “getting drunk every now and then is okay”. VicHealth defines ‘alcohol culture’ as the way people drink including the formal rules, social norms, attitudes and beliefs around what is and is not socially acceptable for a group of people before, during and after drinking (VicHealth 2016a).

When adjusted for the effects of age and SEIFA, men were about three times more likely than women to report levels of alcohol consumption that put them at risk (five or more drinks), four times more likely to report levels of alcohol consumption that put them at very high risk (11 or more drinks), and were also more likely to agree with the statement “getting drunk every now and then is okay” (Figure 9a).

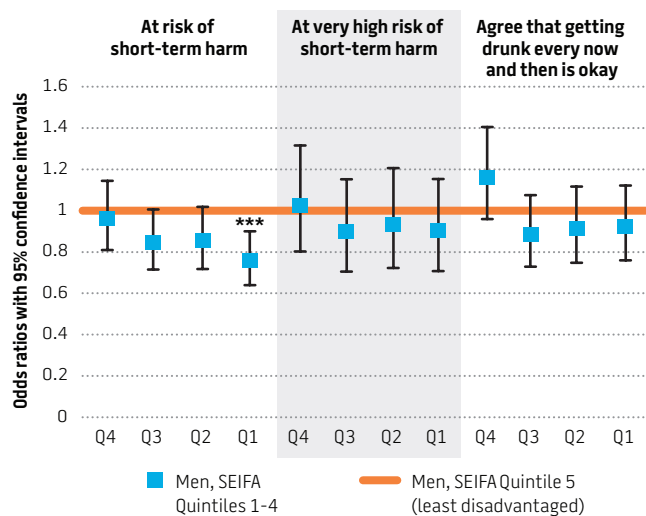
Men who resided in areas of least disadvantage (Quintile 5) were more likely to report drinking at levels that put them at risk of short-term harm (5 or more drinks) than those living in areas of most disadvantage (Quintile 1). However, there was no association between area-level disadvantage and alcohol culture or odds of reporting levels of alcohol consumption that put them at very high risk of short-term harm (11 or more drinks) (Figure 9b).

For women, the association between area-level disadvantage, alcohol culture and alcohol consumption was more pronounced. Women in areas of least disadvantage (Quintile 5) were more likely to engage in alcohol consumption at risky levels (both 5 or more drinks and 11 or more drinks per session) and were more likely to agree that “getting drunk every now and then is okay” compared to those living in areas of greatest disadvantage (Quintile 1) (Figure 9c).

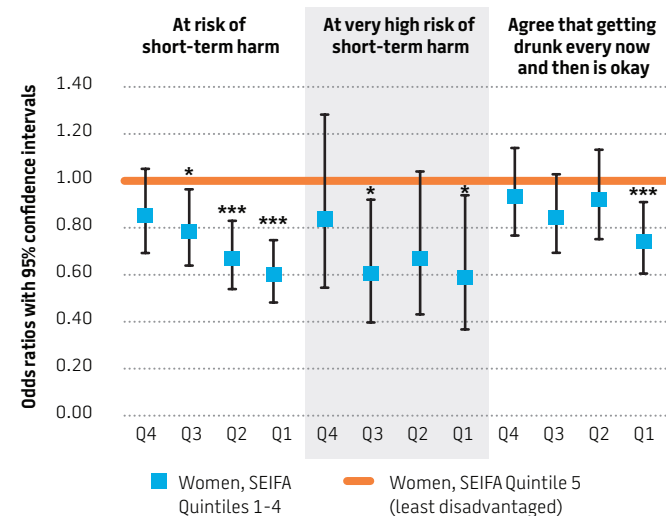
**Figure 9a Odds of being at risk of short-term harm from alcohol each month: for females compared to males**



**Figure 9b Odds of being at risk of short-term harm from alcohol each month: among males, by level of disadvantage**



**Figure 9c Odds of being at risk of short-term harm from alcohol each month: among females, by level of disadvantage**



Odds ratios above one (data points above the orange line) indicate a higher likelihood in the comparison group (blue, indicated in the legend) than the reference group (orange, indicated in the legend); odds ratios below one (data points below the orange line) indicate a lower likelihood than the reference group.

Stars indicate a statistically significant difference, with increasing numbers of stars indicating a stronger statistical significance: \*p<0.05; \*\*p<0.01; \*\*\*p<0.001

All models are adjusted for the effects of age. Model a) is also adjusted for SEIFA.

## Summary and conclusions

The VicHealth Indicators Survey 2015 showed that Victorian women and men were equally satisfied with their overall health. This is consistent with Australian national data (Cummins et al. 2011; Capic et al. 2016). Inequities existed between women and men across all of the other health indicators explored in this report, and many of these were also impacted by level of relative disadvantage. The greatest inequities were observed for feelings of safety walking alone at night and alcohol consumption at very high risk levels.

Victorian women were almost 60 per cent less likely than men to feel safe walking alone during the day and nearly 80 per cent less likely to feel safe walking alone at night than men. Previous research indicates that almost 90 per cent of Australian women have experienced street harassment (Johnson & Bennett 2015), which highlights the importance of work to reduce violence, harassment and sexism in Victoria (Victorian Government 2016). Reducing sexism and harassment, alongside improving gender equality more broadly, has the capacity to improve women's feelings of safety. It can also improve mental health, provide better and more diverse employment opportunities and deliver greater empowerment outside the workplace.

Victorian men were more likely to engage in risky drinking than women, however the intersection of gender and socioeconomic disadvantage plays out differently for women and men with regard to drinking. Area-level disadvantage was not associated with very high risk drinking behaviour or negative alcohol culture for men, however women in areas with lower disadvantage were more likely to drink at risky and very high risk levels than those in areas of greatest disadvantage. Further research examining the intersection between gender and social position and the accessibility (availability and price) and promotion of alcohol is required. It has been reported that differences in exposure to alcohol outlets in Victoria may play a role in explaining socioeconomic disparities in health outcomes, given Victorians living in disadvantaged areas are generally faced with higher levels of alcohol availability (Livingston 2012). It is also important to monitor trends in alcohol consumption and harms as it has previously been proposed that greater equality for women may lead to increased adoption of risky behaviours that have typically been associated with men (Bosque-Prous et al. 2015).

Victorian women were less likely to be physically active than men; a result that is in line with national data (ABS 2016b). Victorian women were more likely than men to participate in physical activity through walking or exercise organised at a fitness centre, whereas they were less likely to participate in organised sports. VicHealth is working with a range of sporting organisations to improve women's participation in sports by raising the profile of women's sport, creating new opportunities for women to participate, and by creating inclusive and welcoming sporting environments (VicHealth 2018).

The level of relative disadvantage where you live plays an important role in health. For both women and men there was a significant additional impact of area-level disadvantage on many of the health indicators explored in this report. Those in areas of greatest disadvantage reported reduced feelings of safety, lower support for gender equality in relationships, lower physical activity levels, and poorer scores across five of the seven wellbeing domains. Interestingly, respondents' satisfaction with personal relationships and feeling part of their community did not display this association, nor did takeaway food consumption. These data indicate that, although women are more satisfied with their level of community connectedness, area-level disadvantage does not play a role in those domains for either men or women. While efforts to improve wellbeing more broadly should focus on those areas with greatest disadvantage, interventions to improve men's social connection and reduce takeaway food consumption should target all men regardless of disadvantage.

Women in areas of greatest disadvantage were less likely to participate in walking or organised activity at a fitness centre than those in areas of least disadvantage, and overall physical activity levels also followed this socioeconomic gradient. There is evidence to suggest that general feelings of safety may help to explain women's participation in physical activity and walking (Timperio et al. 2015). Given that women in areas of greatest disadvantage were also more likely to feel unsafe walking alone than women in areas of least disadvantage, improving feelings of safety among more disadvantaged women, and providing environments more conducive to walking, may help them achieve the recommended levels of physical activity for health and wellbeing.

The findings presented here underscore the importance of applying a gender lens to understanding health inequities. They also highlight the need to consider factors that intersect with gender. Here, we looked particularly at intersections between gender and socioeconomic status; in future research it would also be beneficial to explore additional social influences on health disparities between genders, such as culture or ethnicity, disability and sexual orientation.

Achieving gender equality in health and wellbeing is a complex process that requires sustained action in all layers of influence: the socioeconomic, political and cultural contexts; daily living conditions; and individuals' health-related knowledge, attitudes and behaviours. Action is also required across multiple settings, population groups and methodologies. VicHealth works to improve health and wellbeing by reducing health inequities throughout the community. At the heart of this endeavour is our vision of an equitable Victoria, where all people have the opportunity for a healthy life. [VicHealth's Health Equity Strategy](#) outlines our approach to promoting health equity in Victoria for the years 201–19 (VicHealth 2017b). In recognition of the role of gender equality as a critical determinant of health and wellbeing, VicHealth has also recently released our [Gender equality, health and wellbeing strategy 2017–19](#) which outlines our current and planned actions for 2017–19. (VicHealth 2017a).



## Recommendations

Significant and lasting change to achieve gender equality will require collaboration across government, business, philanthropy, non-profit organisations and citizens. VicHealth recommends applying a number of broad principles to efforts to achieve gender equality: we should target the norms, practices and structures that support gender inequality; we should apply a gender lens and consider intersectionality in all work, particularly in planning and delivery of policy, programs and services; and we should use both whole-of-population and targeted approaches.

The following are recommendations arising from the findings of this report<sup>2</sup>:

### Improve women's feelings of safety in the community

- Reduce the occurrence and acceptability of street harassment, for example by addressing the factors that influence whether or not people act to identify, speak out or engage others in responding to incidents of sexism, discrimination or violence against women (also known as 'bystander behaviour').

### Improve men's wellbeing and satisfaction with life

- Raise awareness of social connection as a protective factor against depression and anxiety, and help create more opportunities for men to connect with one another without potential harms to their health (e.g. social events that do not involve drinking to risky levels).
- Focus efforts to improve men's wellbeing and satisfaction with life more broadly on men from areas of greatest disadvantage. However, interventions to improve men's social connections should target all men, regardless of disadvantage.

### Reduce men's risky drinking

- Continue to advocate for policy and legislative interventions that reach the whole population. The impact of such interventions is significant, and efforts to improve national and state alcohol regulation should continue to be a priority.
- Continue efforts to shift alcohol cultures among men to those that support low-risk drinking, targeting groups most at risk, with a focus on the social and environmental factors that shape their drinking cultures.
- Continue to build the evidence base in relation to gender, alcohol consumption and alcohol cultures:
  - Further research the intersection between gender and social position and the availability, affordability and promotion of alcohol.
  - Continue to monitor trends in alcohol consumption and harms, as it has previously been proposed that greater gender equality may lead to increased adoption of risky behaviours by women.

### Reduce men's junk food intake

- Create food environments that make it easier for Victorians to choose healthy food and drinks, particularly in convenience food outlets including canteens, kiosks, cafes, food courts, restaurants and takeaway food vendors. This could include approaches to influence choices by altering the display, price and promotion of food and drinks to reduce consumption of unhealthy choices.
- Improve men's knowledge and skills to enable preparation of quick, healthy meals as an alternative to relying on convenience foods.

### Increase women's participation in physical activity

- Address barriers to women's participation in physical activity, such as their concerns about being judged by others for their appearance and skill levels while being active.
- Ensure sports clubs and facilities are safe, welcoming and inclusive environments for women.
- Focus on social aspects of physical activity and sport (which women place more importance on than men) when promoting physical activity opportunities for women, and when creating new opportunities.
- Address the current under-representation of women in leadership and decision-making roles within sporting organisations.
- Raise the profile of women's sport by increasing media coverage of women's sport, which is significantly less than that of men's sport at all levels (i.e. national, state and local).

### Continue to build the evidence base on gender and health to help governments, organisations and communities plan and deliver effective health promotion activity that benefits all Victorians, regardless of gender.

- Government and research bodies should continue to work to:
  - identify the best way to ask questions about gender in self-report surveys, particularly for gender diverse, non-binary, trans and intersex respondents. This will allow respondents' needs to be recognised, data integrity to be improved and findings to better reflect the diversity of Victorians' gender identities.
  - explore the relationship between gender and other intersectionalities, such as education levels, income, occupation type, ethnicity, ability, sexuality, religion, Aboriginality, age and place of residence.

## Glossary

**Alcohol culture:** The way people drink, including the formal rules, social norms, attitudes and beliefs around what is and is not socially acceptable for a group of people before, during and after drinking

<sup>2</sup> Recommendations for action are based on a range of previous VicHealth work. Visit [our website](#) for information about [preventing violence against women](#), [improving wellbeing](#), [preventing harm from alcohol](#), [making healthy food choices the easy choice](#), and [increasing women's participation in physical activity](#).

**Beta coefficient:** A beta coefficient is a relative measure of effect, which allows you to compare the strength and direction of membership of the comparison group (for example women) to your reference group (for example men) with the variable of interest. If the beta coefficient is zero, there is no difference between the two groups. Beta coefficients above zero indicate that being in the comparison group has a positive effect on the variable, beta coefficients below zero indicate that being in the comparison group has a negative effect on the variable.

**Confidence intervals:** Confidence intervals allow gauging the reliability of an estimate. Confidence intervals of 95 per cent have been calculated for each indicator estimate in this report. 95 per cent confidence intervals are best interpreted by saying that if we were to sample from the same population 100 times, we'd expect the population estimate to fall within the interval 95 times.

**Discretionary foods:** Food and drinks that are high in energy (kilojoules), saturated and/or trans fats, added sugar and/or salt and are low in essential nutrients.

**Gender:** The socially constructed differences between women and men, as distinct from 'sex', which refers to their biological differences. Gender includes the norms, roles and relationships that exist between women and men.

**Gender diverse, non-binary and trans:** Gender diverse and non-binary refers to people who do not identify as a woman or a man (see 'gender identity' below). Some people may identify as agender (having no gender), bigender (both a woman and a man) or non-binary (neither a woman nor a man). Transgender (often shortened to 'trans') refers to a person whose gender identity, gender expression or behaviour does not align with their sex assigned at birth. Cisgender refers to a person whose gender identity is in line with the social expectations of their sex assigned at birth.

**Gender equality:** Gender equality refers to the equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law.

**Health equity:** The notion that everyone should have a fair opportunity to attain their full health potential, and that no one should be disadvantaged from achieving this potential if it can be avoided.

**Intersectionality:** People's experiences are shaped by the intersection of a number of social conditions, such as gender, ethnicity, ability, sexuality, gender identity, religion, Aboriginality, age, education, occupation type, income and place of residence. Each of these factors, or identity attributes, influences and has an impact on our lives and our experiences. Social structures and systems, and the way they intersect, play a large role in creating social conditions that result in power and privilege or discrimination and oppression, thus shaping the ways in which people experience inequality, disadvantage and violence.

**Intersex:** A term that refers to people who are born with genetic, hormonal or physical sex characteristics that are not typically 'male' or 'female'. Intersex people have a diversity of bodies and identities.

**Odds ratio:** An odds ratio is a relative measure of effect, which allows you to compare the likelihood of a particular variable for your comparison group (for example women) to your reference group (for example men). If the odds ratio is one, there is no

difference between the two groups. Odds ratios above one indicate increased odds in your comparison group and odds ratios below one indicate reduced odds in your comparison group.

**P value:** When you perform a hypothesis test in statistics, a P value helps you determine the probability that a difference in results between different groups is statistically significant. The P value is a number between 0 and 1, with high P values (in this case greater than 0.05) indicating that there is no statistically significant difference between the groups you are comparing, and P values equal to or less than 0.05 indicating that there is a statistically significant difference between the groups you are comparing. The smaller the P value, the more confident you can be that the results are true.

**Statistical significance:** Statistical significance is an indication of the likelihood that a difference between figures is not due to chance. Statistically significant differences between groups were deemed to exist for the purposes of this report when the P value was below 0.05.

**SEIFA:** This report uses the Index of Relative Socio-Economic Disadvantage (IRSD), one of the indices in the Australian Bureau of Statistics' Socio-Economic Index for Areas (SEIFA). It is a general socioeconomic index that summarises a wide range of information about the economic and social resources of people and households within an area. A high score reflects a relative lack of disadvantage. For the purposes of this report, SEIFA has been divided into five quintiles, where Quintile 1 is the most disadvantaged and Quintile 5 is the least disadvantaged.

## References

- ABS 2016a, *ABS Gender Indicators (4125.0) August 2016*, Australian Bureau of Statistics, Canberra.
- ABS 2016b, *National Health Survey: First Results, 2014–15 (4364.0.55.001)*, Australian Bureau of Statistics, Canberra.
- ABS 2017, *4906.0 - Personal Safety, Australia, 2016* Australian Bureau of Statistics, Canberra.
- AIHW 2016a, *Australia's health 2016. Australia's health series no. 15. Cat. no. AUS199*, Australian Institute of Health and Welfare (AIHW), Canberra.
- AIHW 2016b, *Australian burden of disease study: Impact and causes of illness and death in Australia 2011*, AIHW, Canberra.
- Baum, F, Ziersch, A, G, Z & Osborne, K 2009, 'Do perceived neighbourhood cohesion and safety contribute to neighbourhood differences in health?', *Health & Place*, vol. 15, no. 4, pp. 925-34.
- Bosque-Prous, M, Espelt, A, Borrell, C, Bartroli, M, Guitart, A, Villalbí, J & Brugal, M 2015, 'Gender differences in hazardous drinking among middle-aged in Europe: the role of social context and women's empowerment', *European Journal of Public Health*, vol. 25, no. 4, pp. 698-705.
- Capic, T, Cummins, R, Silins, E, Richardson, B, Fuller-Tyszkiewicz, M, Hartley-Clark, L & Hutchinson, D 2016, *Australian Unity Wellbeing Index Survey 33.0*, The School of Psychology, Deakin University; The Australian Centre on Quality of Life, Deakin University; and Australian Unity, Melbourne.
- Cummins, R, Eckersley, R, Pallant, J, Van Vugt, J & Misajon, R 2003, 'Developing a national index of subjective wellbeing: The Australian Unity Wellbeing Index', *Social Indicators Research*, vol. 64, no. 2, pp. 159-90.
- Cummins, R, Woerner, J, Hartley-Clark, L, Perera, C, Gibson-Prosser, A, Collard, J & Horfiniak, K 2011, *Australian Unity Wellbeing Index Survey 25.0*, The School of Psychology, Deakin University; The Australian Centre on Quality of Life, Deakin University; and Australian Unity, Melbourne.

Department of Premier and Cabinet 2016, *Victorian Gender Equality Strategy: Discussion Paper*, State of Victoria, Melbourne.

Dodge, R, Daly, A, Huyton, J & Sanders, L 2012, 'The challenge of defining wellbeing', *International Journal of Wellbeing*, vol. 2, no. 3, pp. 222-35.

Ghosh, A, Charlton, K & Batterham, M 2016, 'Socioeconomic disadvantage and its implications for population health planning of obesity and overweight, using cross-sectional data from general practices from a regional catchment in Australia', *BMJ Open*, vol. 6, p. e010405.

GIWPS and PRIO 2017, *Women, Peace and Security Index 2017/18: Tracking Sustainable Peace through Inclusion, Justice, and Security for Women*, Georgetown Institute for Women, Peace and Security (GIWPS) and Peace Research Institute Oslo (PRIO), Washington, DC.

Harris, A, Honey, N, Webster, K, Diemer, K & Politoff, V 2015, *Young Australians' attitudes to violence against women: Findings from the 2013 National Community Attitudes Towards Violence Against Women Survey for respondents 16-24 years*, VicHealth, Melbourne.

Johnson, M & Bennett, E 2015, *Everyday sexism: Australian women's experiences of street harassment*, The Australia Insitute, Canberra.

Laslett, A, Room, R, Ferris, J, Wilkinson, C, Livingston, M & Mugavin, J 2011, 'Surveying the range and magnitude of alcohol's harm to others in Australia', *Addiction*, vol. 106, no. 11, pp. 1603-11.

Livingston, M 2012, 'The social gradient of alcohol availability in Victoria, Australia', *Australian and New Zealand Journal of Public Health*, vol. 36, no. 1, pp. 41-7.

Mahalik, J, Burns, S & Syzdek, M 2007, 'Masculinity and perceived normative health behaviors as predictors of men's health behaviors', *Social Science & Medicine*, vol. 64, no. 11, pp. 2201-9.

Milton, K, Clemse, S & Bull, F 2013, 'Can a single question provide an accurate measure of physical activity?', *British Journal of Sports Medicine*, vol. 47, no. 1, pp. 44-8.

NHMRC 2013, *Australian Dietary Guidelines*, National Health and Medical Research Council, 2013, <http://www.nhmrc.gov.au/guidelines/publications/n55>.

OurWatch, ANROWS & VicHealth 2015, 'Change the story: A shared framework for the primary prevention of violence against women and their children in Australia', [http://www.ourwatch.org.au/What-We-Do-\(1\)/National-Primary-Prevention-Framework](http://www.ourwatch.org.au/What-We-Do-(1)/National-Primary-Prevention-Framework).

Rehm, J, Baiunas, D, Borges, G, Graham, K, Irving, H, Kehoe, T, Parry, C, Patra, J, Popova, S, Poznyak, V, Roerecke, M, Room, R, Samokhvalov, A & Taylor, B 2010, 'The relation between different dimensions of alcohol consumption and burden of disease: An overview', *Addiction*, vol. 105, no. 5, pp. 817-43.

Schmidt, L, Makela, P, Rehm, J & Room, R 2010, *Alcohol: equity and social determinants*, World Health Organization, Geneva.

Timperio, A, Veitch, J & Carver, A 2015, 'Safety in numbers: Does perceived safety mediate associations between the neighborhood social environment and physical activity among women living in disadvantaged neighborhoods?', *Preventive Medicine*, vol. 74, pp. 49-54.

VicHealth 2015, *Fair Foundations: The VicHealth framework for health equity*, Victorian Health Promotion Foundation, Melbourne.

VicHealth 2016a, *Alcohol Cultures Framework background paper. A framework to guide public health action on drinking cultures*, Victorian Health Promotion Foundation, Melbourne.

VicHealth 2016b, *VicHealth Indicators Survey 2015 Selected Findings*, Victorian Health Promotion Foundation, Melbourne.

VicHealth 2017a, *Gender equality, health and wellbeing strategy 2017-19*, Victorian Health Promotion Foundation, Melbourne.

VicHealth 2017b, *VicHealth Health Equity Strategy 2017-19*, Victorian Health Promotion Foundation, Melbourne.

VicHealth 2018, *VicHealth Physical Activity Strategy, 2018 to 2023*, Victorian Health Promotion Foundation, Melbourne.

Victorian Government 2016, *Safe and strong: A Victorian gender equality strategy*, State of Victoria, Melbourne.

Western, M & Tomaszewski, W 2016, 'Subjective Wellbeing, Objective Wellbeing and Inequality in Australia', *PLoS ONE*, vol. 11, no. 10, p. e0163345.

WHO 2015, *Gender, Fact Sheet No. 403*, World Health Organization, Geneva.

Wilhelm, K, Parker, G, Geerligs, L & Wedgwood, L 2008, 'Women and Depression: A 30 Year Learning Curve', *Australian & New Zealand Journal of Psychiatry*, vol. 42, no. 1, pp. 3-12.

Wong, Y, Ho, M, Wang, S & Miller, I 2017, 'Meta-analyses of the relationship between conformity to masculine norms and mental health-related outcomes', *Journal of Counseling Psychology*, vol. 64, no. 1, pp. 80-93.

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