Growing Up Unequal

How sex & gender impact young women's health & wellbeing

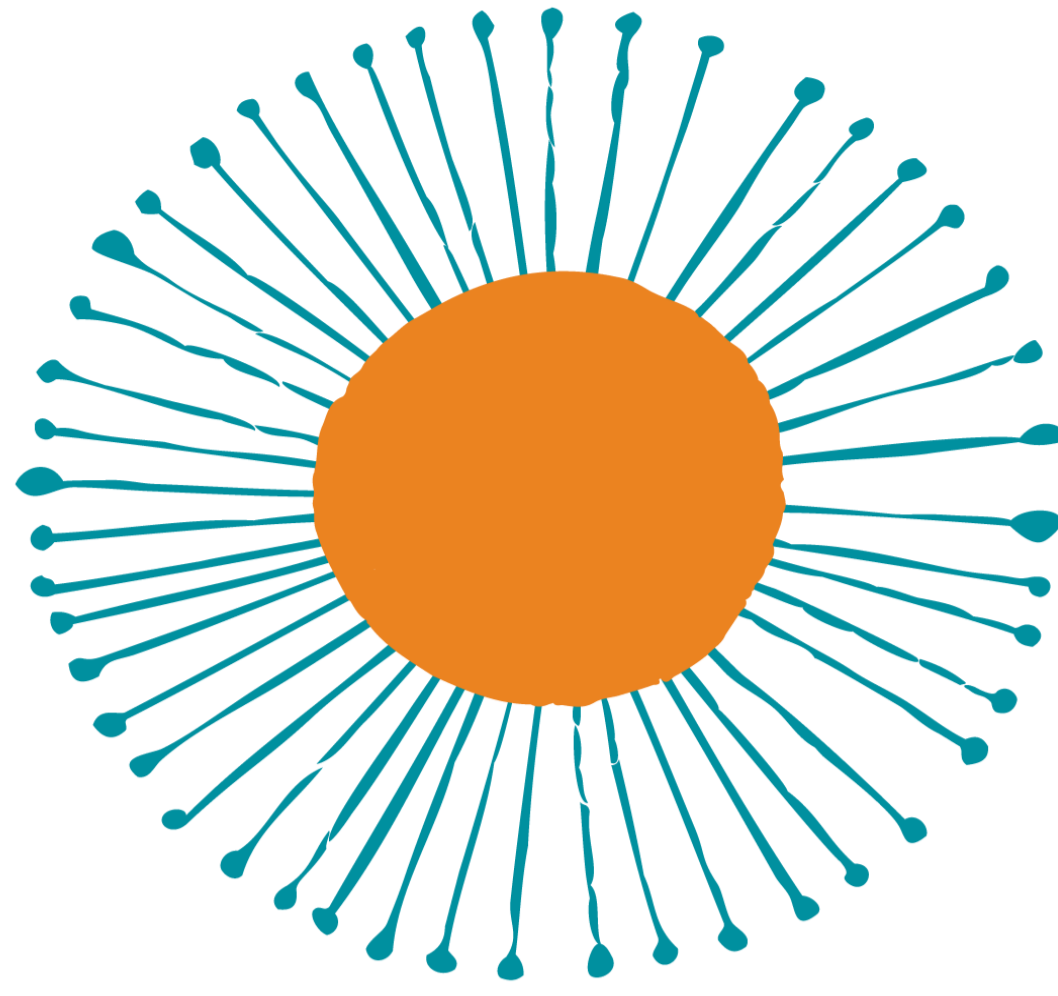**Women's Health**
VICTORIA

ABOUT WOMEN'S HEALTH VICTORIA

WHV is a statewide women's health promotion, information and advocacy service. We work collaboratively with women, health professionals, policy makers and community organisations to influence systems, policies and services to be more gender equitable to support better outcomes for women.

As a statewide body, WHV works with the nine regional and two other statewide services that make up the Women's Health Association of Victoria (WHAV).[1] The women's health services network offers a unique approach to women's health across the state by providing an infrastructure which focuses solely on gender equality, health promotion and improving women's health outcomes.

[1] The three statewide services are Women's Health Victoria, the Multicultural Centre for Women's Health and *Women with Disabilities Victoria*. The nine regional services are Women's Health and Wellbeing Barwon South West, Women's Health Grampians, Women's Health Loddon Mallee, Women's Health Goulburn North East, Gippsland Women's Health Service, Women's Health West, Women's Health in the North, Women's Health East and Women's Health in the South East.
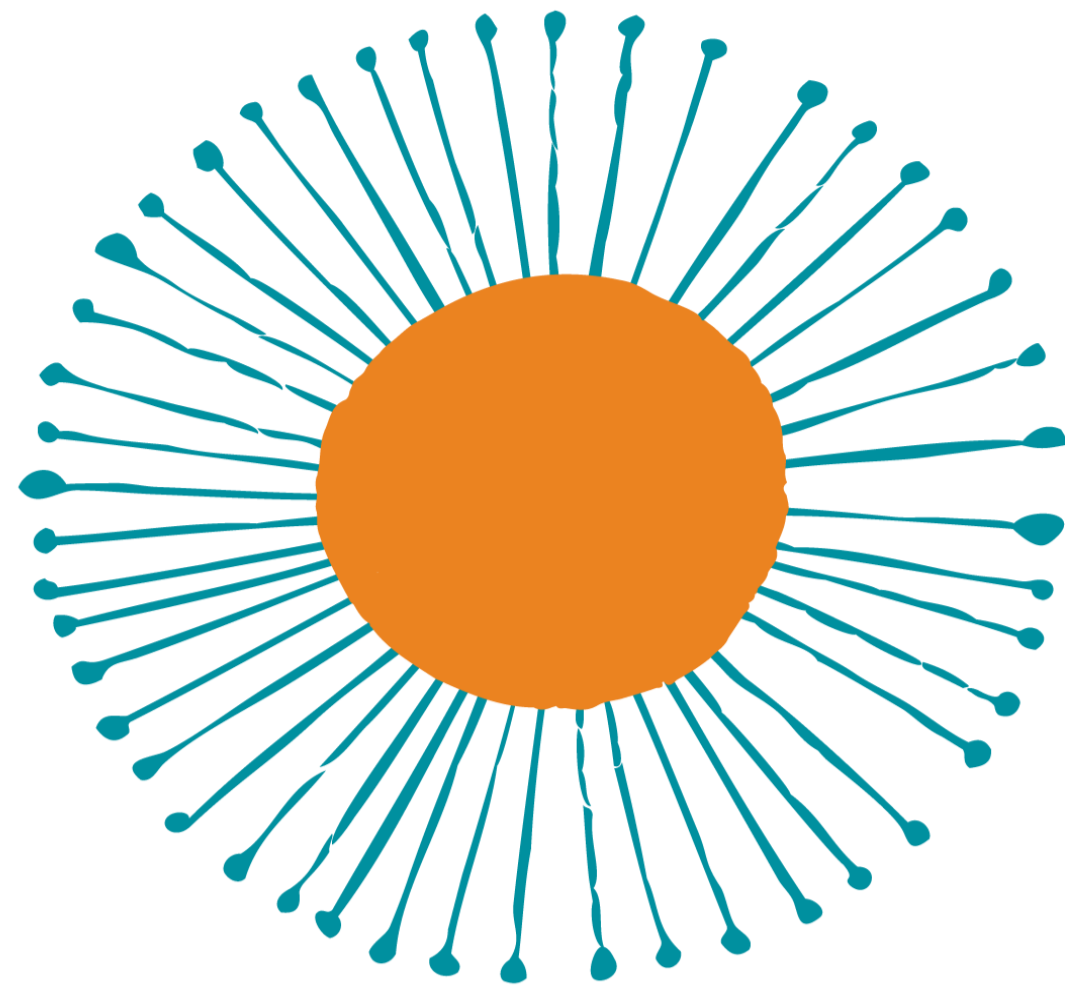
CONTENTS

EXECUTIVE SUMMARY

Girls and boys are subjected to different expectations and pressures during adolescence and between the ages of 10 and 20, young women's experiences and health outcomes can differ significantly from those of their male peers.

For example, nationally in 2016, the top three issues of concern identified by young people themselves were coping with stress, school or study problems, and body image. The proportion of females concerned about each of these issues was much higher than the proportion of males [2].

'Stress' and 'school or study problems' are very broad categories. By taking a closer look at the stressors affecting young women, we can gain a more nuanced understanding of the factors impacting young women's health and wellbeing.

The aim of this paper is to look at young women's health and wellbeing between the ages of 10 and 20 from a multidimensional, holistic, intersectional perspective. The following questions have guided our work:

- On leaving their teens, how are young women positioned in terms of a healthy and happy adulthood, compared with young men?

- What types of interventions show promise in helping girls to leave adolescence on an equal footing with boys in terms of self-confidence, mental health and physical wellbeing?

We explore these questions by examining young women's experience of six interrelated priority health areas: physical health, sexual and reproductive health, body image, relationships, mental health and social inclusion.

PHYSICAL HEALTH

The onset of puberty can change the way young women feel about their bodies and abilities, as well as how they are treated by others, impacting their health and wellbeing. More boys than girls report that their parents let them walk or ride to places, or visit local parks on their own [3]. Young women report feeling concern about the presence of males when exercising and worry about being judged, humiliated and harassed.[4]

SEXUAL AND REPRODUCTIVE HEALTH

Boys and girls experience significant physical changes during puberty. However, for biological (sex) and well as social (gender) reasons, women and girls carry the burden of responsibility in relation to sexual and reproductive health. Girls and women are often provided with minimal information and support for relatively common reproductive health conditions such as polycystic ovarian syndrome (PCOS) [5] and endometriosis. 70% of Australian women with PCOS remain undiagnosed, and there is a lack of consistency in assessment and management of the condition [6].

BODY IMAGE

More than half of Australian girls report that they are most often valued for their looks, rather than their brains and ability [7]. Among Australian women, body dissatisfaction mainly manifests in concerns about weight, even in those who are underweight or a healthy weight [8]. Body dissatisfaction often emerges during childhood and peaks in adolescence when young women are 'acutely attuned' to their body weight and shape [9]. Concerns and pressure about body image can also relate to a young person's gender identity – for example, hostility towards young women who express their physical image in ways which are seen as masculine or gender non-conforming.

RELATIONSHIPS

Research paints a complicated picture of young women's experiences of intimate relationships. Although young people are more supportive of equality in some areas (for example, they support women's equal right to education), they are also more likely to endorse men dominating decision-making in relationships [10] and are less likely to understand that violence against women can include more than physical violence and forced sex.[11] Research specific to the experiences of same-sex attracted youth and young people with disabilities in intimate relationships warrants more attention.

MENTAL HEALTH

Girls and boys have comparable levels of mental health and self-confidence before puberty [12]. However, during adolescence, young women's mental health outcomes worsen compared with young men's [13]. Evidence strongly indicates that this discrepancy is driven by sex and gender-based expectations and experiences. Young women are more than twice as likely to self-harm than young men [14], with studies suggesting that nearly 1 in 3 girls aged 16-17 reported having self-harmed [15]. A lack of understanding by health professionals and parents, and feelings of shame and guilt, can be barriers to seeking help [16].

SOCIAL INCLUSION

Young women still face barriers to social inclusion and are often excluded or discouraged from participating in many spheres of life because of their gender.

- Australian girls report perceiving Australia as a gender unequal place, with 56% reporting being seldom or never valued for their intellect or opinions over their looks [17].

- Young women's movement in public spaces and participation outside the home is restricted by fear of harassment and violence [18].

- At home, adolescent girls spend more time on household chores than their brothers, and yet receive less pocket money [19].

Young women with disabilities are subjected to dual discrimination and stereotyping on the basis of gender and disability, adversely affecting self-esteem and expectations [20]. Young Aboriginal* women are impacted by compounding experiences of gender inequality, racism and trauma [21].

* This paper uses the term 'Aboriginal' to refer to Aboriginal and Torres Strait Islander people as this is the term generally preferred by Aboriginal people in Victoria. In other parts of Australia the term 'Indigenous' may be preferred.

FINDINGS

Young women in Australia are reporting high levels of stress, and this is not surprising when we consider that they are doing more housework and homework than their brothers, feel less comfortable and safe in their neighbourhoods, and are valued less for their brain and abilities than for their looks.

Overall, the paper has found that:

- **Improving gender equality would lead to improved health outcomes and experiences for young women.** Gender unequal norms, practices and structures continue to limit young women's equal and full participation in many aspects of life.

- **An intersectional approach is required to understand and respond to the experiences of young women.** Some young women experience relative privilege while others experience relative disadvantage. Gender inequality is not the only system of oppression contributing to unfair or uneven health outcomes for young women.

- **Challenging sexualisation and objectification of women and girls at the societal level** has the potential to improve young women's body image, increase their physical activity, and improve their mental and emotional wellbeing, sexual experiences and relationships.

- **Health professionals, parents and schools all have a role to play** in challenging and changing the gender norms and expectations that limit and disadvantage young women.

Our findings show that there are many opportunities to improve health and wellbeing outcomes for young women. It is our hope that this paper can be used as a starting point for developing resources and initiatives that recognise the impact of gender on young women's health and wellbeing, and take a more holistic approach to meeting young women's needs.
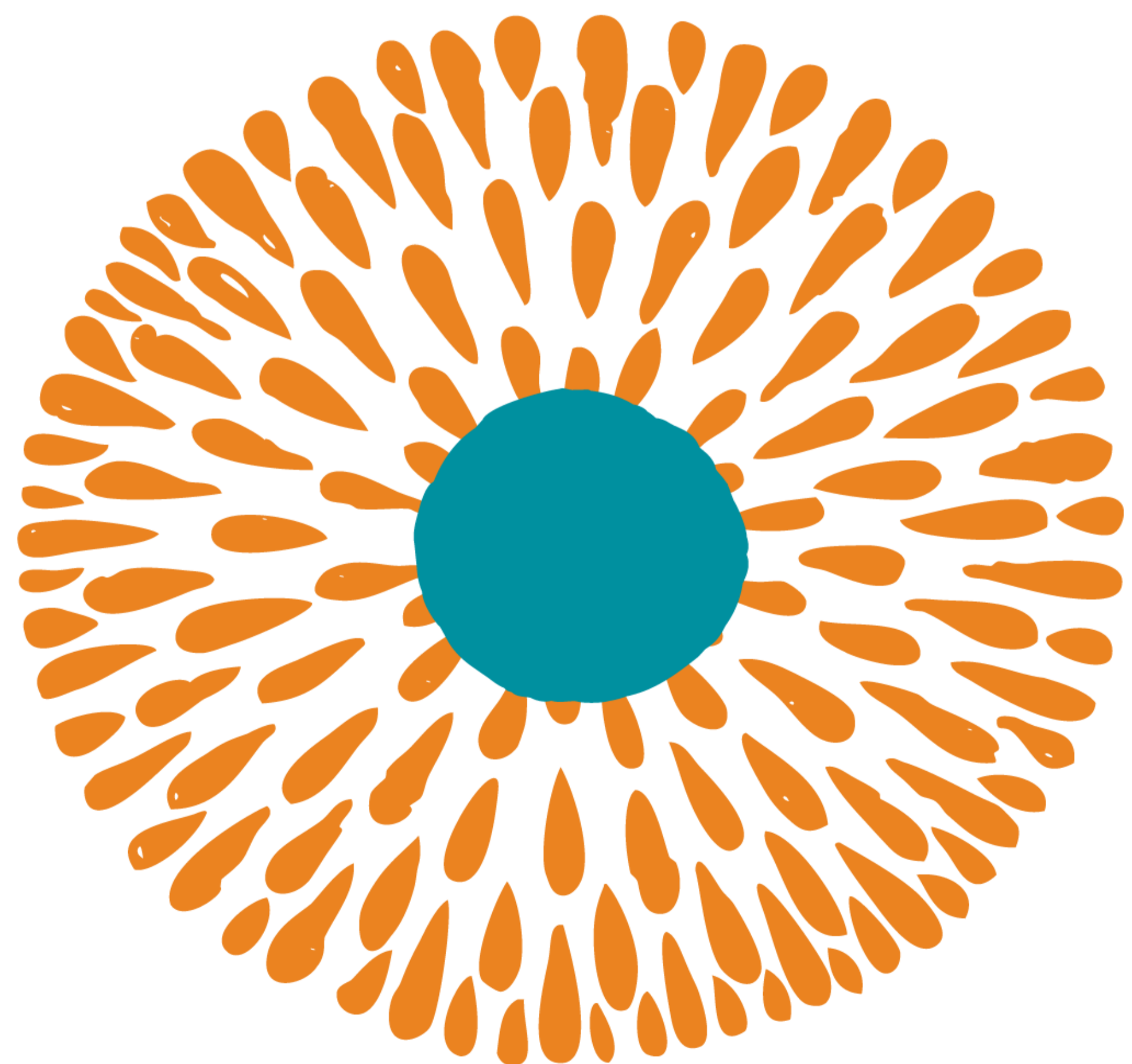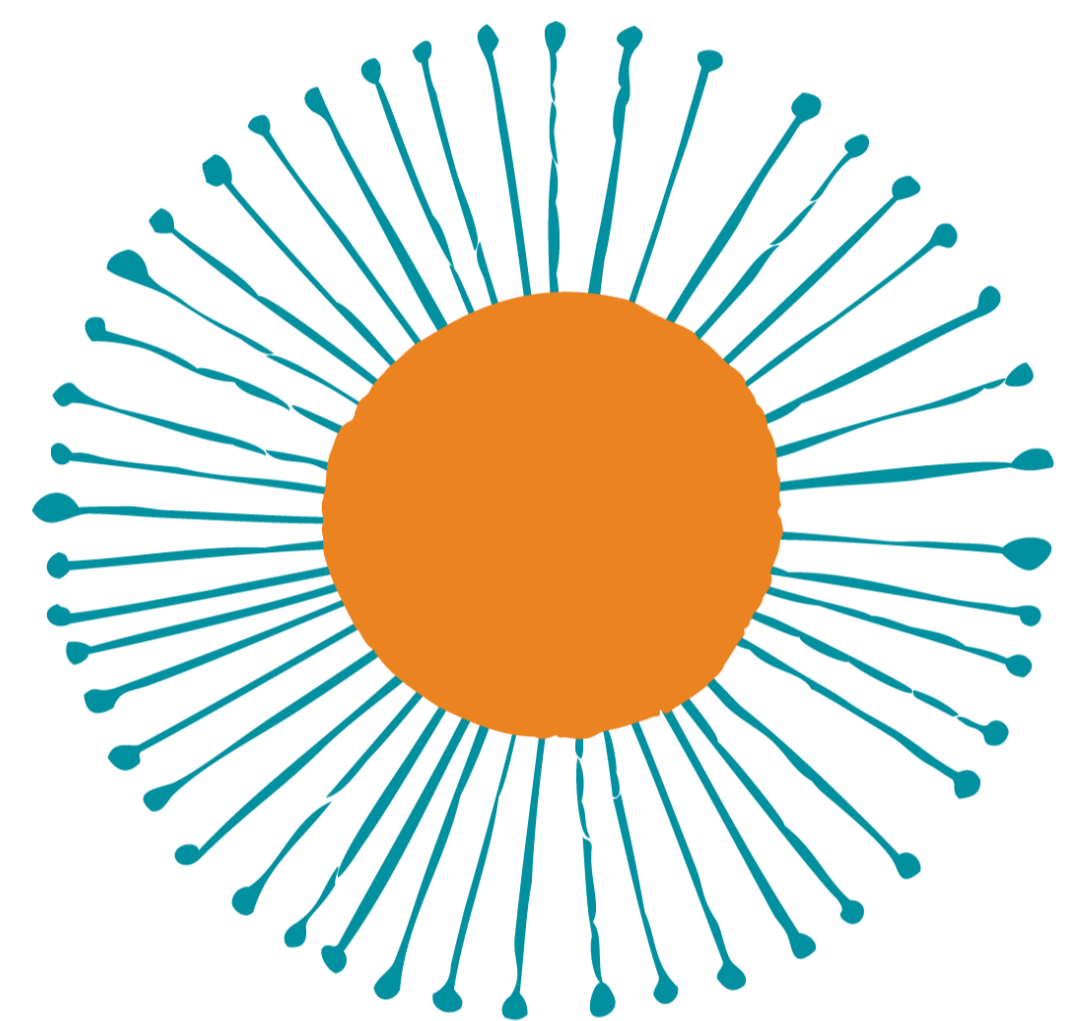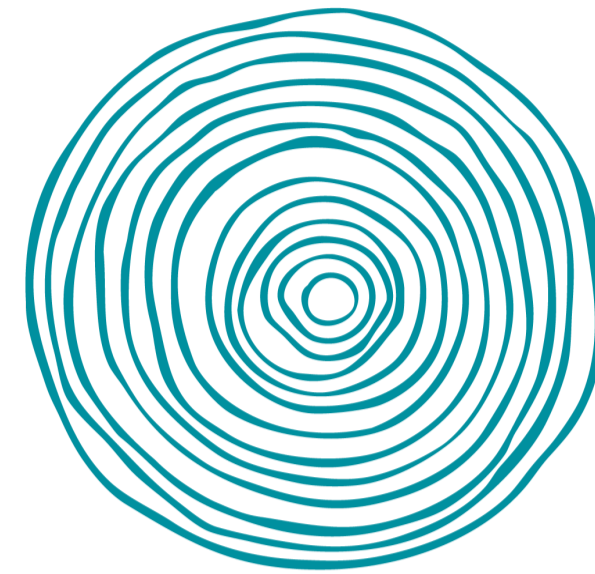
WOMEN'S HEALTH VICTORIA RECOMMENDS:

1   Enhancing young women's health literacy by providing high quality, accessible and engaging health resources and education

2   Actively engaging young women in the design and delivery of initiatives aimed at or affecting them

3   Tackling the sexualisation and objectification of girls and women and promoting positive body image

4   Taking a gender-sensitive approach to research, services and interventions in order to better meet the needs of young women

5   Ensuring that work with young women takes an intersectional approach and is responsive to the other factors that impact young women's lives beyond sex and gender

6   Aiming for gender transformative approaches to working with young people, including working with young men and boys to foster alternative and more positive forms of masculinity

7   Supporting and resourcing parents, teachers, schools, and community organisations to better understand and be responsive to the many specific challenges young women face during adolescence, due to the intersection of sex and gender
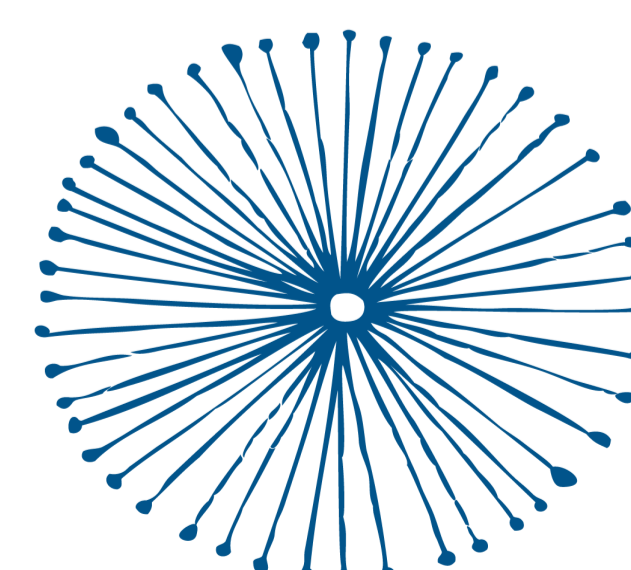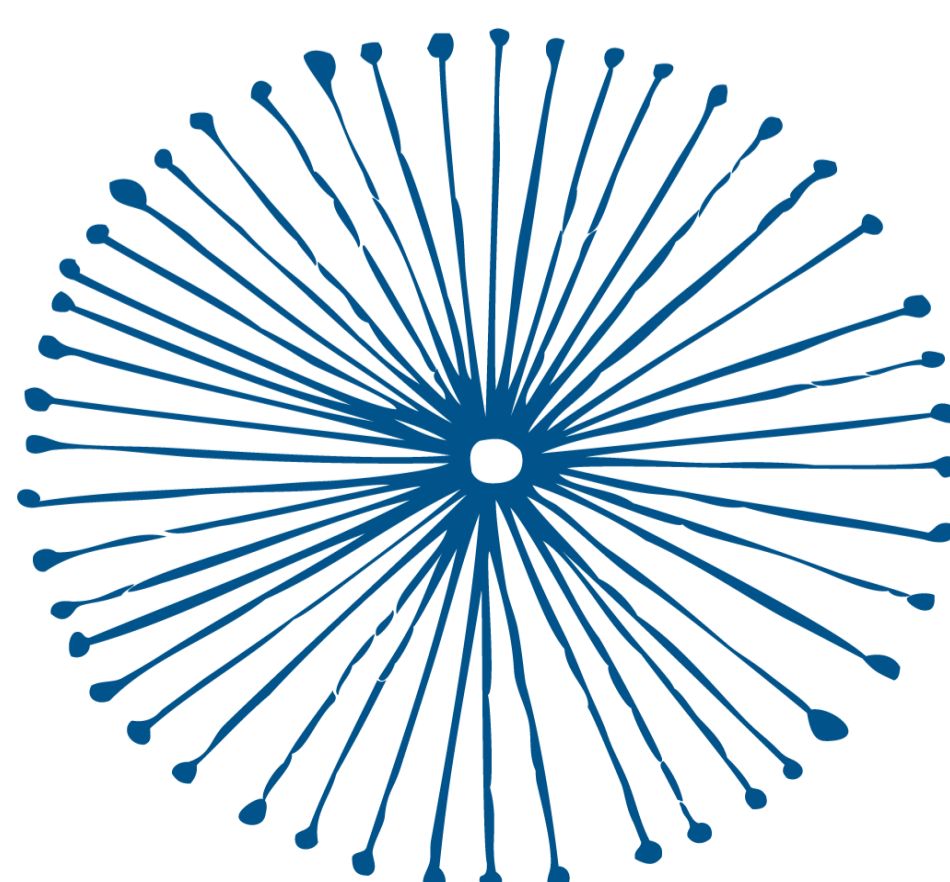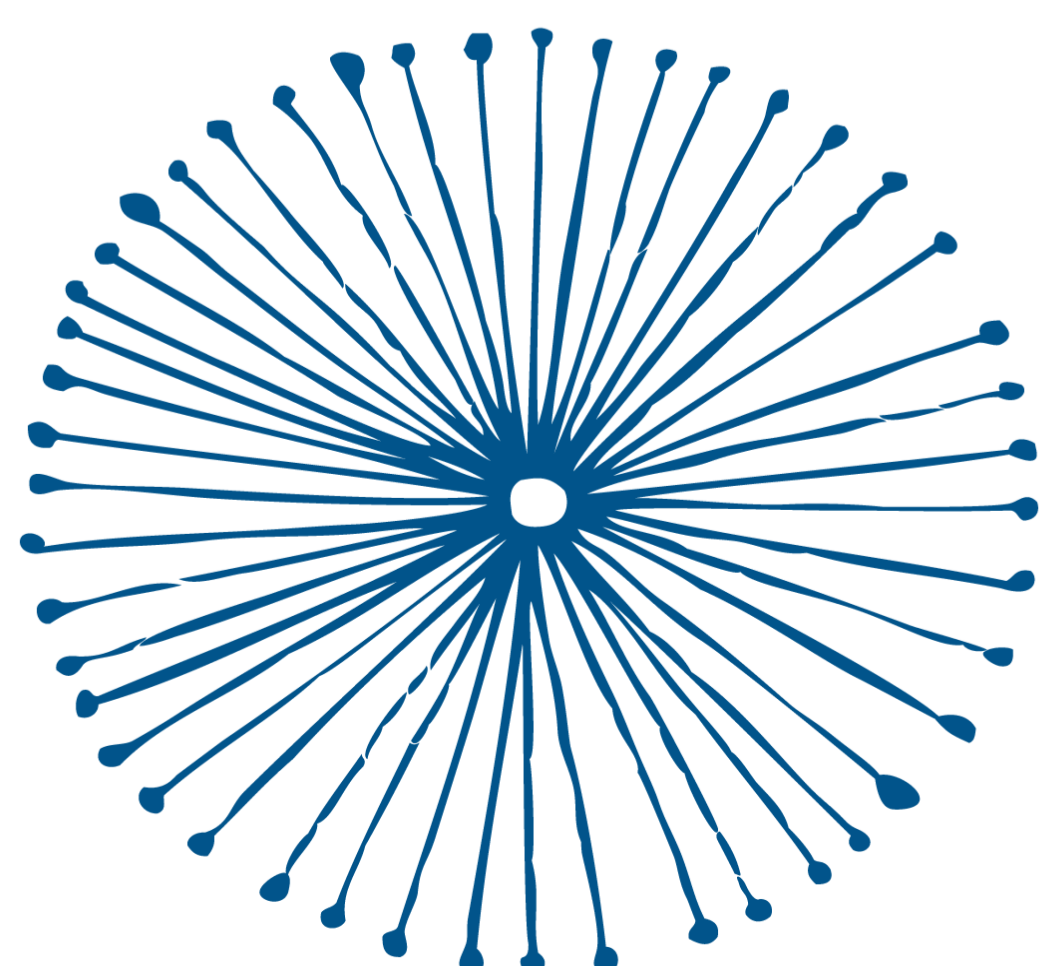
What we found

Over 50% of girls feel they are seldom or never valued for brains over looks

Young women report worrying about being judged, humiliated & harassed while exercising

At home, girls spend more time on housework, but receive less pocket money

Young women experience higher rates of violence than women of any other age group

Rates of depression and anxiety in young women are rising
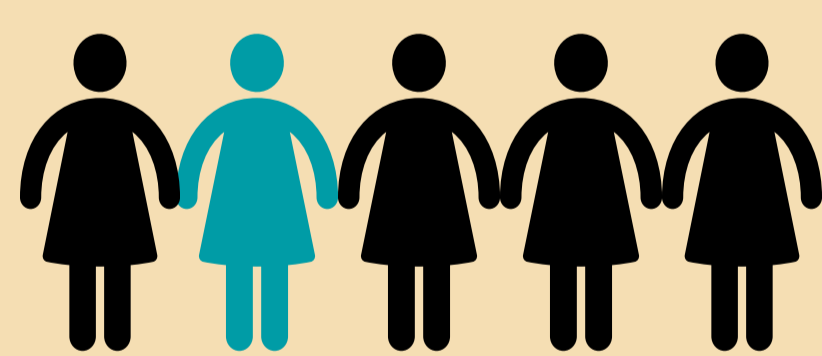
Polycystic Ovarian Syndrome affects 1 in 5 Australian women

Endometriosis affects 1 in 10
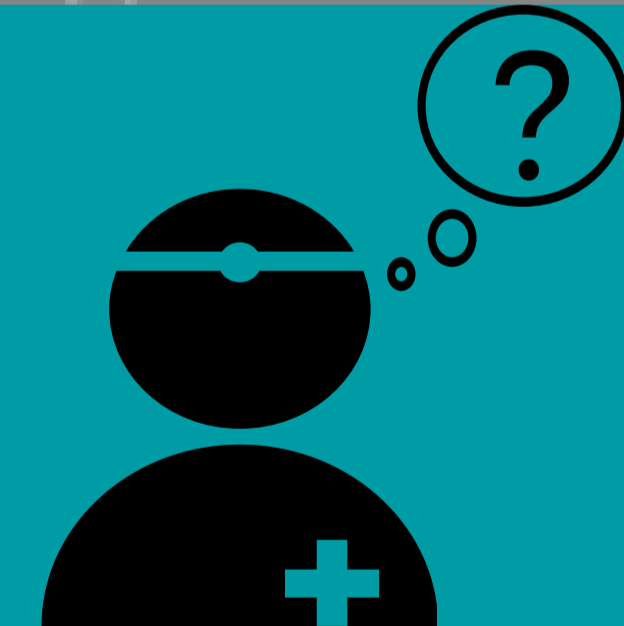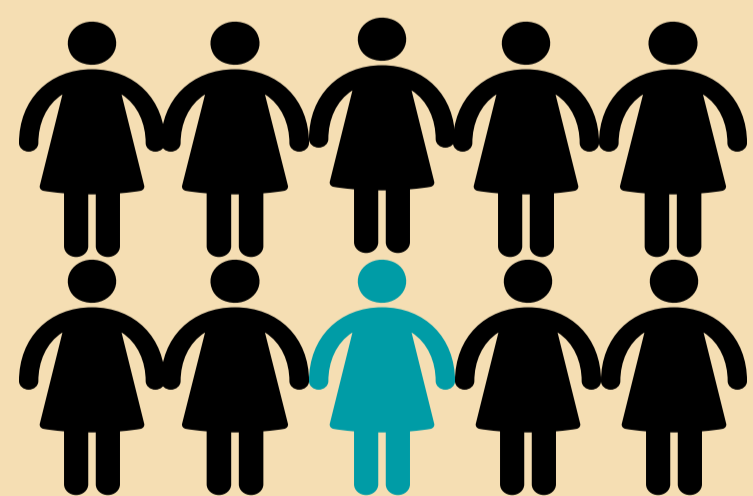
These conditions emerge in puberty & are often poorly understood by health professionals leading to delayed diagnosis

Young women with disabilities subject to dual discrimination & stereotyping of gender and disability

Body image concerns are considerably higher for young women compared to young men
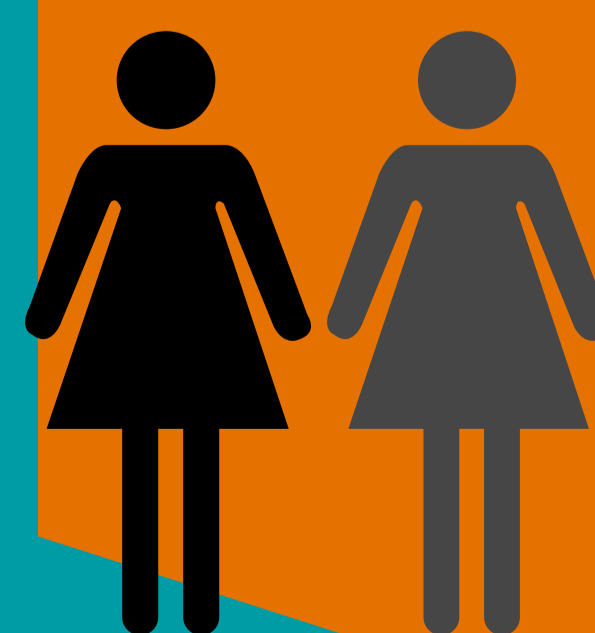
Our vision for the future

Young women feel valued for who they are, not how they look

Young women feel **safe & welcome** exercising in their neighbourhoods

Young women & men are valued equally at home

Young women experience respectful & equal intimate relationships free from violence

Young women enjoy good mental health and positive body image

Young women with PCOS & endometriosis receive the information, support and treatment they require when they need it

Young women see positive, realistic, diverse representation of themselves in public life

INTRODUCTION

Adolescence is associated with physical change, friendships, first intimate relationships, and pressure to lay a strong foundation for a healthy and productive adulthood. During this period of change, most young adults in Australia maintain good health as they embark on a number of new and exciting challenges in life — perhaps managing new education or career opportunities, housing and accommodation, and social and sexual relationships [22].

However, research clearly shows that girls and boys are subjected to different expectations and pressures during adolescence and that between the ages of 10 and 20, young women's experiences and health outcomes can differ significantly from those of their male peers.

What do young women rate as their top concerns?

Australia's best known annual youth survey is conducted by Mission Australia. The 2016 Youth Survey included a total of 21,846 respondents aged 15-19 years.

Nationally, the top three issues of concern were coping with stress, school or study problems, and body image. Around one in five respondents were either extremely concerned or very concerned about depression and family conflict. In each case, the proportion of females concerned about each of these issues was much higher than the proportion of males [23].

'Stress' and 'school or study problems' are very broad categories. By taking a closer look at the stressors affecting young women, we can gain a more nuanced understanding of the factors impacting young women's health and wellbeing.

Importantly, for the first time in 2016, the Mission Australia survey asked young people whether they had experienced any unfair treatment or discrimination. Overall, a higher proportion of female than male respondents reported that they had experienced and/or witnessed unfair treatment or discrimination.

Nationally, the top three reasons indicated by young people for their reported experience of unfair treatment or discrimination were gender (39.1%), race/cultural background (30.8%) and age (22.1%). More than twice the proportion of female than male respondents reported that gender was the reason they had experienced unfair treatment or discrimination [24].

What the literature tells us about young women's health and wellbeing

Key researchers and organisations in Australia and internationally employ a variety of terms and age ranges to describe the young adult population. These include (late) adolescence, youth, young people, early adulthood, and emerging adulthood [25]. This paper focuses on girls and young women between 10 and 20 years old. This is because we want to explore experiences of early puberty, and some of the physiological factors that can impact young women's health and development (such as menstruation), as well as young women's first experiences of intimate relationships and (paid) work, in order to build a more holistic understanding of the state of young women's health and wellbeing as they transition into adulthood.

Much of the existing literature, resources and services related to the health and wellbeing of young people take a gender-insensitive approach. Often, data and research focus either on young people (and makes no distinction between the experiences of males and females) or on women generally (and does not distinguish particular issues faced by younger women).

Much of the literature adopts a homogeneous concept of a young Australian adult. However, like adults, young people's lives are shaped by their gender, class, ethnicity, race, sexuality, geographical location and community. Ignoring this diversity may exclude, for example, the experiences of young adults who are disengaged from formal education or employment [26], young people with disabilities or who live in rural and remote locations, and young people from migrant and refugee backgrounds.

Boys and young men also experience a range of negative experiences and health outcomes related to gender and expectations associated with masculinity. Transgender and intersex young people will experience the interplay of sex, gender and adolescence in different ways as well. Some of the content in this paper related to sex and gender may resonate with these young people, whether in terms of the physical changes associated with puberty and menstruation, or in terms of navigating sometimes harmful and limiting gender expectations. WHV recommends further research into the specific needs and experiences of gender and sexuality diverse young people.

Where the literature does focus on young women specifically, it tends to take a narrow view, focusing on very specific aspects of young women's lives. For example, a study might focus on sexting, or eating disorders, or sexual harassment, without considering how these experiences come together in the lives of young women. In reality, young women often experience many of these things, in addition to the physical changes associated with puberty, and pressure to do well at school, at the same time.

Given these different experiences and negative outcomes, it is understandable that much of the literature on young women's health problematises young women's bodies and experiences, focusing on the risks young women face (such as the risks of pregnancy, sexually transmitted infections, and damage to reputation) and how they can protect themselves, or how society can protect them. What tends to be missing from the literature is an approach that acknowledges young women's autonomy, strength and resilience in the face of the challenges they face.

Overall, this paper shows that many of the poor health outcomes experienced by young women share the same drivers – gender unequal norms and expectations. In some cases, gendered expectations, such as the pressure to conform to beauty standards, are promoted by media and popular culture and internalised by young women. In other cases, it is the gender-insensitive approach taken by health professionals that results in poor health outcomes, for example the poor response young women often receive when seeking support for the symptoms associated with polycystic ovarian syndrome and endometriosis. Expectations from parents, teachers and other adults (whether conscious or unconscious) that girls should do more housework than boys, or that girls only have skills in certain areas, can limit young women's options. The impulse to avoid 'risk' can also mean young women are given less freedom and autonomy than young men.

The evidence suggests that the most effective way to reduce the risk of poor physical, emotional and mental health outcomes for women is to create a more gender equal society for girls to grow up in.

Our aim

The aim of this paper is to look at young women's health and wellbeing from a multidimensional, holistic, intersectional perspective. It is relevant to anyone who is interested in or works with young people, including professionals such as youth workers and health practitioners, policy makers, teachers and schools, parents and young people themselves.

The following questions have guided our work:

- On leaving their teens, how are young women positioned in terms of a healthy and happy adulthood, compared with young men?

- What types of interventions show promise in helping girls to leave adolescence on an equal footing with boys in terms of self-confidence, mental health and physical wellbeing?

We have explored these questions by examining young women's experience of six interrelated priority health areas: physical health, sexual and reproductive health, body image, relationships, mental health and social inclusion. In building this multidimensional picture of young women's health and wellbeing, it has become clear that the unifying factor influencing young women's health across all of these areas is the influence of gendered norms and expectations as young women transition from childhood into adulthood.

Our approach

For this project, we have conducted an extensive desktop review of the most recent research relating to the experiences of young women and girls in Australia. Our work is informed by a feminist perspective, with a focus on how sex and gendered norms, practices and structures impact health outcomes. Because the literature relating to young women's health has tended to focus on risk, we have made an effort to highlight examples of promising practice and protective interventions throughout the paper to fill this gap. Similarly, we have endeavoured to include young women's voices as much as possible, to understand how adolescence is experienced by young women themselves. As a statewide organisation our focus is on young women in Victoria, and this is reflected in our selection of examples and case studies.

Finally, we have included a list of key recommendations and opportunities for policy makers, health professionals and educators to improve health and wellbeing outcomes for young women. It is our hope that this paper can be used as a starting point for developing resources and initiatives that recognise the impact of gender on young women's health and wellbeing, and take a more holistic approach to meeting young women's needs.

On leaving their teens, how are young women positioned in terms of a healthy and happy adulthood, compared with young men?

PHYSICAL HEALTH

Physical activity and nutrition are important for physical health and mental wellbeing, but young women's attitudes to both are heavily influenced by gender norms. The onset of puberty can change the way young women feel about their bodies and abilities, as well as how they are treated by others. The combination of puberty, body image concerns and gender norms can reduce young women's interest and confidence in physical activity. Positively, young women's consumption of alcohol and tobacco is declining [27], though there are indications that this too is a reflection of gender norms and stereotypes related to the performance of femininity.

2.1 Participation in physical activity

More young people are active than adults overall. Physical Education (PE) classes represent the top weekly physical activity for young people (with 78% participating) [28]. Some studies have suggested young Australian women are twice as likely to be sedentary or less active than their male counterparts [29]. More recent Victorian research does not support this finding, but does show gendered differences in girls and boys' engagement in physical activity. More boys than girls report that their parents let them walk or ride to places, or visit local parks on their own [30]. Young women report feeling concern about the presence of males when exercising and worry about being judged, humiliated and harassed [31]. Self-consciousness about their skills and appearance when exercising is heightened during puberty, and compounded by body image concerns and gender norms, which limit young women's interest and confidence in physical activity [32]. Being part of their friendship group is a reason for being active for 58% of boys, but only for 38% of girls [33], reflecting gender norms relating to team sports.

'You have to be fit to be included. They judge you based on your appearance'

Year 11 girl from a regional area [35]

A South Australian study found that 'the girls generated a number of different reasons for ceasing to play sport, including losing interest, lack of competence and insufficient time. Girls also reported feeling like they were crossing traditional gender boundaries when playing sport, particularly for sports traditionally classified as 'masculine' [34].

Self-objectification (where women internalise a critical view of themselves and their bodies [36]) has been found to significantly predict physical activity for women, with women who engage in more self-objectification less likely to be physically active. This finding may imply that women who have high self-objectification try to avoid activities that could potentially elicit the gaze of others and cause social physique anxiety, which limits the health benefits of being physically active [37]. Social norms around what physically active people look like, namely 'thin' and conventionally 'attractive', can be unattainable for some and reinforce the idea/ perception that physical activity is not for them [38]. Sexualisation through uniform and sportswear design can make girls feel uncomfortable playing sport [39]. A real or perceived lack of skill can also lead to young women disliking physical activity, and give rise to bullying and exclusion [40].

'I'm never going to look like that so why should I even try?'

Year 12 girl from a metropolitan area [41]
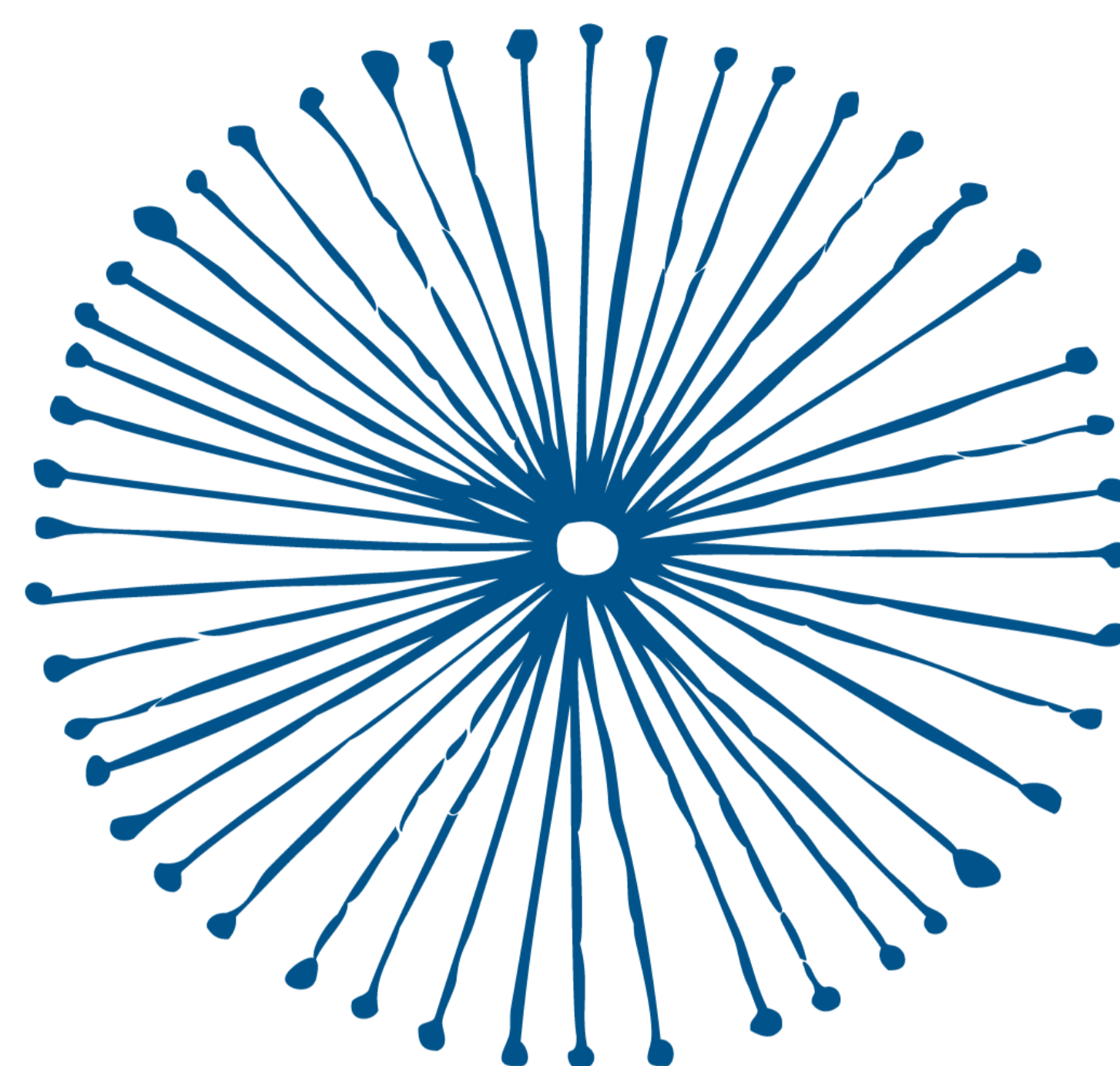
Gender norms impact on girls' and boys' relationships with sport and recreation. Whereas traits like strength, competitiveness and aggression, sweatiness and practical clothes are closely associated with masculinity, the opposite gender norms and expectations apply to girls. Traditionally girls have been discouraged or actually prevented from engaging in sports deemed to be 'masculine' (such as football, soccer, AFL or boxing). Girls from low-income families are also likely to experience practical barriers to taking part in many forms of exercise such as affordability of uniforms/equipment. Those living in rural and regional areas experience other barriers, such as access to transport, or a limited range of sports to choose from.

Gender norms associated with femininity dictate that a woman's or girl's value is closely tied to beauty and desirability, and in how she cares for others. However, improving participation in physical activity can have a lifelong positive impact on women's health and relationship with their bodies.

Young women report worrying about being *judged, humiliated & harassed* **while exercising**
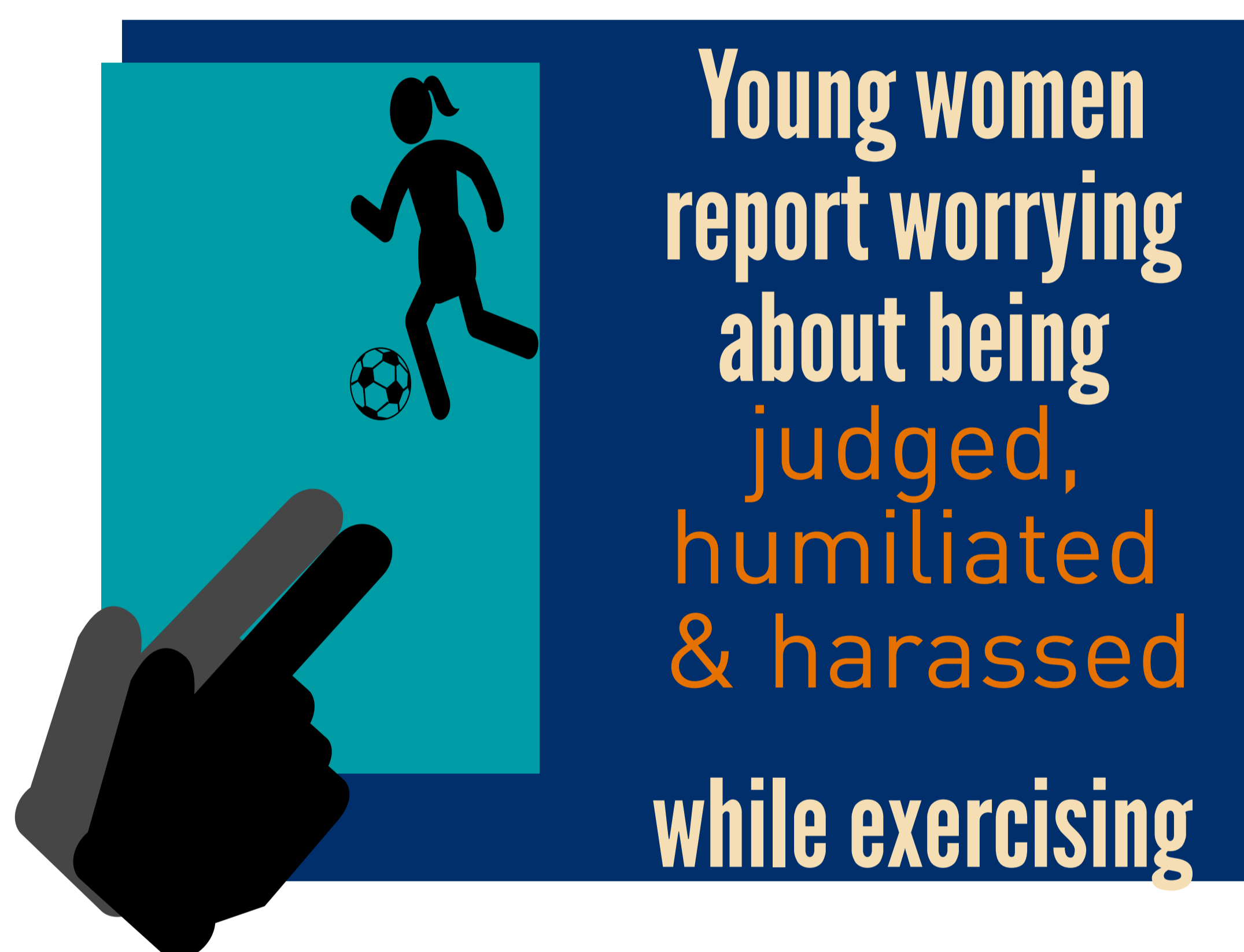
'This Girl Can' is a recent campaign from the United Kingdom which aims to increase physical activity among young women. 'This Girl Can' is a positive and welcome initiative which aims to break down some of the barriers to women's participation in sport, including body image. The Commonwealth has recently adapted a national version of the campaign, entitled **'Girls, Make Your Move'**, and VicHealth is currently adapting the campaign for use in Victoria.

Launched in March 2016 the Australian version of the campaign aims to increase physical activity of girls aged 12-19 years [42]. The campaign encourages exercise for enjoyment instead of weight-loss, focusing on the positive, social aspects of physical activity rather than emphasising the health risks of being inactive[43]. According to evaluation findings, the diversity of women and girls portrayed in the ads (in terms of fitness levels, body types and cultural backgrounds) resonated strongly with young women[44].

2.2 Food and eating

Choosing what to eat, cooking for friends and family and going out for a meal are some of the most pleasurable aspects of gaining independence during adolescence. For some young women the rapid changes in their body size and shape during puberty can be hard to come to terms with. This can trigger body dissatisfaction leading to unhealthy eating and weight control practices such as skipping meals [45]. It is common for young women and girls to say they feel pressure to change their bodies to meet a 'thin' ideal – which is associated with appearing 'healthy' – and are more likely to report exercising for appearance and weight-related reasons [46]. Adolescent girls are the most at-risk population of developing an eating disorder [47]. Up to one-third of young Australian women experience episodes of binge or overeating, with socially disadvantaged women at greater than average risk [48].

Eating habits are also affected by changed behaviours in adolescence and by hormonal changes. Adolescence often means having greater autonomy around choosing what you eat which can lead to a diet higher in processed foods, resulting in poor nutrition. Young women have much higher daily iron requirements than young men due to menstrual blood loss, and are therefore at high risk of iron deficiency [49]. However, young women consume less sugar [50] and are more likely to meet the recommended daily intakes of fruit and vegetables than young men [51].

2.3 Smoking, alcohol and other drugs

A positive trend is apparent in surveys of young women's consumption of alcohol and tobacco; young women's use of alcohol and tobacco between the ages of 12 and 17 years is declining [52]. In 2014, 80% of adolescent girls reported that they had never smoked and 32% of girls aged 12 to 17 years of age had never consumed alcohol [53]. Girls were less likely than boys to engage in risky drinking (consuming more than 5 drinks on one occasion), but 54% of girls aged 16-17 reported having engaged in risky drinking at least once [54].

Despite being less likely than boys to engage in risky drinking, young women's alcohol use is often subject to moralising gender discourses [55]. A recent UK study of teenage drinkers found that girls believed it was their responsibility to manage their bodies around alcohol and 'protect' themselves [56], whereas boys rarely focused on their own responsibilities and regarded their behaviour as shaped by others [57]. These gendered expectations are reflected in anti-binge drinking campaigns which position women's drinking as responsible for their (seemingly inevitable) experiences of sexual harassment and assault [58].

It is estimated that 10% of Australian young women aged 16-24 years old have substance use disorders (compared to 16% of young men)[59]. Most young women who access treatment for substance abuse have had a history of neglect, and sexual, physical or emotional abuse [60].They are more likely to have been separated from their families and involved with child protection, and to experience homelessness [61].

Discrimination experienced by same sex attracted and gender questioning (SSAGQ) young people is linked to poorer health and wellbeing compared with their heterosexual peers. SSAGQ young people are at increased risk of drug use, including marijuana and injecting drug use [62].

2.4 Opportunities to improve young women's physical health

Despite some positive trends in relation to alcohol and tobacco use, there are opportunities to improve young women's physical health by removing gendered barriers to engagement in physical activity. Physical education programs in schools, as well as sports programs outside of the school setting, should take a gender sensitive approach, including more options and activities designed to foster a positive lifelong relationship between young women and their bodies.

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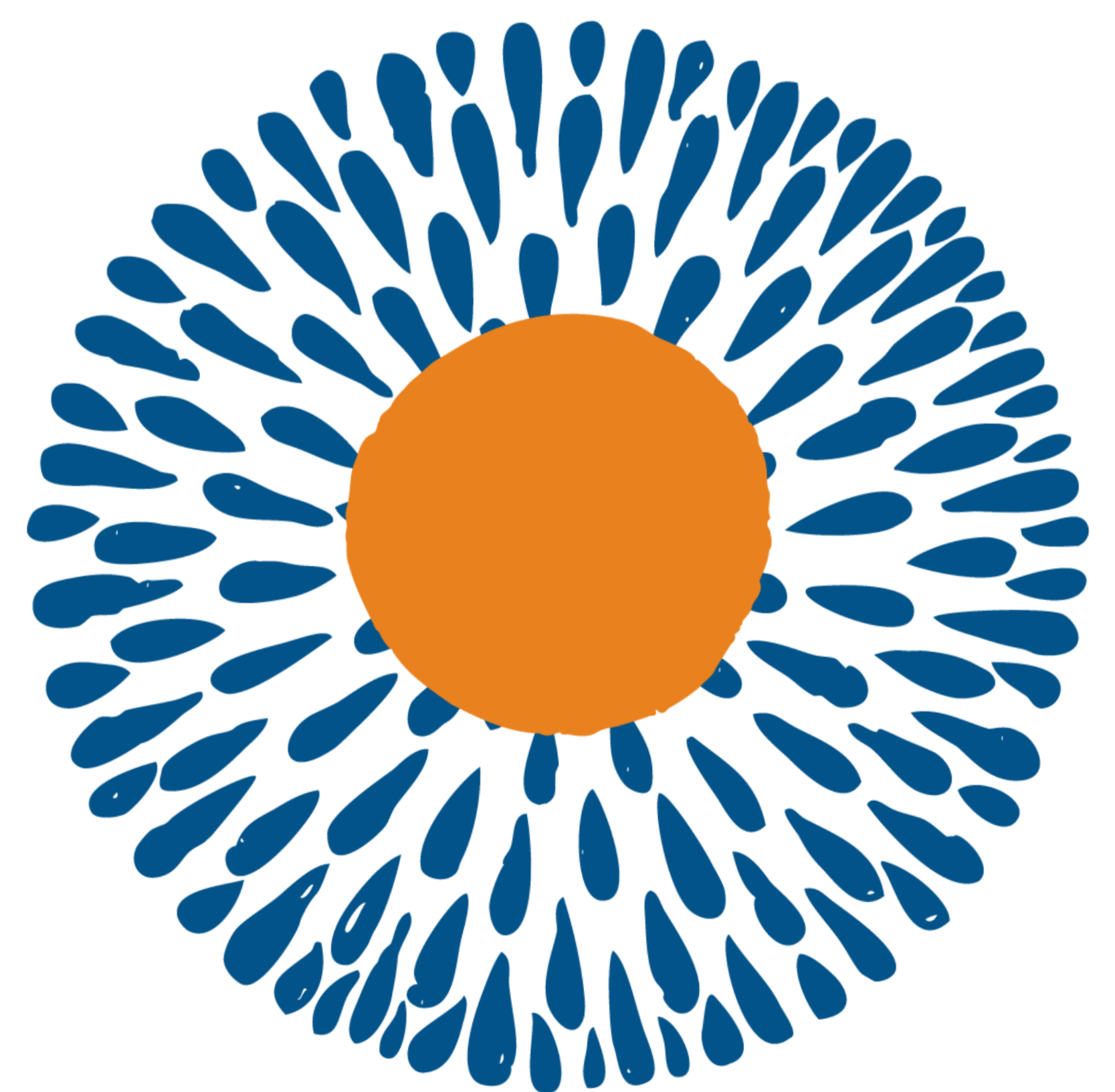
SEXUAL & REPRODUCTIVE HEALTH

Sexual and reproductive health refers to a woman's ability to manage her fertility, have safe, respectful and pleasurable sexual relationships, and access essential health services such as contraception and abortion. It also includes the experience and treatment of specific reproductive health conditions such as polycystic ovarian syndrome and endometriosis. Adolescence is a time of significant physical, emotional and social change for young women. It is a critical period for the development of sexual identity and interpersonal relationships, and can involve the onset of sexual attraction [63]. As puberty causes physical changes, external social narratives about what these changes mean for young girls can be internalised.

Both boys and girls experience significant physical changes during puberty, including the development of pubic and underarm hair, hormonal changes, and growth in height and weight. However, the nature of some physical changes associated with puberty and the social and cultural meanings ascribed to them are very different depending on sex.

Underarm and pubic hair is a good example of this, because although boys and girls go through this physical change at the same time, underarm is seen as acceptably masculine for young men, whereas young women are increasingly expected to remove all pubic, underarm and other body hair in order to conform to feminine beauty norms.

Messaging from parents and peers, as well as self-directed investigation, also play important roles in how well equipped young people are to deal with the sex and gender based challenges associated with puberty. In recent years, sexual and reproductive health curricula have improved significantly, although the quality and depth of sex and health education young people receive varies from school to school. Formal and informal sex education can often frame the physical changes girls experience during puberty in terms of procreation ('your body is getting ready to have a baby') or risk (whether in relation to sexually transmitted infections (STIs), unplanned pregnancy or a girl's reputation). The framing of puberty in this way may be particularly unhelpful for same sex attracted and gender diverse young people.

'I call myself a trans-man, mostly cos I think it sounds kinda nice... it is my way of saying I'm a female-to-male transsexual (which doesn't sound nice at all)... ie. A man who has XX chromosomes, or to use an awful cliché, a man trapped inside a woman's body... For as long as I can remember, I have known I was male. When I was a little kid, I believed I would grow up into a man and everyone would see the horrible mistake they'd made. I was so convincing, all the other kids believed me and I was able to be a boy, right up until we properly learnt the 'facts of life' and puberty struck me and I grew up into a woman, not a man.'

Excerpt from a transcript of an interview with a young transman [64]

3.1 Menstruation

Starting menstruation is a normal (though often challenging) part of physiological development for young women, yet talking about menstruation is still taboo. Academics have noted that menstruation marks girls and women as different from the normative and privileged male body [65] and that the mess and pain associated with menstruation is at odds with notions of discreet, contained femininity. Advertisements for menstrual products 'have contributed to the communication taboo by emphasising secrecy, avoidance of embarrassment, and freshness [66].'

The stigmatised status of menstruation has important consequences for young women's health, sexuality and wellbeing, particularly for those girls who regularly experience heavy bleeding and pain. An Australian study reported 36% of their sample of young women had missed school due to a painful period [67].

Depending on the nature of their disability, young women with disabilities may experience additional challenges with menstrual management (for example, having a vision impairment and not being able to see blood, not being able to independently manage it, or not having feeling in that area).

There are opportunities to de-stigmatise periods for young women, and to make them easier to manage. In the same way public condom vending machines are provided in community and youth settings and public toilets, schools and other settings could provide free pads and tampons for students to access independently. This would help to de-stigmatise and normalise periods and ensure that girls have ready access to the supplies they need to participate equally in school life.

All About Me is a New Zealand secondary school education program designed by Endometriosis New Zealand to educate teenage girls about menstrual health and the signs of endometriosis [77]. Specialist speakers give a 60-minute presentation aimed at students aged 14-18 years-old. This evaluated program [78] has been well received by students:

'Thank you, I thought I was dying or something.'

'My sister found out she had endometriosis from looking at the pamphlet that was given out.' [79]

A South Australian program based on this model in being trialled in eight schools in 2017.
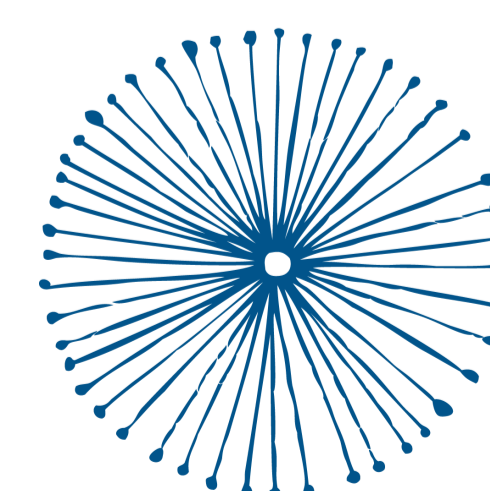
3.2 Polycycstic ovarian syndrome & endometriosis

Girls and women are often provided with minimal information and support for relatively common reproductive health conditions such as polycystic ovarian syndrome (PCOS) [68] and endometriosis.

PCOS is more common than is generally understood, affecting up to 1 in 5 Australian women of reproductive age, with even higher rates in some ethnic groups (for example, Indian, Asian and Aboriginal women)[69]. During adolescence, symptoms may include menstrual irregularity, weight gain, acne and increased facial and body hair [70]. 70% of Australian women with PCOS remain undiagnosed, and there is a lack of consistency in assessment and management of the condition [71]. Unsurprisingly, depression and anxiety are common in women with PCOS; it has been shown that the longer it takes to receive a diagnosis of PCOS, the more likely women are to be depressed or anxious [72].

Endometriosis is a chronic, recurring disease that is experienced by approximately 10 per cent of women worldwide. Common symptoms include painful menstruation, heavy menstrual bleeding, painful sex and infertility [73]. It takes an average of 7 years to be diagnosed with endometriosis and many women report suffering undiagnosed in their teenage years, unaware that the condition even existed [74]. Women often feel frustrated and angry at unsatisfactory experiences with healthcare providers, and raise concerns about the effectiveness and side effects of treatments [75]. Although endometriosis affects half as many people as diabetes, endometriosis receives approximately five percent of the funding directed to diabetes [76].

It is encouraging to see more attention being paid to these common reproductive health conditions. However, there is a need for more information and support for both women and health professionals to ensure that diagnosis, treatment and care is provided in an accessible, timely and sensitive manner.
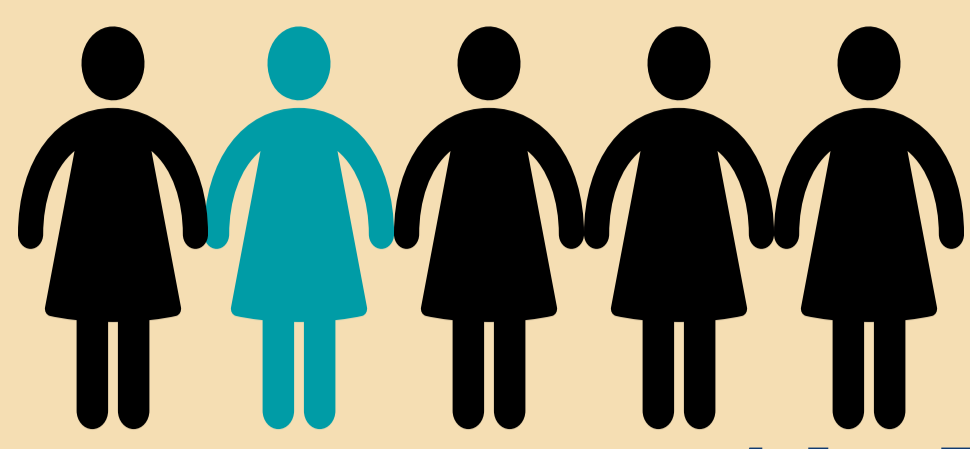
Polycystic Ovarian Syndrome affects 1 in 5 Australian women

Endometriosis affects 1 in 10

These conditions emerge in puberty & are often poorly understood by health professionals
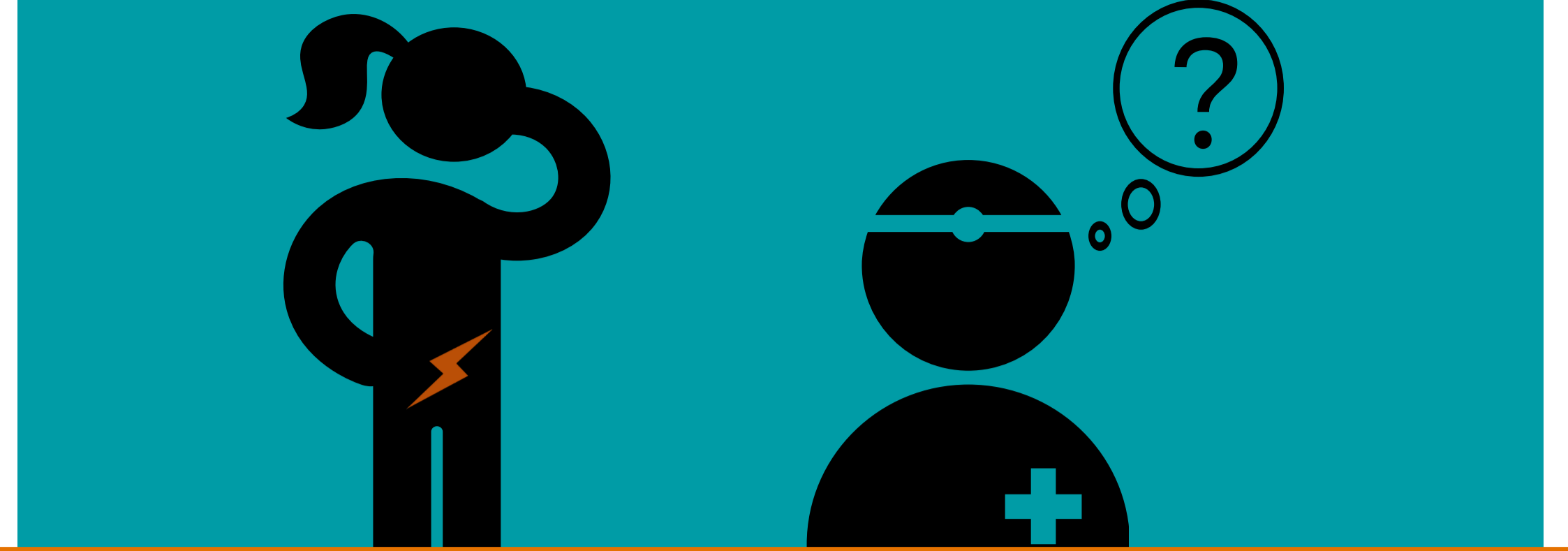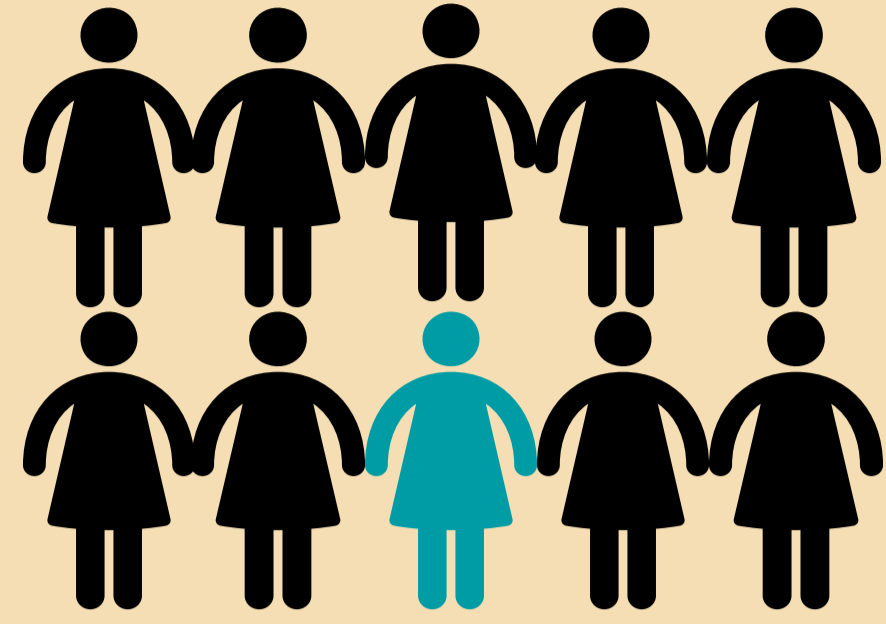
leading to delayed diagnosis

3.3 Sexuality & sexual experiences

An essential element in the sexual health and wellbeing of young people is developing a positive body image and the skills and confidence to negotiate interpersonal relationships and make informed choices about sexual activity [80]. In the past, studies of adolescent sexual behaviour have focused on heterosexual experiences, particularly vaginal intercourse. This tendency is partly due to concern about teenage pregnancy; Australia has high rates of teenage pregnancy compared with many Western countries [81]. However, young people engage in a range of sexual activities beyond heterosexual intercourse.

A major Australian study conducted in 2013 found that approximately 7 out of 10 students in Years 10-12 has experienced some form of sexual activity [82] (such as deep kissing and/or sexual touching). Over one third of the sample report having given or received oral sex [83].

The 2013 study shows significantly different sexual experiences for boys and girls. For instance, young men are more likely to have sexual partners younger than themselves, whereas young women are more likely to have older sexual partner [84]. This has implications for the degree of power and control young women are able to exercise in early relationships with older male partners.

Young women also face cultural pressures to appear sexually inexperienced, and to go along with sexual situations which they may not like, which can lead to harmful outcomes [85]. Overall, a lower proportion of young women report high positive sentiment after sex compared with young men [86]. Alarmingly, a much higher proportion of young women report being influenced by their partner (61% versus 37%) into having sex when they didn't want to, and being frightened [87]. This points to the importance of education and broader change in cultural attitudes in relation to what constitutes meaningful consent, and what constitutes sexual assault.

Studies indicate that girls with learning or emotional disabilities experience first sexual intercourse in different types of relationships from girls without disabilities [88]. For example, adolescents with learning or emotional disabilities have greater levels of discussion about birth control with their first sexual partners than those without disabilities [89].

Sexual and reproductive health services and education programs should be tailored to meet the needs of different groups of young women, including women and girls with disabilities. Education programs should include critical discussion of gender, as well as sex and biology, and on sexual pleasure (including masturbation and consent) and positive communication.

3.4 Pregnancy & contraception

Because it is young women who become pregnant, when 'the problem of teenage pregnancy' arises, it is young women who bear the brunt of the scrutiny and repercussions while the men involved remain relatively invisible. Young motherhood is not necessarily a negative or unwanted experience. However, the age at which women become mothers is likely to affect the types of support they need, and has implications for the levels of income and education they will be able to attain. Teenage motherhood, in particular, is often (although not always) associated with higher than average rates of poverty, poor housing, early school-leaving, and depression [90]. These negative outcomes can be prevented if young parents are provided with appropriate supports.

Responsibility for contraception falls mainly to young women. Young women are more likely than young men to believe that girls are solely responsible for condom use, possibly reflecting young women's sense of responsibility for managing the risks associated with sex [91]. Messages such as 'boys only want one thing' or 'boys will be boys' reinforce the belief that young men don't have equal responsibility for family planning and contraception.

Just under two thirds of sexually active students in year 11 and 12 report using a condom the last time they had sex [92]. However, the relationship between young people's use of contraception and condoms, and rates of STI transmission, pregnancy and parenthood, is not a simple one. Many forms of protection can fail or be used incorrectly [93].

Long-acting reversible contraception (LARC) offers an effective method to help decrease unintended pregnancies; however, current uptake by young Australian women remains low. Common barriers for young women include concern about side effects and difficulties accessing LARC. An additional barrier identified by young women was a perceived lack of control over hormones entering the body from LARC devices [94].

Young women who have been exposed to partner violence are more likely to experience unplanned pregnancy, termination or miscarriage. These young women are also slower to make contact with health services for antenatal care than women who have not been exposed to violence [95].

Young women and girls with disabilities face additional barriers relation to sexual and reproductive health. Young women often prefer to access sexual and reproductive health services in private, particularly independently from their parents. Girls with disabilities may face transport and access barriers which stop them from having independent access to key services and information. Due to these barriers, some girls with disabilities will not be able to access contraception, while others may be pressured to use certain forms of contraception, or even to be sterilised, in the belief that they are not able to control their own fertility.

3.5 Sexual & reproductive health disparities among young women

According to the Victorian Department of Education's State of Victoria's Children report (2013) and Adolescent Community Profiles series (2010), there are significant disparities in sexual health outcomes between rural and metropolitan Victoria [96]. Poor access to high quality sex education and services often translates into negative sexual and reproductive health outcomes for young women in these areas.

Problematic alcohol and substance use, low literacy, insecure housing, depression, trauma and sexual abuse are also consistently associated with poorer sexual and reproductive health outcomes.

Social isolation may result in fewer opportunities to learn about sex from peers, to engage in sexual experimentation, and to develop the social skills necessary to build sexual relationships [97]. This is particularly relevant for young women with disabilities.

3.6 Sexual & reproductive health education services

Nine in ten students report receiving some sex education at school, mostly in Health and Physical Education classes [98]. Outside of school, both boys and girls most commonly consult their mother (36%) or a female friend (41%) about sex and relationships. Doctors and teachers are also common sources of sexual health information (29% and 28% respectively) [99].

The quality and content of sexual and reproductive health education provided by schools varies widely and has tended to focus on heterosexuality and risk management rather than mutual pleasure or respectful and equal relationships.

The Victorian roll out of **Doctors in Schools** has the potential to particularly benefit young women who, for biological as well as social reasons, carry most of the burden for contraception, STI prevention and unplanned pregnancy. Furthermore, half of the schools participating in the program are located in regional Victoria, where families often face barriers to accessing healthcare. This will help to address inequality experienced by young women in regional areas.

'All the information I have found has not been through school. We only learnt about what condoms were (didn't even see one or explain how to use it effectively) and that women got pregnant. The other stuff was all "Puberty Ed" stuff. Nothing on sexuality, pleasure, contraception other than condoms / the pill? ... but I think that's downright stupid. I had to research everything myself so that I didn't end up pregnant, diseased, or in serious pain.' [100]

A 2015 national survey of women aged 16-21 who had attended school in Australia found that young people want their sex education in school to be more comprehensive and inclusive. Tellingly, three quarters of respondents reported that they had learned nothing from their sex education classes in school that had helped them when dealing with sex and respectful relationships [101].

The exclusion of information for same-sex attracted, intersex and gender diverse young people contributes to young people's experiences of heterosexism and homophobia, which in turn contributes to higher rates of suicide, mental health problems and risk-taking behaviours, including risk-taking in sexual activities [102].

Source of Advice for Sex Ed Info

■ Females ■ Males
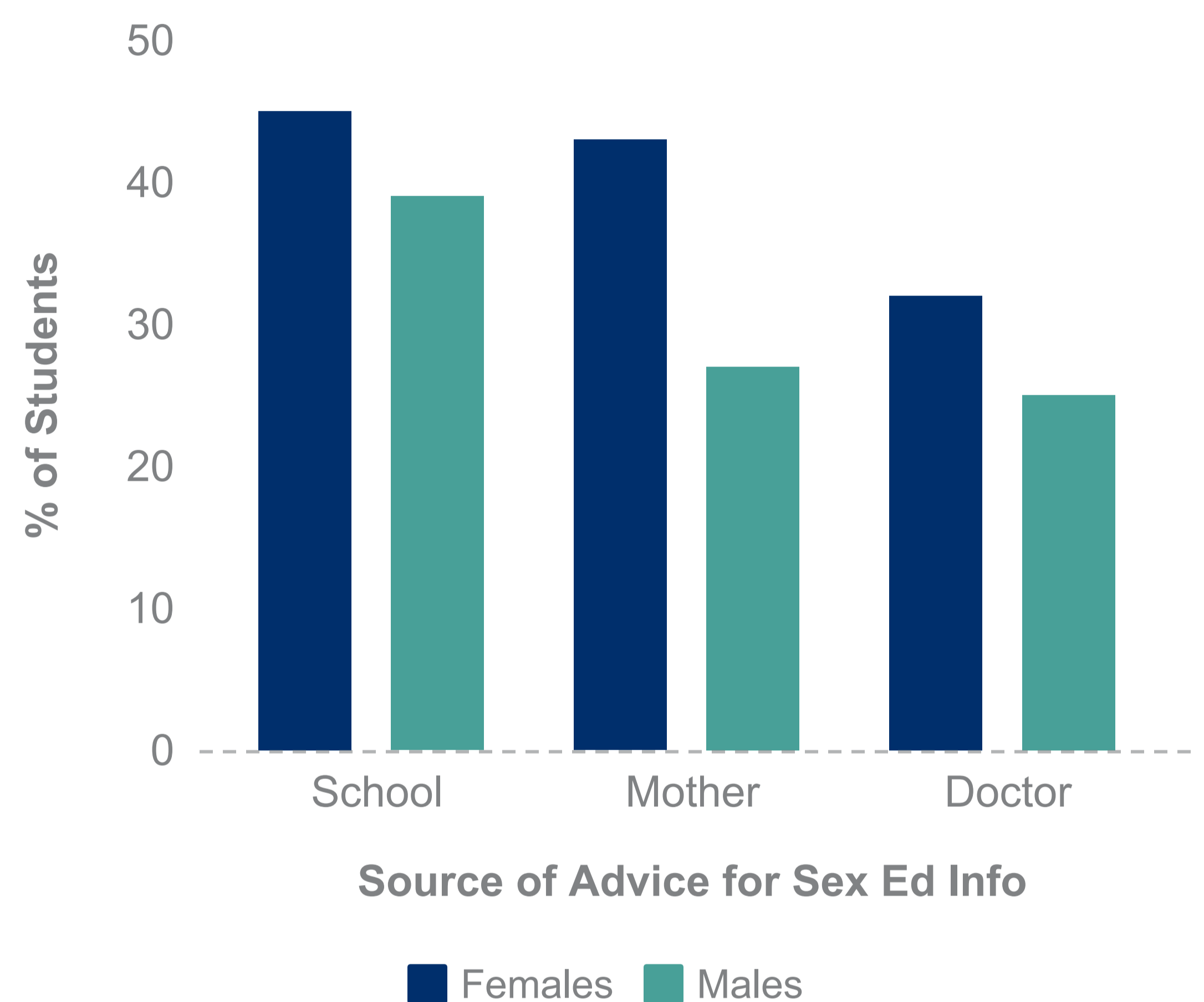
Source: Mitchell, Kent, Heywood and et al. (2014) 5th National Survey of Australian Secondary Students and Sexual Health [99]

'My school didn't talk about safe sex for LBGTIQ people, and as a result I know a few same sex attracted girls are under the impression that they don't have to worry about getting STIs from having sex with other girls...'

[103]

There is a need for accessible, plain language sexual and reproductive health resources, that are both available for young people to access independently online, and embedded within the school curriculum, to fill critical gaps in young people's knowledge.

04
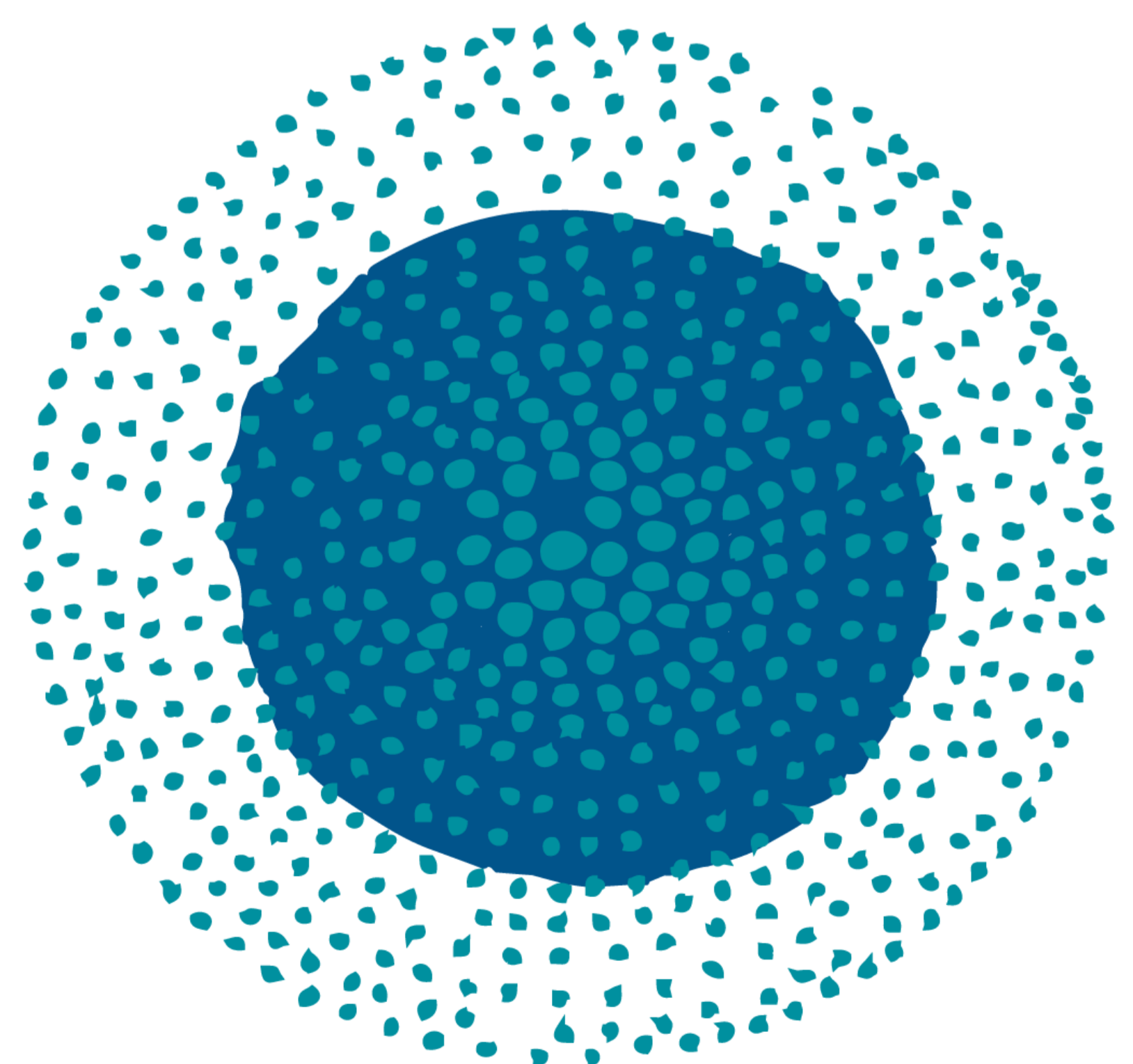
BODY IMAGE

Body image is the perception that a person has of their physical self and the thoughts and feelings (positive and/or negative) that result from that perception. Striving to conform to rigid and unrealistic beauty standards can dominate young women's self-worth and can have serious physical and mental health implications including anxiety and depression. Body image concerns can also profoundly impact how women interact with the world around them.

Young Australian women report considerably higher concerns about body image than young men (41.4% compared with 17%) [104]. And more than half of Australian girls report that they are most often valued for their looks, rather than their brains and ability [105].

Among Australian women, body dissatisfaction mainly manifests in concerns about weight, even in those who are underweight or a healthy weight [106]. Body dissatisfaction often emerges during childhood and peaks in adolescence when young women are 'acutely attuned' to their body weight and shape [107]. Concerns and pressure about body image can also relate to a young person's gender identity – for example, high levels of hostility and shaming towards young women who express their physical image in ways which are seen as masculine or gender non-conforming.

Beauty standards apply to weight, thinness and body shape as well as skin tone and colour, body and pubic hair, height, age lines and hair colour.

Removal of body and pubic hair, and cosmetic surgeries (such as botox and labiaplasty) are increasingly normalised in health and medical marketing as 'good grooming'. Discrimination based on race, class, sexual orientation and ability interact with gender-based discrimination to create specific stereotypes and expectations about different groups of women and men in society. The physical, emotional and financial costs of adhering to beauty standards are high for young women.

Over 50% of girls feel they are seldom or never valued for brains over looks

4.1 Self-objectification

Self-objectification refers to the way girls are acculturated to internalise a third-person view of their bodies as the main way to think about themselves [108]. This process has significant consequences for young women's health, including increased feelings of anxiety and shame, reduced mindfulness of internal bodily cues, and decreased 'flow,' which is defined as being entirely immersed in a mental or physical pursuit [109].

'The media has already messed up this generation's view of what is "beautiful"... Years ago, an Australian size 14-16 for a woman was considered healthy and attractive; now a size 14-16 is considered overweight and unattractive. I think it's disgusting how many teenage girls consider suicide and fall into depression when really they are such beautiful people. I hate how I judge others by appearance.

Young Aboriginal woman, 17 years old [110]

Women's Health Victoria developed **The Labia Library**, a unique online resource that supports positive body image. Aware that women are increasingly altering their genitalia through the practice of female genital cosmetic surgery, the Labia Library informs women about the natural diversity in normal female genital appearance.

The Labia Library provides an opportunity for women to learn about the appearance, anatomy and diversity of normal genitalia. The initiative has been so successful that the Labia Library has had over 13 million page views from around the world, and around 4,500 people visit it every day.

'I'm 16 and I'm young and this… made me cry I'm so happy I'm normal. I've always hated my labia … I've always been worried about if a guy saw it and was like ew but idk [sic] I'd say I think I'm beautiful and a part of me now really thinks I truly am. I feel like you should get through to schools like through sex ed and show… both girls and boys [so they] know that this is normal and beautiful. I just… I'm glad I saw this. Thank you so much, really you made me feel beautiful.' [111]

There is a growing body of evidence that premature exposure to sexualised images and adult sexual content has a negative impact on the psychological development of children, particularly on self-esteem, body image and understandings of sexuality and relationships [112].

The objectification of young women is also associated with less sympathetic responses to girls who experience bullying. Studies have shown that people care less when sexually objectified girls have been harmed, show less favourable attitudes towards helping them, and have a greater belief that the girls are responsible for being victimised [114].

'For example, that advert, where … the woman is just a type of symbol and it disturbs me … Often in soap operas and stuff, yes, the girls are so enormously made up and gorgeous and perfect. Well, they are just like they are not people, the girls, they are only symbols.' [113]

4.2 Community enforcement

Popular culture including advertising, TV films and computer games, as well as the attitudes of parents and teachers, can reinforce the belief that a young woman's value lies principally in her looks and sexual attractiveness to men.

Advertising and media often exploit gender stereotypes and sexualise girls and young women in order to sell products. There are numerous examples of the gendering of toys and other products that reinforce harmful and rigid gender stereotypes. Products for girls and young women tend to focus on caring roles and on cultivating a submissive and attractive appearance in order to attract boys and men. On the other hand, toys and other products for boys and young men tend to emphasise a masculinity built on aggression, physicality and unilateral heroism.

Research suggests that promoting 'ideal' and 'normal' depictions of masculinity and femininity may lead to lowered self-esteem or depression when children do not feel they fit into this mould [115].

Parents, extended family, carers, teachers and the broader community all play a role in teaching children about gender norms – and not just as buyers of toys for children. The emphasis that family members and other adults put on how girls and young women look, rather than on their achievements or strengths, can have a big impact on their sense of self value. More frequent comments from mothers about their daughters' weight are associated with poorer psychological health, harmful weight control behaviours, and greater prevalence of binge eating. Notably, mothers' more frequent talk about their own weight, shape, or size is also associated with lower self-worth and higher depressive symptomology among their daughters [117].

> 'Women with disabilities are largely invisible in Australian society, but it's not because there just aren't that many of us. People with disabilities make up roughly 20% of the Australian population, and disability is slightly more prevalent among women. So why is it that when asked to think of a high-profile disabled woman, we struggle?'
>
> *Stella Young* [116]

In March 2017, the city council of Paris, France, officially **banned sexist and discriminatory advertising** from appearing in public outdoor spaces. The ban will apply to advertising employing sexist or homophobic stereotypes, including degrading, dehumanising, or offensive representations of women and men. In Britain, new guidelines are being developed to ban advertisements that promote gender stereotypes, sexually objectify women, or promote an unhealthy body image.

Similarly, research shows that friends' attitudes influence young women's body image. Body dissatisfaction tends to be higher when adolescents are exposed to friends' weight loss strategies, engage in social comparisons, or when friends convey the importance of thinness and appearance for social acceptance [118]. The influence of mothers and friends points to the need for strategies to improve body image for women of all ages.

Pre-adolescence and adolescence are tumultuous periods of development for many girls, but they present a particular challenge for girls who are overweight or obese [119]. Studies have shown that a high relative body weight is associated with less favourable social and material conditions for women, but not for men [120]. This may reflect stereotypes associated with masculinity where being large can be more positively associated with strength and dominance.

Interventions that focus on promoting self-esteem and positive body image for young women and girls —starting just before the onset of puberty at age 8 or 9 – are amongst the most promising for supporting positive body image in young women [121].

4.3 Intimate relationships

Body image concerns profoundly impact young women's experience of early intimate relationships. When young women engage in sexual activity, they are more likely than their male peers to report low sexual self-esteem and are less likely to experience pleasure [122]. There is also evidence that women with poor body image are less confident in negotiating safe or pleasurable sex, and are more likely to engage in risky sexual behaviours [122]. A common explanation is that young women who feel unattractive also feel less able to assert themselves with male partners [124].

The attitudes and behaviours of young women's partners, particularly young men, play a key role in shaping young women's experiences in intimate relationships. Men who objectify women are more likely to endorse sexist attitudes toward women [125].

Research indicates that children and young people are accessing pornography at increasing rates, with boys aged 14-17 years being the most frequent underage consumers of pornographic material [126]. When a woman knows that their male partner views pornography, her concern regarding her partner's sexual attraction toward her own body increases [127].

4.4 Protective factors

A New South Wales study found that young people who saw family, strong friends and achievements as centrally important in their lives were buffered from viewing body image as the critical factor that determined their self-worth [128]. This suggests that the strongest protective factors for body image are associated with an integrated view of wellbeing that is validated by the people and world around us.

The same study found that Indigenous participants were politicised around issues to do with Aboriginality and discrimination and this acted as a protective factor in shaping the way they experienced body image pressures. Pride in 'Indigenous bodies' appeared to involve a difficult balancing act between belonging to family and community and distancing oneself from the negative stereotypes that continue to be associated with Aboriginality [129]. Participants were conscious of mainstream adherence to culturally narrow perceptions of beauty and were quick to identify with African-American culture and role models from Indigenous Australian communities [130].

Factors that have been found to help preserve self-esteem for some girls include physical activity, perception of good health, family communication and closeness, authoritative parenting, perceived teacher support, being part of a religious community, and feeling safe at school [131]. In other words, in addition to the health and wellbeing benefits of physical activity, girls and young women benefit from being in spaces, or being with people, who consistently reinforce messages that counteract objectification.

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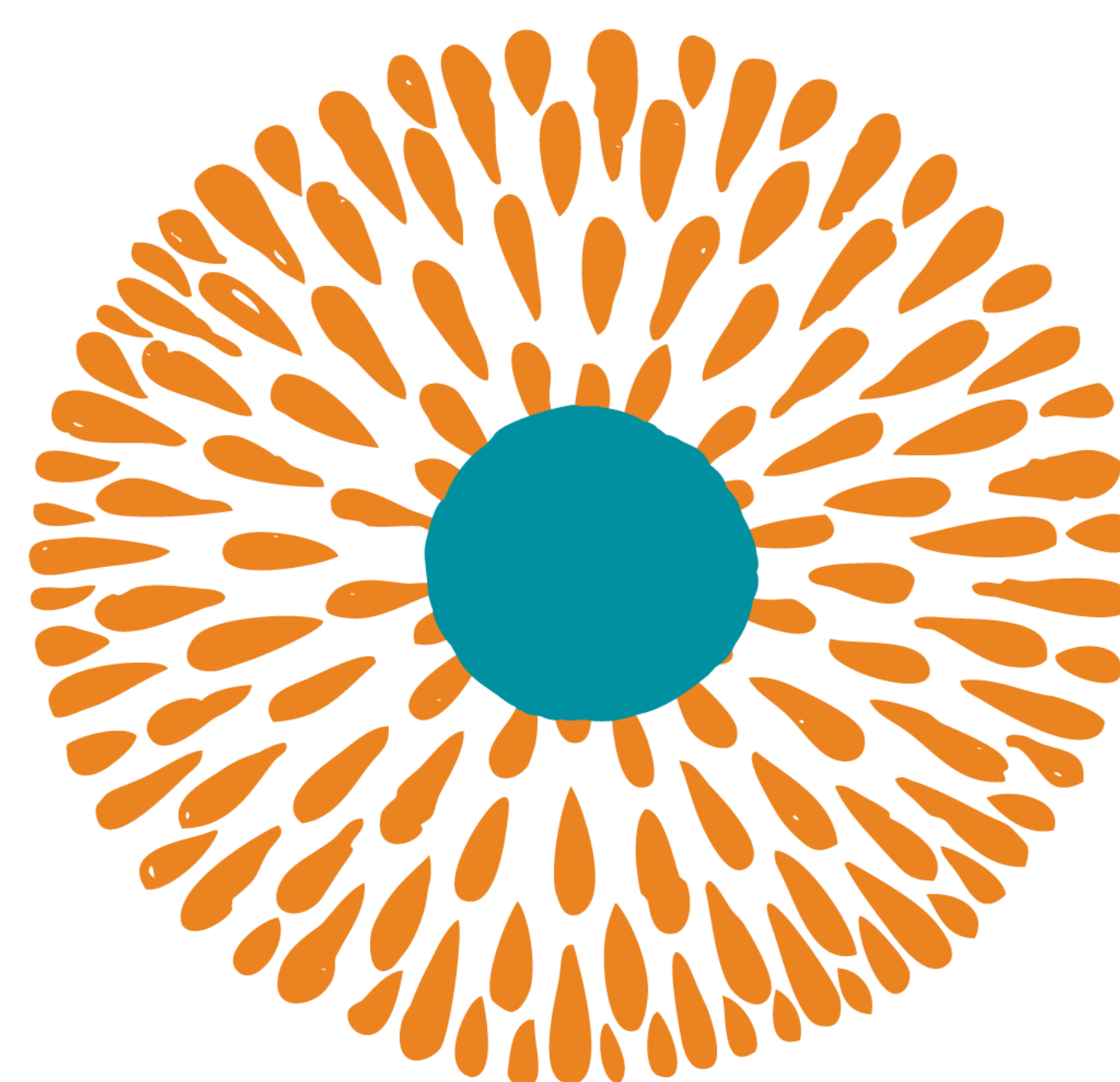
RELATIONSHIPS

The formation of romantic relationships and engagement in sexual behaviours are normal and expected parts of growing up [132]. Yet much of the research relating to young women's experiences of intimate relationships has tended to focus on risk (in relation to sexual assault, reputation, and STIs and unplanned pregnancy), rather than pleasure.

Young peoples' and researchers' definitions of 'relationships' are diverse and include commitment, exclusivity, casual hook-ups and friendship. Adolescent relationships are typically brief in early adolescence, progressing into sexual relationships in mid-adolescence (14–15 years) and onto more intense, committed relationships during later adolescence (16–18 years) [133].

Adolescents (particularly girls) spend a lot of time thinking and talking about romantic relationships, whether the focus is on past relationships, or potential future relationships, even when they are single [134]. Parents/carers, friends and partners play an important role in shaping young women's attitudes and expectations about relationships and intimacy, as do gender-related expectations and experiences. Young women aged 18 – 24 experience significantly higher rates of physical and sexual violence than women in older age groups [135]. Importantly, young people's early romantic and sexual experiences can create a 'blueprint' for future relationships [136].

5.1 Young peoples' experiences of & attitudes to relationships

Recent research paints a complicated picture of young women's experiences of intimate relationships. Adolescent romantic experiences and relationships form the foundations of young people's 'romantic self-concept' (that is, how they see themselves within romantic relationships). The challenges of developing and maintaining romantic relationships also allow adolescents to build many important skills that they will rely on as adults including the ability to manage strong emotions and cope with break-ups [137].

> **Young women aged 18 – 24 experience significantly higher rates of physical and sexual violence than women in older age groups**

Increased relationship commitment has been shown to predict increased sexual pleasure for young women. Young women in both opposite and same-sex attracted relationships report higher sexual body esteem and self confidence in long-term romantic relationships than shorter relationships [138]. Same-sex relationships have been found to be associated with a greater perception of entitlement to self-pleasure [139].

Our Watch has developed **The Line** [142], an interactive website for young people to talk about relationships, gender, sex, bystander action, technology and communication. One aspect of The Line is the FETH test (Fairness, Equality, Trust and Honesty) which aims to help young people self-assess how healthy and respectful their relationship is.

Young people in romantic relationships have been shown to have higher levels of stress, anxiety and depressive symptoms than those who are not in romantic relationships [140]. Cohabitation is associated with increased reports of relationship violence than non-cohabiting relationships for young adult women, with both married and cohabiting couples experiencing more violence, victimisation and perpetration than those in dating relationships [141]. This points to the need to include content on gender equity and cohabitation in the respectful relationships education curriculum as adolescents transition to young adulthood.

Adolescents who are involved in a romantic relationship typically spend less time with their families – this alone can be a significant cause of conflict or tension. There is some evidence that girls may be particularly sensitive to such changes [143].

It is widely reported that women with disabilities experience high levels of family and sexual violence and face additional barriers to seeking support and leaving abusive relationships. Women with disabilities experience the same kinds of violence experienced by other women but also 'disability-based violence'[144] and ableism. However, there is a clear need for more up to date Australian research on the experiences of women and girls with disabilities:

'Whilst Australian research indicates high rates of violence and abuse and reflects the gendered nature of violence and abuse experiences by women with disabilities, it remains anecdotal, and the cited literature for most part remains in the domain of grey literature.' [145]

The 2013 National Community Attitudes Survey found areas for concern, as well as optimism, in relation to young people's attitudes to relationships and violence against women.

Although young people are more supportive of equality in some areas (for example, they support women's equal right to education), they are also more likely to endorse men dominating decision-making in relationships [146] and are less likely to understand that violence against women is broader than physical violence and forced sex [147].

These findings may suggest that young people support gender equality in the abstract, but less so in the context of their personal relationships [148] or the belief that gender equality has been achieved and so there is no longer a need to strengthen women's rights [149].

Compared to young women, young men show a lower level of understanding of violence against women; a lower level of support for gender equality; and a higher level of attitudinal support for violence against women [150].

'When I was 19 when I started dating my now ex-boyfriend. At first he seemed charming, witty, funny, and adventurous. I fell in love with him right away. For the first couple of months everything was great, but then the fights started – at first over very petty things, like my not having a special ringtone for him on my phone.

It escalated into things about my behaviour – suddenly everything I was doing was wrong, and I found myself apologising to him several times a day for things I did that upset him, which was nearly everything….

Learn to stick up for yourself and don't let yourself fall under the control of a partner. Also, don't take the signs of abuse lightly, and don't brush off your partner's behaviour. Just because he's not hitting you does not mean you're not being hurt. If you feel unhappy in your relationship and feel that you're not being treated as you know you deserve, seek help and do everything you can to get out of it. You deserve to be cherished as the person you are.'

Andrea's Story [151]

5.2 The role of parents, friends and bullies

Friends, parents, peers, teachers and the broader community also influence girls' and boys' attitudes to intimate or romantic relationships. For example, a recent Australian study showed that more frequent and higher quality communication between mothers and daughters was related to more knowledge and confidence in relation to safe sex. Higher quality communication with fathers was also related to more positive attitudes to sex [152].

The attitudes of peers and friends play a powerful role in establishing and policing expectations around young women's relationships and sexuality. Girls are more likely to be targets of bullying when they fail to conform to norms around sexual behaviour and femininity [153]. Although bullying is often conceptualised as a 'youth problem', its content often reflects the attitudes and ideologies of adults [154]. In this way, 'bullying is both a gendered practice and a gendering process' [155].

Research shows that young women delineate sexual and relationship norms along a number of lines, including a girl's sexual orientation; the sex acts she participates in (for example, masturbation, oral or anal sex); the context in which she has sex (for example, while drunk, in public); the sexual partners she has; and sexual consequences (for example, pregnancy/abortion, STIs) [156]. At the same time, research suggests that 'hook-up' (casual or 'one off') relationships are increasingly normative for young adults, both personally and in popular culture [157].
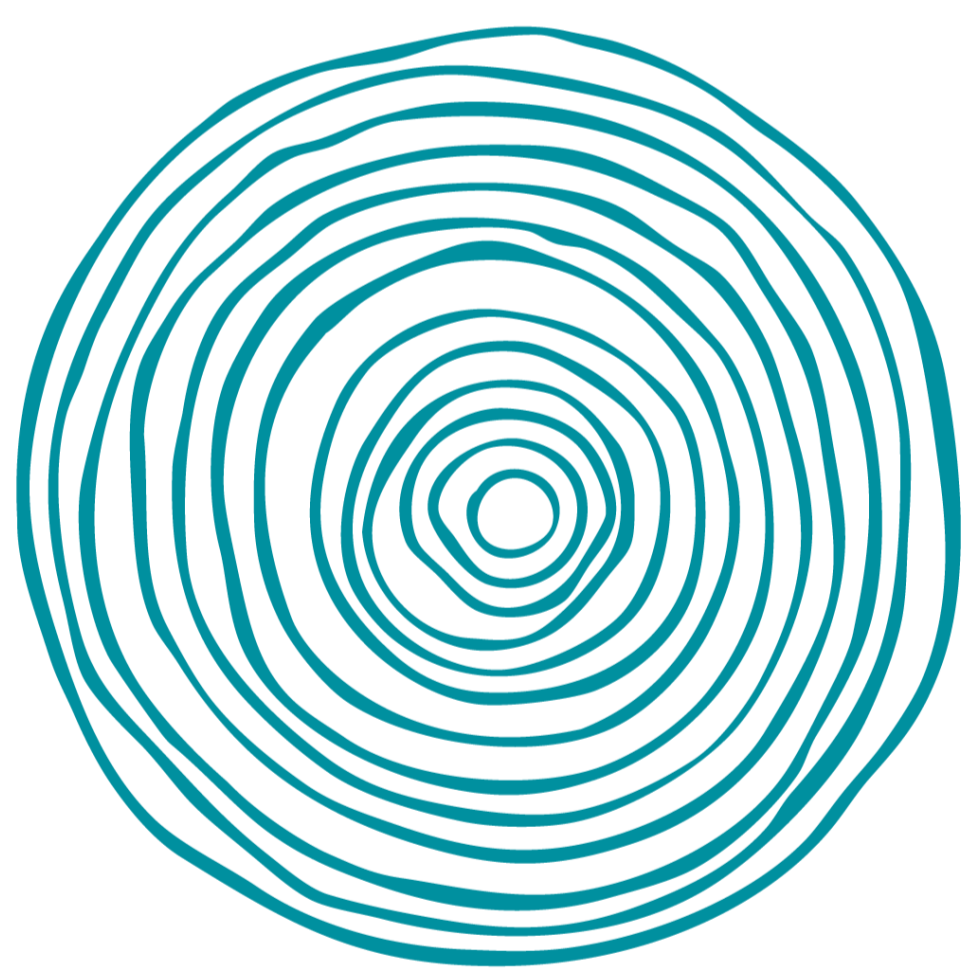
5.3 The role of media, pornography & new technologies

The rising significance of new media forms, especially social media, has hastened and extended the ways in which people communicate and connect. It also means that young people are exposed to negative, sexualised media representations of women at an earlier age and more often than previous generations [158].

Research has shown that women and men exposed to sexually objectifying images from mainstream media are significantly more accepting of rape myths, sexual harassment, sex role stereotypes, interpersonal violence, and adversarial sexual beliefs about relationships [159]. Exposure to sexualised content has also been shown to affect how women behave and how men treat and respond to real women in subsequent interactions: after being exposed to sexualised content, men's behaviour toward women becomes more sexualised, and they treat women more like sexual objects [160].

'A friend of mine is in a relationship with a boy and he watches porn on the Internet and the first time they decided to have sex together he decided that to get off he would like to be tied down. You know part of me thought well how does he know that this is something that's attractive to him, but obviously he's watched it and for some reason that's excited him, [but] I don't think I'd want that to be my first time. To have to get bungie ropes and tie someone down – it's almost like yeah it's kind of like violence as well...'

Molly, 16 years [161]

New technologies can be seen as increasing risk, for example, through exposure to online harassment via social media, 'sexting', GPS tracking, and increased exposure to pornography [162]. Culturally, the burden of managing these risks, and dealing with the consequences, is assumed to lie mostly with girls and young women as potential or actual victims, rather than with boys, as potential or actual perpetrators.

'I think that even sex and violence are so inextricably linked these days ... the girl always has to dress up in a subordinate role, being a nurse or a maid or an airhostess. It's just making us seem so subordinate to men and then they use that dominance against us.'

Camille, 20 years [163]

The advent of smartphones has also offered a range of positive benefits for young women. Answers to questions that are difficult for young women to ask parents or teachers (for example in relation to pornography, periods or body image) can now be sought out in relative privacy online. Online dating sites such as Tinder are also used by young people. Interestingly, Bumble, which permits only women to initiate conversations, is the most popular dating app for young people (aged 18-29) [164].

The Victorian Royal Commission into Family Violence recommended that comprehensive **respectful relationships education** (RRE) be rolled out across all public and Catholic primary and secondary schools in Victoria as one of the state's key strategies for preventing violence against women before it begins.

Following a successful pilot, in 2015 schools and early childhood services across Victoria (including public specialist schools) have been introducing RRE. The curriculum aims to equip students with skills and knowledge to support equitable and respectful relationships, as well as embedding gender equity in school polices, structures and practices. The 2015 pilot found that awareness, attitudes, language and behaviour improved in both staff and students.

5.4 Promising trends

Despite the challenges outlined above, there are promising trends in young people's attitudes to relationships. Since 2009, there has been a 10 percentage point decrease in the proportion of young men who hold violence-supportive attitudes [165]. While adherence to rigid gender stereotypes may be strong in adolescence, 'this developmental stage is also a time during which prospects for prevention [of violence against women] are particularly strong,' [166] as young people are still forming their values and beliefs about gender. Young people should be supported to develop healthy attitudes about gender, love and respect before they begin their first intimate relationships, including through school-based programs like Respectful Relationships Education and online resources such as *The Line and Love, The Good, The Bad and the Ugly.*

There are a number of opportunities for further expansion and enhancement of RRE in Victoria, including: a stronger focus on a whole-of-school of approach; expansion to all faith-based and independent schools; and development of strategies for reaching young people who are not engaged in school. At a national level, while it is encouraging that all state and federal Ministers have endorsed the Foundation to Year 10 Australian Curriculum, implementation across states and territories is uneven.

'We don't have a good enough system, to teach boys about how to treat a woman properly and vice versa. Both need to be taught boundaries and be taught that we... shouldn't... feel pressured to have sex.' [167]

06

MENTAL HEALTH

Girls and boys enjoy comparable levels of mental health and self-confidence before puberty [168]. However, during adolescence, young women's mental health outcomes worsen compared with young men's [169]. Evidence strongly indicates that this discrepancy is driven by sex and gender-based expectations and experiences. The decline in young women's mental health is linked to societal factors rather than poor health care [170].

Some groups of women are particularly likely to experience poor mental health. Higher levels of suicide and self-harm are reported among lesbian and bisexual women, women with intersex characteristics and trans women. This has been linked to experiences of stigma, discrimination, harassment, homophobia, transphobia, abuse, bullying and family and societal alienation [171].

For young Aboriginal and Torres Strait Islander women, the compounding effects of a history of colonisation and dispossession, intergenerational trauma, removal from family and community, racism and discrimination [172] have a detrimental effect on mental health.

6.1 Stress

Young Australian women have consistently reported 'stress' as one of the top concerns affecting their lives [173]. Multiple and intersecting stressors affect young women. They include:

- Pressure to be successful and achieve good marks [174], and feeling that they need to work 'harder' than boys to be successful [175].

- Pressure to be 'perfect' – to be the perfect friend/pupil/partner and have the perfect body – as well as guilt associated with inactivity and 'inefficiency' [176].

- Pressure to be pleasing and care for others (therefore not having enough personal time) [177].

- Having more expected of them than of their brothers [178].

- Pressure on appearance, and the notion that the female body needs to be controlled (for example, through dieting, body hair removal).

- Exposure to gender-based violence and harassment, and fear of assault.

- Adolescent girls experience higher levels of interpersonal stress than boys [176] and those who experience peer-related stress are most likely to develop depression [179].

Research suggests that SSAGQ young people living in rural and regional Victoria face added pressures due to higher levels of homophobia, increased surveillance, and reduced access to relevant information, resources and services [182].

'There is way too much pressure nowadays on students to exceed exceptionally in the HSC. For a lot of people, we feel as if we are defined by our ATAR. A NUMBER! If we do not do well, we become extremely disappointed in ourselves and feel worthless. The amount of stress put on us is ridiculous and has driven a lot of people into mental health issues.'

Young woman, 17, Sydney [181]

6.2 Eating disorders

While eating disorders can occur across all ages, socio-economic groups and genders [183], being female and experiencing puberty are key risk factors for the onset of an eating disorder [184]. Approximately one in 100 adolescent girls develops anorexia nervosa, and 75 per cent of children diagnosed with the condition are female. Eating disorders are the third most common chronic illness in young females [185].

Rates of depression and anxiety in young women are rising

6.3 Depression & anxiety

Rates of depression, anxiety and psychological distress are on the rise in young women. The Australian Longitudinal Study on Women's Health has found that about a third of young women have been diagnosed with or treated for either depression or anxiety [186]. A UK report found a 55% increase in rates of depression and anxiety among 11-13 year old girls between 2009 and 2014, but no such dramatic increase for boys [187]. This steep increase in depression and anxiety could be attributable to increased sexualisation and objectification of girls and young women, as well as exposure to social media and increased pressure on school performance [188].

Twice as many rural adolescent girls report symptoms consistent with depression compared to their male counterparts [189].

While more research is needed to determine the effect of socio-economic status on rates of depression among rural populations, the study found that lack of availability and long waiting lists for mental health services, stressors involved in interpersonal relationships, and a perceived lack of mental health support account for higher rates of depression among young rural women [190].

Young people from migrant and refugee backgrounds are shown to be largely very reluctant to seek professional support with their psychosocial problems due to a range of individual, cultural, and service-related barriers [191].

6.4 Other anxiety disorders

Significantly more young women than men are diagnosed with some types of anxiety disorders, and. symptoms often first appear during late adolescence and early adulthood.

Anxiety disorders can also have gendered expressions. Obsessive compulsive disorder (OCD) is experienced by 2-3% of the population and symptoms often develop in adolescence [193]. OCD is characterised by having uncontrollable repetitive thoughts leading to impulses or actions that are 'distressing, time-consuming or limiting to normal functioning.' [194] Women with OCD exhibit more contamination/cleaning compulsions and have a greater comorbidity with eating disorders, which may relate to gendered social roles. [195]

The **Our Voices, Changing Cultures Project**, delivered by the Multicultural Centre for Women's Health was designed specifically to build resilience, capacity and leadership amongst young same-sex attracted women from culturally diverse immigrant and refugee backgrounds.

Through the group discussions and performance-based workshops, the project created a space for young same-sex women to feel safe to discuss issues that affect them. Creating this space helps to link up same-sex attracted women who may be dealing with cultural and migration related issues with each other, enabling them to share their experiences and strategies, and helping to improve their mental health. [192]

6.5 Self-harm

Rates of self-harm and suicidal behaviour are high among Australian teens with young women at greater risk than boys of both self-harm and suicidal behaviour [196]. The 2016 Longitudinal Study of Australian Children found that one in four girls had had thoughts about self-harming, and 15% had engaged in some form of self-harm. When it came to suicide, 12% of girls had thought about suicide in the past year, with 6% actually attempting suicide. Boys were, however, much more likely to act impulsively and make an unplanned suicide attempt [197]. Young people who were same-sex attracted, bisexual, or unsure of their sexuality were at greater risk of self-harm than heterosexual teens [198].

Self-harming behaviours are still poorly understood. Reasons for self-harm are diverse, but can include:

- a coping mechanism in response to intense emotional pain and psychological distress [199],

- a form of self-punishment, and/or

- an attempt to 'feel something' in response to numbness from depression [200].

A lack of understanding by health professionals and parents, and feelings of shame and guilt, can be barriers to young women seeking help [201].
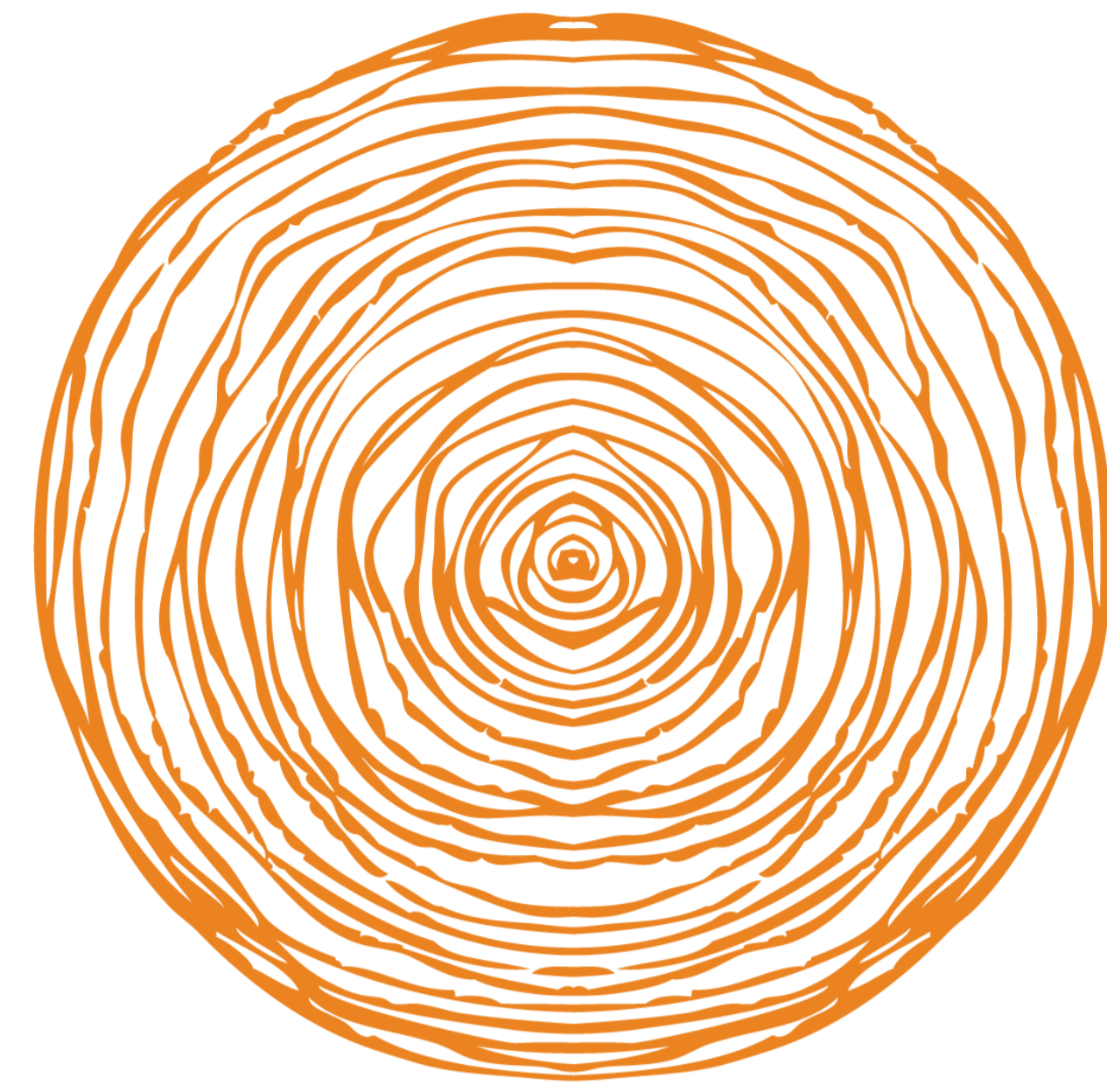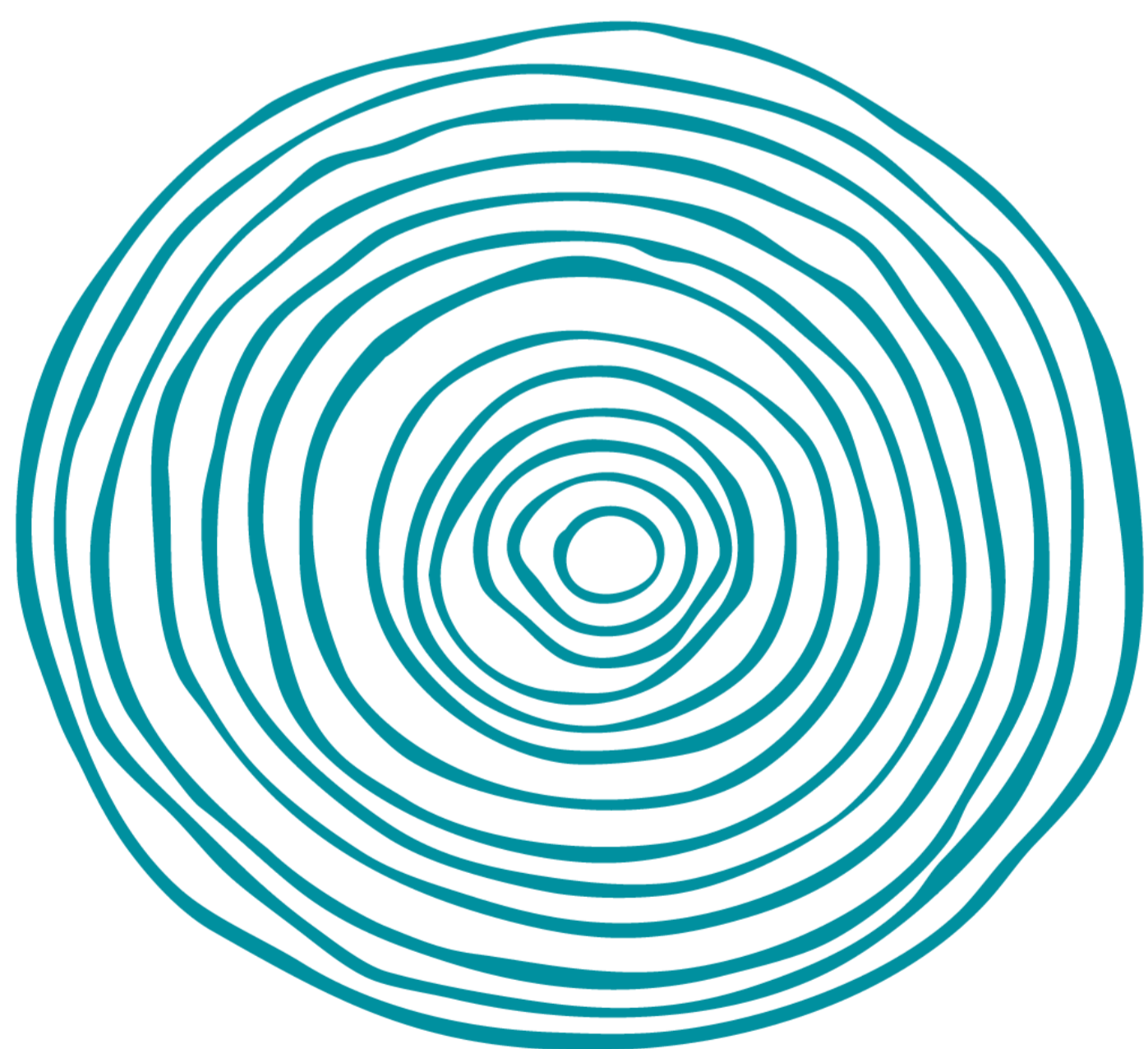
6.6 Suicide

Although often perceived as an issue primarily affecting young men, suicide is the leading cause of death for young women aged 15-24 [202]. Alarmingly, suicide rates of young women have increased by 47% over the past decade. Young women attempt suicide three times as often as young men [203].

Lesbian and bisexual women, women with intersex characteristics and trans women are at increased risk of suicidal behaviour, being almost four times as likely as their heterosexual peers to have tried to self-harm or suicide [204]. Suicide rates among Aboriginal and Torres Strait Islander women aged 15-19 are 5.9 times higher, and self-harming rates five times higher [205], than the corresponding rates for non- Aboriginal young women.

Connection to country and culture is important to the health of Aboriginal and Torres Strait Islander young women and strengthening this connection is widely considered the key to disrupting cycles of disadvantage [206]. Programs to address Aboriginal and Torres Strait Islander mental health and suicide prevention should include community-specific and community-led programs that focus on strengthening social and emotional wellbeing and cultural renewal, and should be delivered by community members [207].

Suicidal behaviour and self-harm in women can be viewed by family, health professionals and the community as attention-seeking, manipulative and non-serious [210], which can negatively influence how young women are treated. Suicide prevention efforts have focussed more on suicide mortality, which disproportionately affects men, rather than non-fatal suicide behaviours, which disproportionately affect women. There is a need for further research on suicide and suicidal behaviours in women in order to inform effective suicide prevention efforts.

Recent research has found that Aboriginal young people have a high uptake of digital technology [208] indicating the potential for the development of effective specialist digital/online health resources for Aboriginal young people.

The **iBobbly App** has been designed for Aboriginal young people aged 16-35 who are experiencing suicidal ideation and mental distress. iBobbly delivers messages and information to reduce suicidal thought in a culturally relevant way. Developed by the Black Dog Institute in partnership with Aboriginal organisations, the iBobbly pilot has received strong positive feedback. The app format overcomes geographical isolation and privacy concerns, giving it strong potential to reach those who don't normally seek help [209].

6.7 Opportunities to improve young women's mental health

Young women's mental health often begins to decline in late adolescence and early adulthood and is impacted by gender-based experiences. To improve the mental health trajectory of young women, health professionals, teachers, parents and peers need to take young women's concerns and symptoms more seriously. More than this, there is a need to 'join the dots' between women's experiences of sexual harassment, violence and trauma, and poor mental health outcomes.

Prevention and early intervention initiatives (including education, peer support and services) have the potential to significantly improve young women's mental health, however they are often not sensitive to the specific risk factors, needs and experiences of young women. Public mental health discourses tend to reinforce a focus on young men's mental health needs(for example in relation to suicide), and where gender-sensitive mental health services do exist, they tend to be aimed at men (for example, Mensline). More mental health promotion, prevention and early intervention initiatives should be developed, specifically addressing the needs and experiences of young women.

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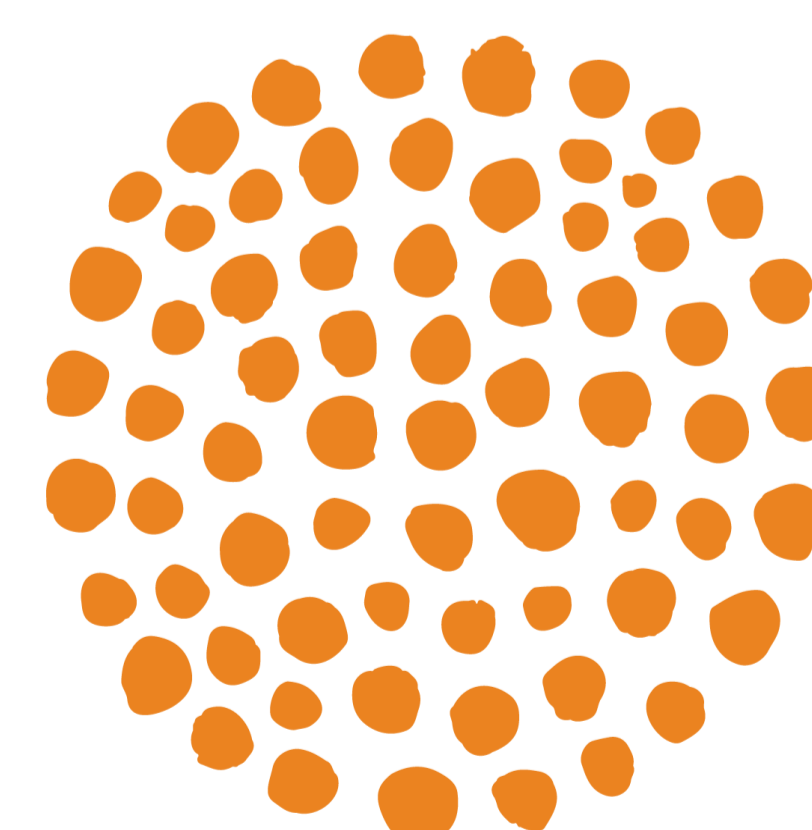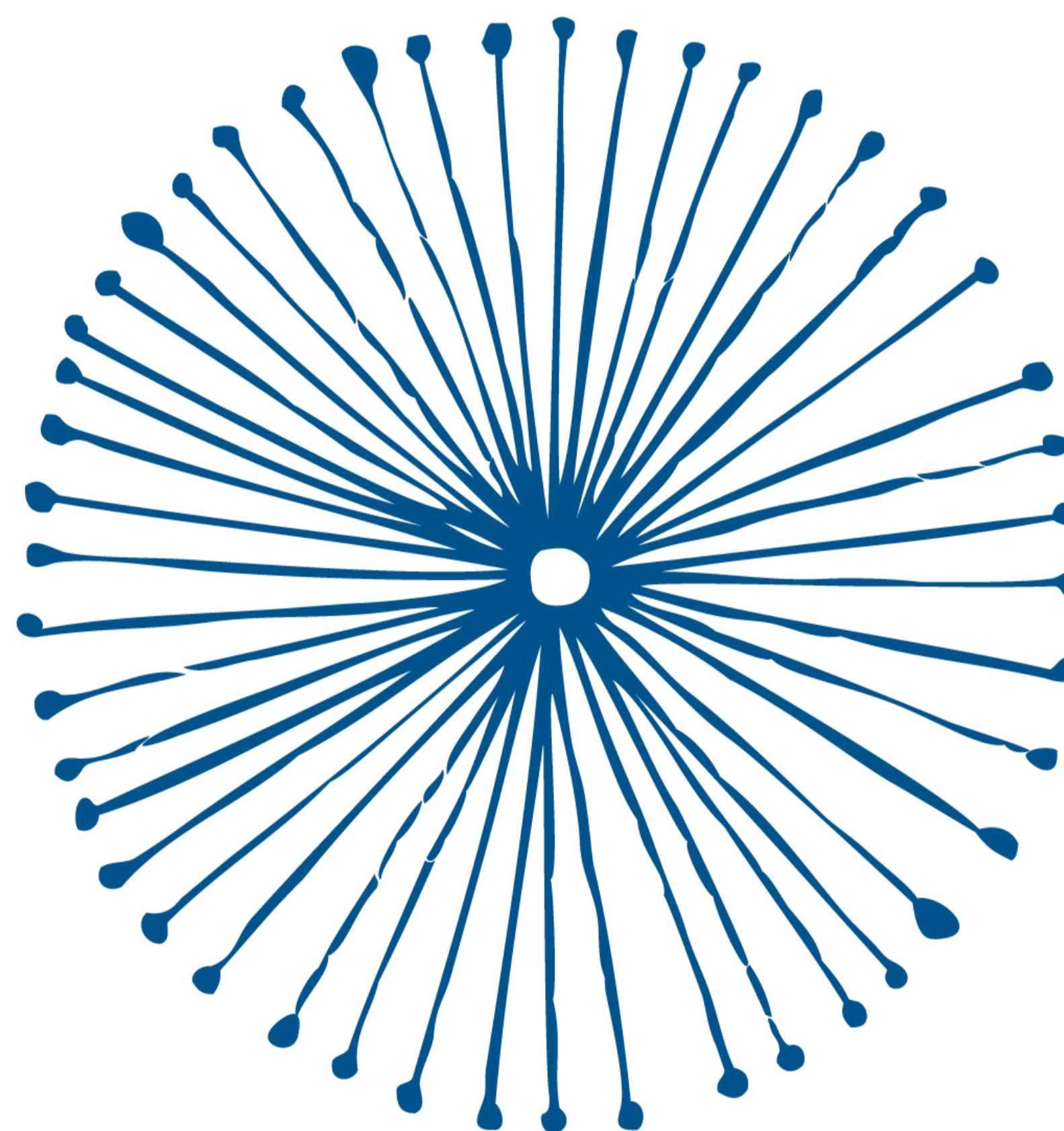
SOCIAL PARTICIPATION & INCLUSION

Full social inclusion means having the resources, opportunities and capabilities to participate fully and equally in education, employment and all aspects of community life, free from discrimination and disadvantage [211].

Many young women are active in taking on leadership and social-change roles within their school communities and other youth service settings. Indeed, young women are more likely than young men to report taking part in volunteering and student leadership activities [212] (for example, youth advisory groups such as student representative councils, the Victorian Government's Multicultural Youth Network and advisory groups for youth services such as Headspace).

Large numbers of young women are showing leadership and willingness to get involved in social change. If their youthful initiative is not leading to high-status, well-paid roles in the adult world, this is not due to any deficit in young women. Rather, we must address the discriminatory structures and attitudes which cause young female change-makers to be ignored and devalued. [213]

However, this experience of 'youth leadership' does not necessarily translate into leadership roles for these young women when they get out into the 'adult' world.

Young women still face barriers to social inclusion and are often excluded or discouraged from participating in many spheres of life because of their gender. For example:

- Only one in ten girls feels that they are always treated equally to boys and two-thirds believe that gender inequality is a problem in Australia [214].

- 56% of Australian girls report being seldom or never valued for their intellect or opinions over their looks [215].

- Young women's movement in public spaces and participation outside the home is restricted by fear of harassment and violence [216].

- At home, girls spend more time on household chores than their brothers, and yet receive less pocket money [217].

- In the workplace, it is reported that young women regularly experience sexual harassment from colleagues, customers and/or managers [218].

- Online, young women are more likely to be the targets of digital harassment by male perpetrators [219].
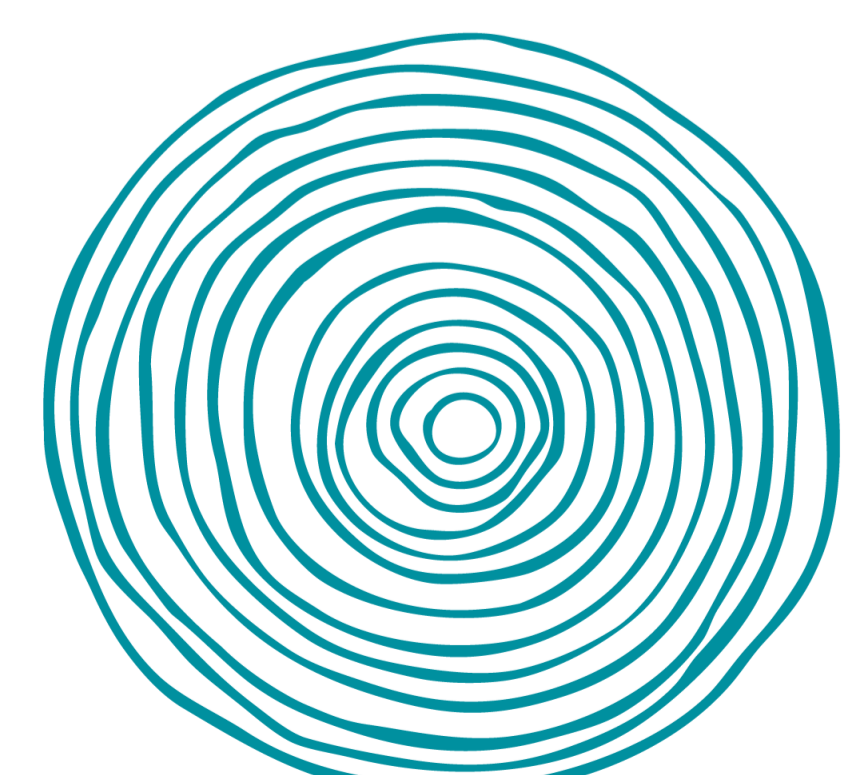
The **Fitzroy High School Feminist Collective** began its life in 2013. It started with a 'Book Club' elective class, where a student discussion about the violence visited upon a nameless female character in the text 'Of Mice and Men' revealed a sense of anger and frustration about gender inequality more broadly. This led to much discussion about the 'everyday sexism' the young women in the class endured, and that the young men in the class witnessed, and gave way to the realisation that young people needed to take action to address these issues in a secondary school context. A lunchtime Feminist Collective quickly developed into a timetabled elective class [220]. The Collective has now developed a teaching resource for other schools to use [221]. Called FightBack, the resource has units on systemic sexism, objectification and violence against women for Year 9 students [222].

Many young women experience additional and intersecting pressures and discrimination. Young women from migrant and refugee backgrounds experience barriers to accessing services for a range of reasons including increased family responsibilities, social isolation [223] and experiences of racism and discrimination. Young women with disabilities experience discrimination and violence in multiple settings including the home, the community and institutional settings [224].

These early experiences of gender-based discrimination, exclusion and harassment impact young women's health and the choices they make about their future.
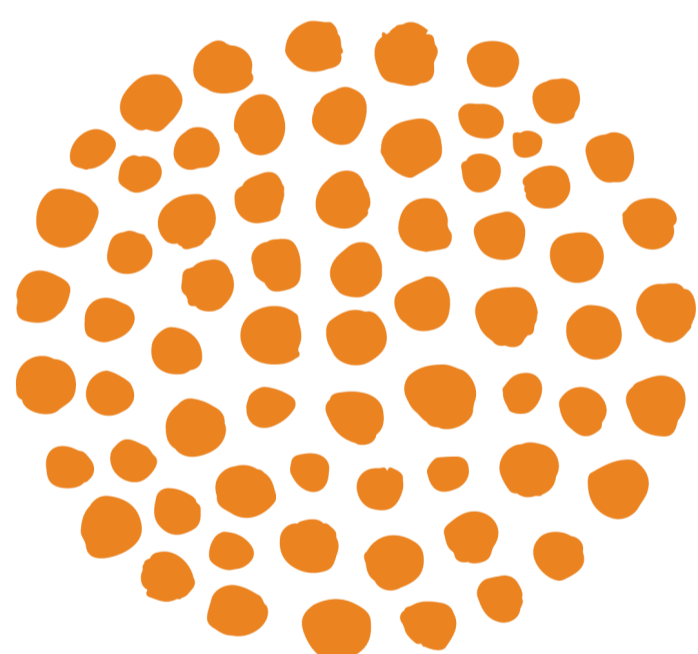
7.1 Home

Despite having more opportunities outside the home than previous generations of women, today's Australian girls aged 10-11 still spend more time on household chores each day than boys, including cleaning, cooking and taking care of pets [225]. Girls are aware that they do more housework than their brothers or boyfriends [226] and also report doing more homework than boys [227]. Despite doing more work at home, Australian girls receive on average 35% less pocket money than boys (on average $9.60 per week compared with boys' $13). It appears that young people in regional areas earn significantly less pocket money than their metropolitan peers [228]. Young women's experiences of gender inequality in the home, while they are growing up, shape expectations for adulthood. In 2017 in Australia the gender pay gap (for adults) is 15.3%, and women still do significantly more unpaid caring and housework than men.

Young women who have newly arrived in Australia face unique challenges. The settlement process during adolescence can be compounded by cultural dislocation, loss of social networks and, for some, the traumatic nature of their refugee experience [229]. A strong sense of their own cultural identity and traditions helps children build positive cultural identities for themselves [230]. However, negotiating maintaining cultural values while adapting to a new community may lead to tensions in some families [231]. Young migrant and refugee women have reported that compared with their brothers, they experience less freedom and greater expectations to help out at home [232].

'... there's not a lot of freedom in African families, and there's different treatment between boys and girls in families ... [girls are] being treated less than boys, boys are always being treated better.'

Young Sudanese woman, 21 years [233]

Though sex-disaggregated data is not available, research has found that Aboriginal and Torres Strait Islander adolescents report better subjective wellbeing in rural communities compared to their counterparts in urban centres. The authors speculate this may be due to greater kinship connections which bring a greater feeling of safety and security [234].

7.2 Education

In 2016, 83% of Australian young women aged 15-19 were engaged in study [235]. However, there are significant disparities in educational outcomes amongst young women. Approximately half as many Aboriginal young women aged 20-24 complete Year 12 [236] compared to the general population of young women in Australia [237].

Young women with a disability are significantly less likely than their peers without disabilities to finish Year 12 [238]. Negative community attitudes also restrict participation in education for girls with disabilities [239] and many students with disabilities are still educated in segregated environments.

'[Students and parents are] faced with two impossible options; a mainstream school with a meaningful curriculum but not enough support, or a special school where their child's physical needs may be met, but where they won't get the skills they need to compete in the labour market or enter tertiary education.' [240]

Girls may be subjected to sexualisation and sexual harassment at school [241]. For example, 71 Australian schools were recently implicated in 'pornography rings', where graphic sexual images of female students were shared without their consent by male students [242]. While many commentators blamed the young women themselves for taking the photos, others challenged this victim-blaming narrative, placing the responsibility on the male students who shared the images.

Sharna Bremner from the Australian university advocacy group End Rape on Campus argues that the sharing of explicit images of young women and girls without their consent is not just "innocent" adolescent male sexual curiosity. Young men and boys are able to access limitless pornography online, and in the case of school pornography rings: 'What they are getting off on is the very fact that these images are not consensual and that the victims have no idea they are being exploited.' [243]

When schools and universities do not intervene in student sexual harassment, it sends a message that it is acceptable behaviour [244]. How schools handle sexual harassment influences whether girls will report gendered violence in the future and whether they internalise the blame [245].

In 2017 the Australian Human Rights Commission released a National Report on Sexual Assault and Sexual Harassment at Australian Universities. The survey found that one in five students (26%) had experienced sexual harassment in a university setting, with women twice as likely as men to have experienced it [246].

Enabling Younger Women is a community development and leadership program run by Women with Disabilities Victoria. The program empowers young women with disabilities to develop their leadership, knowledge and advocacy skills in their transition from secondary education. Young women with disabilities are recruited to co-facilitate the program which aims to better prepare young women with disabilities to make the transition from secondary education to life post-school.

7.3 Clothing & school uniforms

Clothing, hair and personal grooming play a central role in shaping the body image of young people. The pressure to attain certain 'looks', through wearing brands and particular items of clothing, can exclude young people from economically disadvantaged backgrounds. While some students believe that school uniforms level out these pressures to some extent within school environments [247], school uniforms can also limit how girls move about at school.

Skirts and dresses restrict movement and can make playing sport uncomfortable. An Australian study found girls did significantly less exercise when they had to wear a dress than when they wore shorts [248]. The Victorian Equal Opportunity and Human Rights Commission has recently stated that requiring female students to wear dresses instead of pants may amount to 'direct discrimination' [249]. Requiring girls to wear uniforms that are stereotypically feminine is also problematic for girls who do not wish to conform with these ideals, or who wish to express a more androgynous or masculine gender identity.

In September 2017, the West Australian government made it compulsory for state schools to ensure girls had a choice of trousers and shorts. In Victoria, the state government is currently considering what steps it can take to ensure girls have the right to wear shorts and pants at every Victorian state school.

More and more schools are moving towards unisex uniform policies to allow their female students to wear pants and shorts [250].

School uniform requirements should be reassessed in terms of their contribution to creating equitable, diverse and inclusive school communities. This was highlighted recently when two sisters from African backgrounds in Melbourne were asked by their high school to take out their braids,on the basis that that white students at the school were not permitted to wear them.[251] However, the sisters argued that braids were part of their African culture and reported that braiding their hair made it healthier and easier to manage;

'It's a protective style. It looks good and it keeps our hair growing. Your hair is your crown, it is about embracing yourself, accepting yourself. It is part of our identity.' [252]

The sisters were subsequently given a school uniform 'exemption'.

7.4 Work

Significant gender differences are apparent in the types of jobs desired by 14-15 year old boys and girls. Top rated jobs for girls were doctor, education professional and legal or social professional. Top rated jobs for boys were engineering and transport professionals, ICT and construction [253].

Approximately two thirds of school students aged between 15-19 are in paid work [254]. However, while girls generally perform better than boys at school and attain higher qualifications, their average graduate salaries are 9.4% lower [255]. Young women report increasing rates of sexual harassment at work, especially in hospitality; many were teenagers at the time they were harassed [256]. A recent national survey by United Voice found that 89% of hospitality workers had experienced sexual harassment at work; 90% of those were women and half were younger than 24 years old [257].

Young women's experience of sexual harassment in the workplace can be normalised as part of providing 'good customer service' and is often not taken seriously by employers [258].

'I was asked to work early and late at age 15-16, without any supervision. At this time I was solicited for sex by a customer... I said no and kept working'

[259]

The Fair Work Commission's ruling in 2017 to reduce penalty rates for the retail and hospitality industries [260] will disproportionately affect young women, who make up a high proportion of these workforces. The retail industry is the largest employer of women under 25 years of age [261]. This will have a particularly negative impact on young women who leave school without a Year 12 or equivalent qualification, who are likely to go into part-time work in the industries affected.

Research identifies that young women believe that it would be easier to get a job if they were male, and that the lack of government support for affordable child care and adequate paid parental leave will impact their decision to have children [262]. Gendered experiences and pathways into work set young women up for higher rates of part-time and casual employment. For individual women, this leads to financial insecurity, and more broadly results in significant differences in pay and superannuation for women, compared to men [263].

7.5 Online

Girls use social media more frequently than boys [264], and girls and young women are overwhelmingly more likely to be the targets of harassment online, particularly sexual harassment, from male perpetrators [265].

Young women's experience of online harassment can include harassment on social networking sites, spreading rumours online, receiving unwanted and uninvited sexually explicit content, and posting of embarrassing or intimate images without permission. In a recent survey, 70% of Australian girls aged 15-19 reported believing that online harassment and bullying was endemic and that receiving unwanted sexually explicit content was common behaviour [266].

'[I want] more online and social media monitoring with the right authority and to offer protection for all girls.' [267]

Young women are expected to conform to contradictory gender. The taking and uploading of photos or 'selfies' on social media platforms is routinely derided as narcissistic, trivial and feminine. Yet, at the same time, in a world where they are objectified and valued for their looks over their opinions, young women are often pressured into taking 'sexy' photos of themselves [268].

New research highlights that Aboriginal and Torres Strait Islander young people use social media to connect with family and mob across the country and maintain intergenerational connections [269]. Social media is used by Aboriginal and Torres Strait Islander young people to learn and express their identity in a safe space [270]. However, most still report experiencing racism online.

7.6 Public spaces

Concerns about safety can restrict young women's movement in public places and outside the home [271]. A survey of 600 girls found that many had internalised victim-blaming attitudes, with one third believing that, in order to be safe, girls should not be in public spaces at night, and one quarter believing that they should not travel alone on public transport [272]. Experiences of harassment lead some young women to exclude themselves from nightlife.

Young women with a disability are significantly more likely to feel unsafe in the community [275].

Plan International's **Free to Be** project invited young women across Melbourne to map where they do and don't feel safe in the city [276]. Spaces where young women felt unsafe often included concentrations of businesses with masculine names and objectifying logos and advertising [277]. Crowded spaces were viewed as areas that perpetrators had the opportunity to conceal harassment, such as groping. Many young women reported negative experiences from being in the city at night [278].

Federation Square and the State Library were generally viewed as 'happy' spaces, with the busy-ness of these spaces viewed positively. The spaces that were rated most positively by young women tended to have small, unique brands with 'friendly' and 'attractive' graphics [279].

'I rarely go out after dark in the city any more after years of harassment from drunk men. To be catcalled, then verbally abused in a very aggressive manner if I don't respond or turn them down is incredibly scary. I don't like that they've won over the space, but I don't want to be bashed or raped. And the only way seems to be not for the men to stop but for me to leave.' [273]

'[Teach] boys not to be offenders rather than telling girls not to go out at night [or] wear certain clothing' [274]
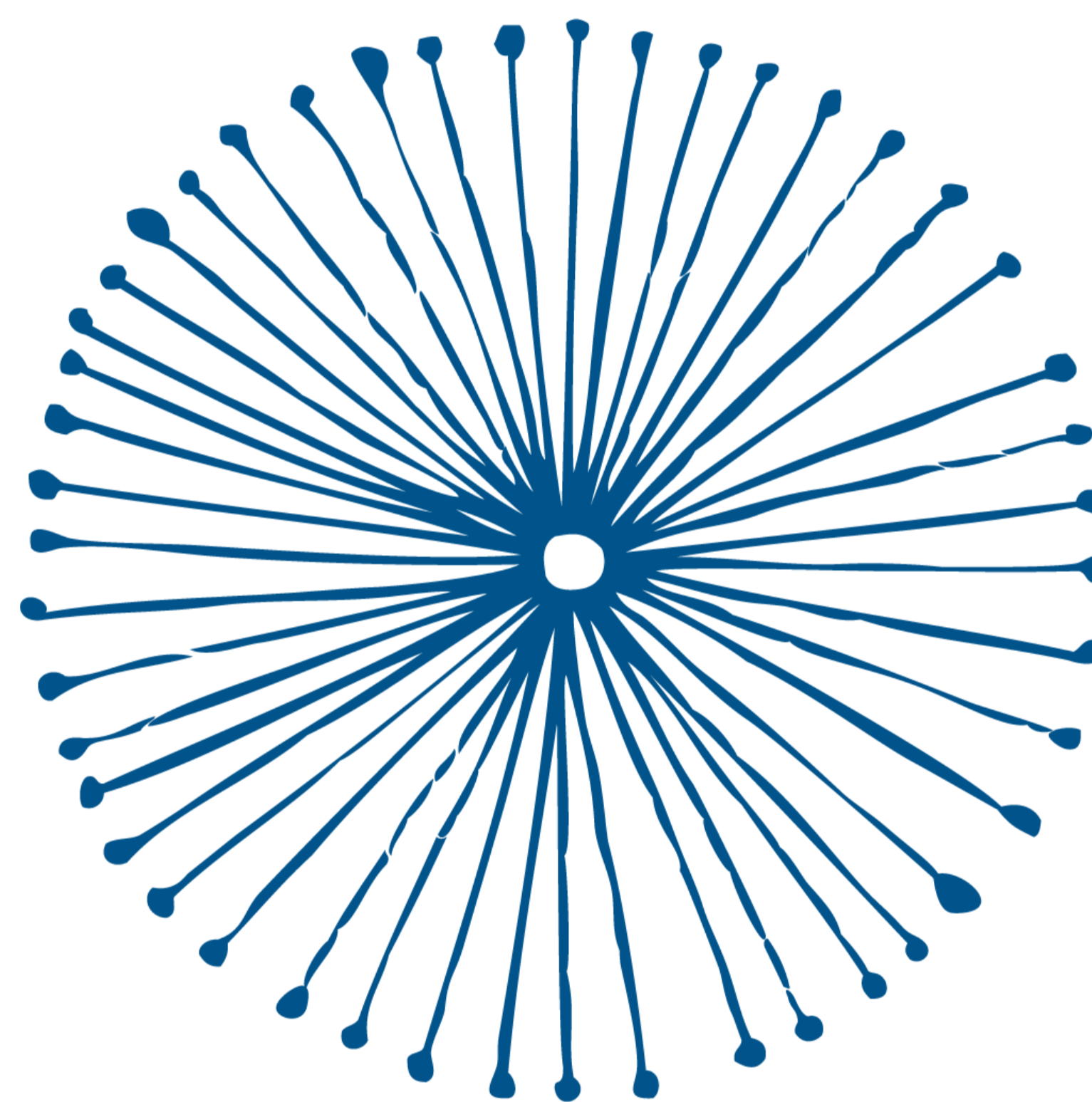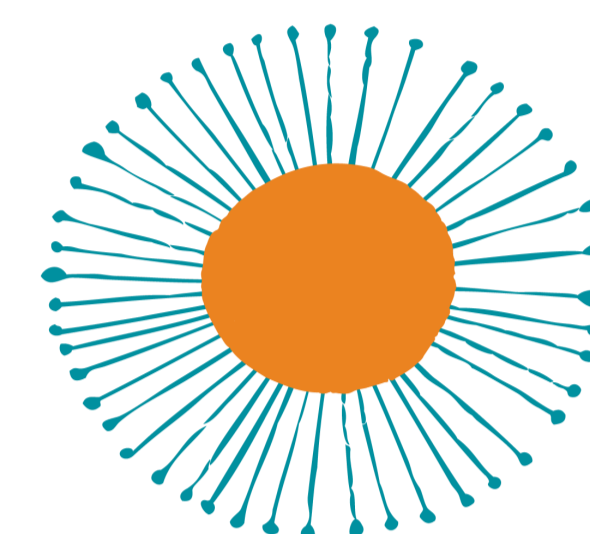
7.7 Opportunities to increase young women's social inclusion participation

It is encouraging to see emerging public critiques of school uniform requirements and increasing recognition of the impact of gender expectations on young women both inside and outside the home. Initiatives such as the *Free to Be* project are helping to bring young women's experiences of public spaces to light. Importantly, these types of initiatives also show young women that their experiences of harassment or exclusion are not individual, personal, or their fault. Instead, young women's experiences reflect a broader culture of entrenched gender inequality.

There are clear opportunities to enable young women to exercise their right to participate equally in the social and economic life of our community by improving gender-sensitive planning of public spaces, and introducing measures to prevent and respond to sexism, discrimination and sexual harassment in education, work and online environments.
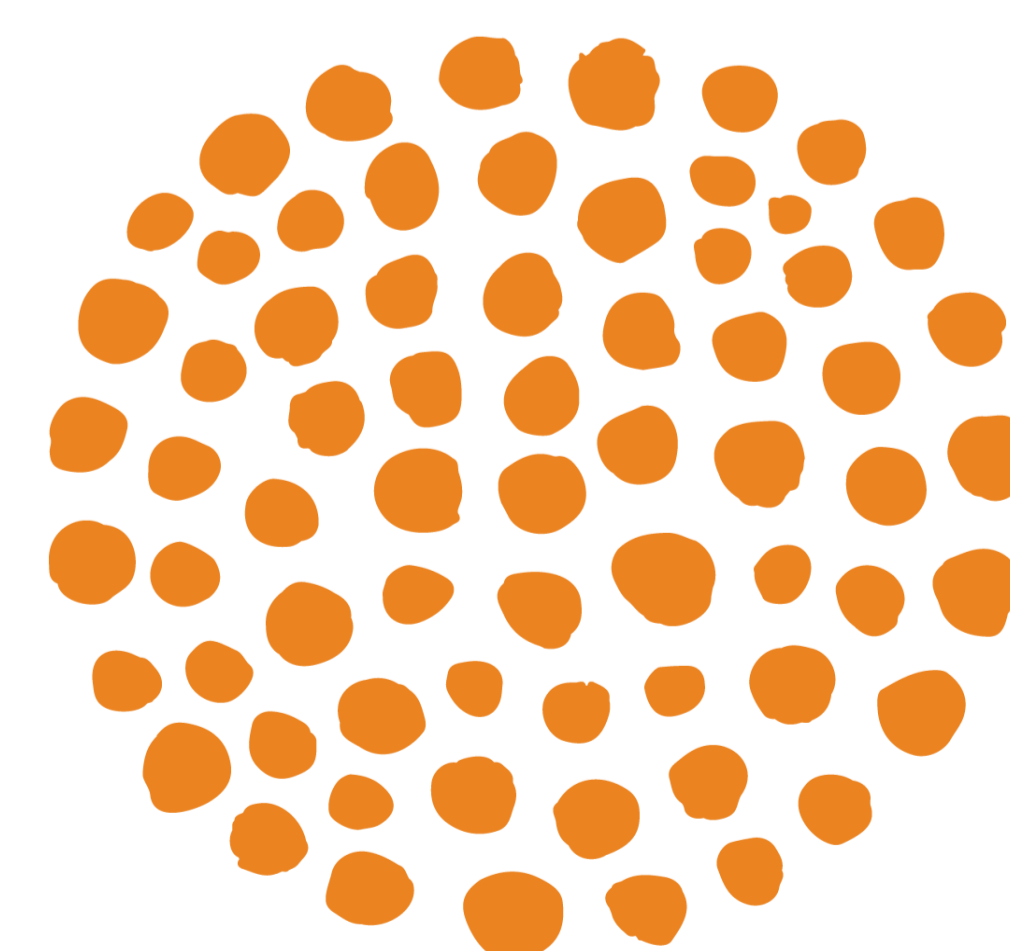
CONCLUSION

While most of the literature about young women focuses narrowly (and often necessarily) on one or another of the challenges experienced by young women, such as sexting, STIs or relationship violence, this paper has taken a different approach. We have tried to understand young women's experiences and health outcomes from a more multidimensional, holistic perspective, closer to the lived experience of being a young woman today.

To do this we have examined young women's experiences across six interrelated priority health areas: physical health, sexual and reproductive health, body image, relationships, mental health and social inclusion. By 'zooming out' and taking a wider perspective on young women's lives we have shown that the confluence of sex and gender expectations, in a broader context of gender inequality, profoundly shapes health outcomes for young women.

Young women report high levels of stress, and this is not surprising when we consider that they are doing more housework and homework than their brothers, feel less comfortable and safe in their neighbourhoods, and feel valued less for their brain and abilities than for their looks.

Many of the findings in this paper paint a bleak picture of the challenges and harms young women experience before the age of 20.

This reflects both the tendency for literature relating to young women to focus on risk (risk to reputation, risk of pregnancy or sexual assault), but also the challenging, complex and difficult reality of young women's lives. We have made an effort to highlight examples of promising practice, attitudinal change and protective interventions throughout the paper. Excitingly, many of these promising initiatives have been developed or led by young women themselves.

Several key themes have emerged through this research, as being key to young women's health and wellbeing:

- **Improving gender equality would lead to improved health outcomes and experiences for young women.** Gender unequal norms, practices and structures continue to limit young women's equal and full participation in many aspects of life.

- **An intersectional approach is required to understand and respond to the experiences of young women**. Some young women experience relative privilege while others experience relative disadvantage. Gender inequality is not the only system of oppression contributing to unfair or uneven health outcomes for young women.

- **Challenging sexualisation and objectification of women and girls at the societal level** has the potential to improve young women's body image, increase their physical activity, and improve their mental and emotional wellbeing, sexual experiences and relationships.

- **Health professionals, parents and schools all have a role to play** in challenging and changing the gender norms and expectations that limit and disadvantage young women.

Preparation of this paper has identified several gaps in the research related to young women in Australia. For example, qualitative research investigating the role of young women's friendships as a protective factor for health, and research into the impact of exposure to/consumption of pornography on young people's relationships and sexual experiences.

WHV also recommends further research into the specific needs and experiences of gender and sexuality-diverse young people. In particular, there is an opportunity to investigate whether there are shared 'drivers' that contribute to poorer health outcomes across all of these groups – for example, pressure to adhere to a narrow and limiting set of gender expectations. If so, this may suggest the need to apply a gender transformative approach to improving young people's health, in order to break down rigid and limiting gender stereotypes, norms and structures, and the systems of privilege and discrimination that both underpin and reinforce them.

In addition to gaps in the research, more needs to be done to ensure that resources and services do not adopt a homogeneous view of young people and are responsive to intersections of class, gender, ethnicity, race, sexuality, geographical location and community.

Based on these themes and gaps, we have developed both general and detailed recommendations to support better, more equitable health outcomes for young women and girls. These overarching recommendations complement and build on the opportunities to improve young women's health identified throughout this paper.

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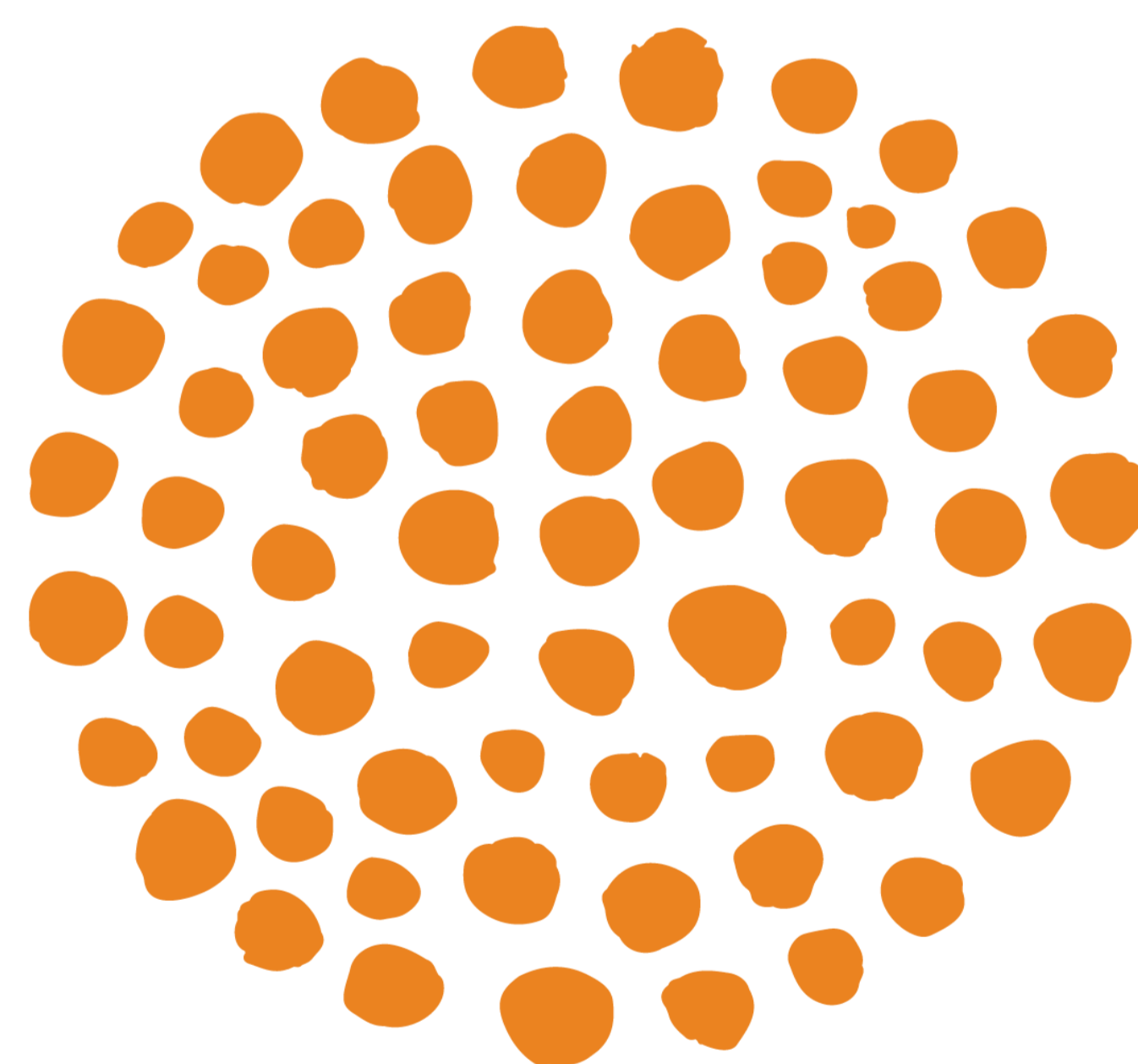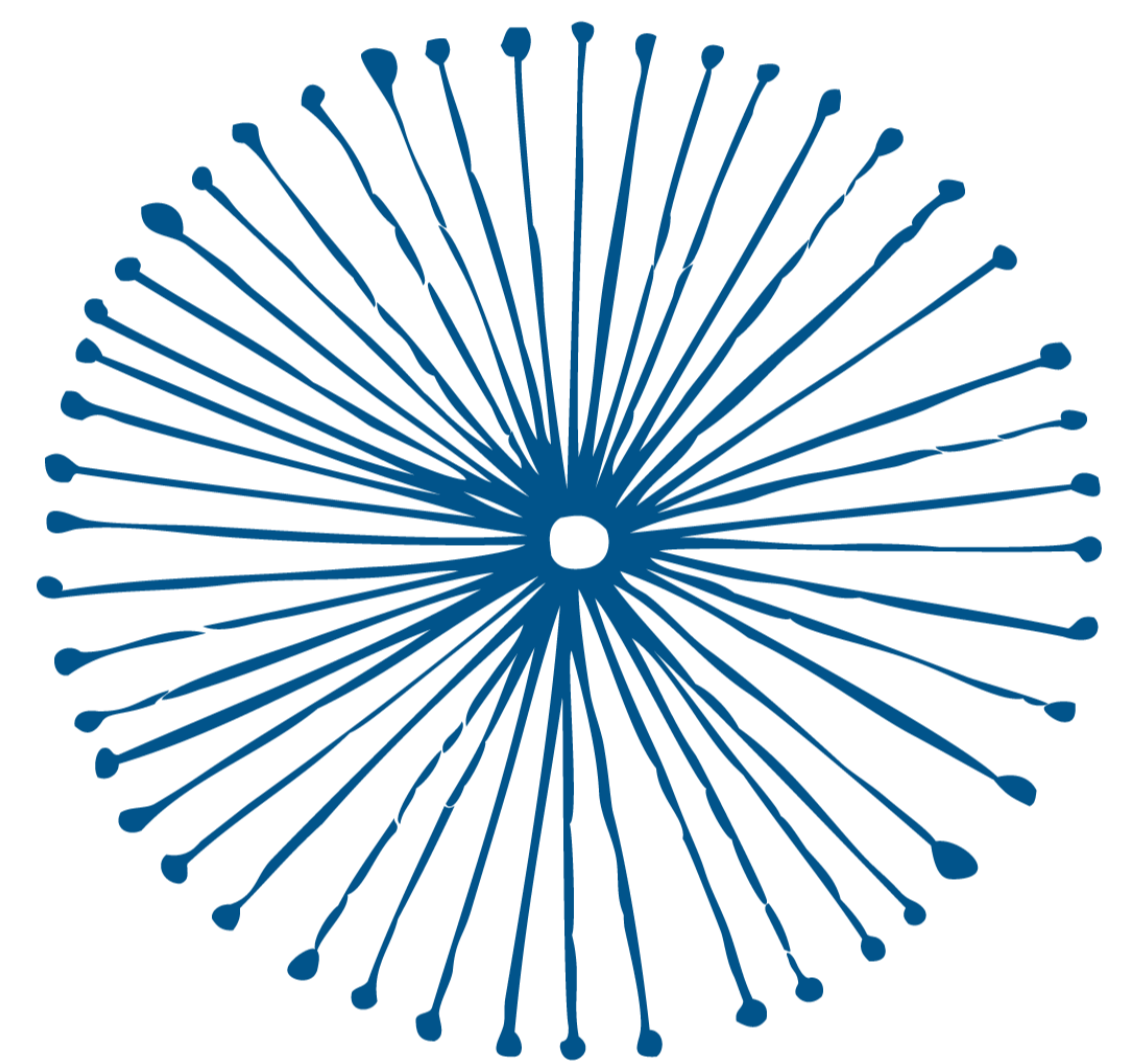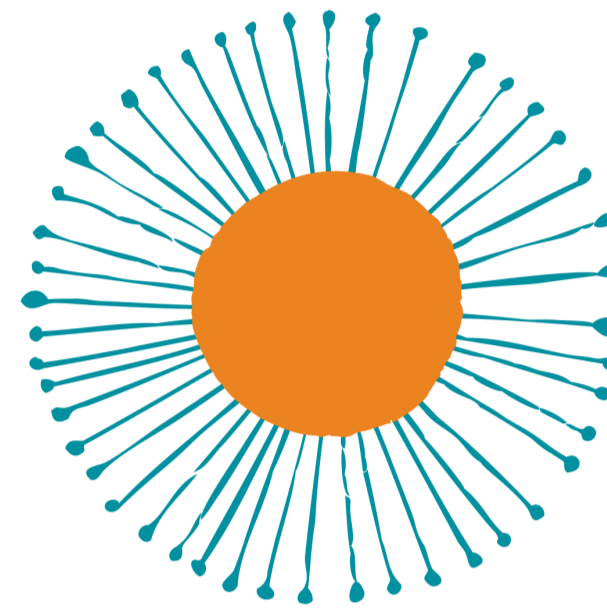
RECOMMENDATIONS

1

Enhance young women's health literacy by providing high quality, accessible and engaging health resources and education

- Create resources on mental health, body image and self-esteem especially for young women, guided and informed by their experiences.

- Ensure sexual and reproductive health education programs include (critical) discussion of gender and gender inequality as well as sex and biology, includes a focus on women's sexual pleasure and masturbation.

- Create accessible, plain language sexual and reproductive health resources that young people can access independently online or via apps (on topics such as body image, menstruation and healthy relationships).

- Promote existing digital resources such as *The Labia Library* and *Love: The Good the Bad and the Ugly* and integrate these resources into education programs.

- Ensure tailored sexual and reproductive health information and education programs are available in a range of languages and formats, and are sensitive to cross-cultural variations in understandings of sexuality and gender roles and relations.

2

Actively engage young women in the design and delivery of initiatives aimed at or affecting them.

- Celebrate and acknowledge the positive aspects of young women's health, agency, resilience and leadership.

- Actively consult with young women when developing services or initiatives, including through representative groups such as the Victorian Student Representative Council and the Multicultural Youth Network.

- Empower young women to know their rights, especially in relation to health services and how to provide feedback and make effective complaints.

- Undertake qualitative research investigating:

  - The ways young women manage and conceptualise risk and exercise agency and resilience.

  - How concepts and experiences of friendships are impacted by gender, and the role of friendships as a protective factor for health.

3

Tackle sexualisation and objectification of girls and women and promote positive body image

- Raise awareness about the impacts of poor body image for young women and its drivers, including sexualisation, gender inequality, racism and ableism.

- Mobilise and equip young people, researchers, schools, health professionals and parents to start a new conversation about the objectification of women and how everyday attitudes, language and language can impact how young women feel about themselves and how they are valued by others.

- Include critical media skills in health, sex and relationships education.

- Ensure that strategies for promoting gender equity and preventing violence against women prioritise work with all forms of media and popular culture (including film, television, advertising and entertainment) to make the link between sexualisation and objectification of women, gender inequality and the drivers of violence against women.

- Advocate for improved representation of women and girls in public spaces, including through stronger regulation of advertising.

- Undertake research into the impact of exposure to/consumption of pornography on young women's body image, sexual and reproductive health, sexual pleasure and relationships. Undertake complementary research with young men about how pornography influences their sense of sexuality and attitudes to young women and pleasure.

4

Take a gender-sensitive approach to research, services and interventions to better meet the needs of young women

- Mainstream gender sensitivity by ensuring that services and professionals working with young people consider and are responsive to the specific challenges that young women experience due to sex and gender expectations.

- Encourage health professionals to take young women's experiences seriously, acknowledging their concerns, pain and experiences, particularly in relation to poor body image, reproductive health conditions such as polycystic ovarian syndrome and endometriosis, and in relation to self harm.

- Examine current and new services, resources and interventions and consider opportunities to change language or approaches that might exclude or be harmful to young women:

  - Have their symptoms or concerns been taken seriously?

  - Are young women empowered to make meaningful choices about their health?

  - Have sex or gender differences in risk factors, symptoms and/or treatment options been considered?

  - Has support provided been culturally sensitive and safe?

  - Has support provided come from a holistic perspective that acknowledges the context and complexity of young women's lives?

- Ensure that research and interventions affecting young women are informed by sex disaggregated data.

5

Ensure that work with young women takes an intersectional approach and is responsive to the other factors that impact young women's lives beyond sex and gender.

- Avoid homogenising approaches to young women's health and wellbeing by recognising that the experience of sex and gender based inequality interacts with experiences of ableism, homophobia, racism and socio-economic and rural disadvantage.

- Work in partnership with organisations with specialist expertise on the needs of specific groups of young women, such as Aboriginal women and women from newly arrived and migrant backgrounds, to ensure that services are culturally safe.

- Ensure that multilingual health information and resources are available and provided in a range of community languages.

- Access workforce development and training provided by organisations with expertise on gender and disability to ensure that young women with disabilities are included in programs and services, and that disability services are provided in a gender sensitive way.

- Apply an intersectional gender lens to planning for public spaces and commissioning of public art to ensure these spaces are as welcoming, safe and inclusive of young women and girls.

6

Aim for gender transformative approaches to working with young people, including working with young men and boys to foster alternative and more positive forms of masculinity.

- Take a gender-transformative approach by working with young men and boys to challenge and critique rigid gender expectations for both sexes and harmful forms of masculinity that lead to poor health outcomes for women and men.

- Shift the focus onto young men's choices and responsibilities in relation to sexual assault, sexual harassment, relationship violence and unplanned pregnancy, instead of focusing on choices made by young women.

- Equip young men with the skills and knowledge to ensure they have informed consent from their sexual partners.

- Ensure work with young men and boys is pro-feminist and evidence-based and does not reinforce rigid gender norms or a sense of power and entitlement over women.

7

Support and resource parents, teachers, schools, and community organisations to better understand and be responsive to the many specific challenges young women face during adolescence, due to the intersection of sex and gender.

- Ensure all young people are provided with high quality RRE, tailored to meet the needs of specific groups as appropriate. Support schools to adopt a whole of school approach to RRE.

- Support parents to raise healthy, happy daughters by creating resources for parents about gender and language, how to support positive body image, how to challenge victim blaming, and how to promote gender equity in relation to chores and pocket money, etc.

- Proactively review the way that physical education is taught in schools to ensure that it is meeting the needs of young women and girls.

- Ensure that non-school based sports and recreation program, clubs and services are equitable, welcoming and inclusive for young women and girls.

- Create opportunities for young women to share experiences and provide support to one another, like the Fitzroy High School Feminist Collective.

10

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